31 July 2025

Via submission portal: https://www.pc.gov.au/inquiries/current/mental-health-review#interim

Catholic Health Australia Submission: Mental Health and Suicide Prevention Agreement Review

Thank you for the opportunity to provide Catholic Health Australia (CHA)'s views on the interim report of the Mental Health and Suicide Prevention Agreement Review. CHA appreciates the work of the Treasury and Productivity Commission in exploring policy options to transform and improve Australia's mental health and suicide prevention system.

CHA's submission addresses key recommendations and information requests from the draft report, drawing on the experience of our members as providers of holistic, person-centred care. We offer both support and suggestions for strengthening the proposed reforms, particularly in areas such as collaborative commissioning, workforce development, suicide prevention, peer workforce integration, and national governance.

We welcome the Commission's recognition of the need for a more coordinated, accountable, and outcomes-focused mental health and suicide prevention system. The next Agreement is a vital opportunity to address longstanding fragmentation and ensure services meet the needs of individuals, families, and communities in ways that are both evidence-based and compassionate.

CHA welcomes the opportunity to contribute to ongoing discussions and assist in the implementation of a new National Mental Health and Suicide Prevention Agreement that is fit-for-purpose and delivers on its commitments to a more resilient, sustainable, and equitable mental health care system for all Australians.

If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

Dr Katharine Bassett
Director of Health Policy
Catholic Health Australia

Catholic Health Australia

Submission: Mental Health and Suicide Prevention Agreement Review

July 2025

Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Background

The Productivity Commission (PC) is leading a review of the National Mental Health and Suicide Prevention Agreement (the National Agreement), which sets out the shared intention of Commonwealth, state and territory governments to work in partnership to strengthen the mental health system and reduce the incidence of suicide of all Australians.

The National Mental Health and Suicide Prevention Agreement (National Agreement) sets out the shared intention of the Commonwealth, state and territory governments to work together to:

- improve the mental health of all Australians
- reduce the rate of suicide towards zero
- improve the Australian mental health and suicide prevention system.

The interim report of the Mental Health and Suicide Prevention Agreement Review (the Review) articulates the following:

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

CHA understands that the PC has assessed progress under the National Agreement (Chapter 2), evaluated its overall effectiveness (Chapter 3), and identified key areas for future focus and reform (Chapter 4). We have also explored the unique considerations for supporting the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples (Chapter 5), as well as opportunities to strengthen suicide prevention services (Chapter 6).

This submission consolidates CHA's views on the draft recommendations, findings and information requests outlined in the interim report. It includes proposals aimed at enhancing productivity across the care economy and supporting the long-term integration of care systems. Additionally, it offers broader commentary on key opportunities to ensure the findings meaningfully inform the development of a new National Agreement that strengthens the mental health system and contributes to the Productivity Commission's broader goals of advancing national prosperity and economic progress.

As Australia's largest non-government network of health, community, and aged care services, Catholic Health Australia (CHA) and its members play a leading role in the care economy. With deep experience across the sector, CHA is well positioned to meaningfully contribute to the current policy reform agenda. This submission reinforces the case for a cohesive, system-wide response that delivers care more efficiently and, most importantly, returns more time to care.

Overall comments

Mental health is a fundamental aspect of an individual's overall health and wellbeing. It is influenced by a variety of factors, including personal attributes, as well as a range of cultural, economic, political, and environmental elements.

Addressing these factors necessitates a comprehensive, whole-of-government approach encompassing awareness, prevention, treatment, and recovery. Notably, mental health is closely linked with physical health, as individuals with mental illnesses are more susceptible to developing physical ailments and often have reduced life expectancy compared to those without mental health conditions.

Australia's mental health system is built on a stepped care model, which aligns the intensity of support with individual needs. This approach promotes early intervention and efficient resource use, ensuring people receive the least intrusive care necessary, with escalation only when required. Private hospitals play a vital role in this model, offering specialised inpatient and outpatient services that complement public and community-based care. The next National Agreement presents a pivotal opportunity to embed consistency, collaboration, and transparency at the heart of Australia's mental health reform. While the current National Agreement has laid important groundwork by fostering cooperation between the Commonwealth, state, and territory governments, significant structural and operational challenges remain.

CHA acknowledges the progress made toward systemic, coordinated, and compassionate reform. However, fragmented funding models, siloed service delivery, and potentially duplicative governance arrangements continue to impede the development of truly integrated, person-centred care.

We emphasise the need to leverage private sector capacity to meet growing care demands and improve system productivity. Including both public and private sectors in governance arrangements will ensure reforms are grounded in the realities of service delivery and better positioned to deliver timely, effective care.

To address these challenges, the next National Agreement should commit to:

- consistency in service delivery, funding approaches, and policy implementation across jurisdictions, including across both public and private sectors
- collaboration that actively includes all stakeholders, including governments, service providers, communities, and people with lived experience
- transparency in funding flows, performance outcomes, and decision-making processes
- clarity in roles and responsibilities, particularly for national leadership bodies such as the National Mental Health Commission and the National Suicide Prevention Office, to ensure accountability and avoid duplication
- breaking down siloes across the health, aged care, and disability sectors to enable seamless, whole-of-person support
- continuous monitoring and evaluation to track progress, inform policy adjustments, and drive quality improvement across the system.

By embedding these principles, the next National Agreement can deliver a more equitable, resilient, and compassionate mental health and suicide prevention system. CHA remains committed to working with government and sector partners to support reform implementation. Genuine collaboration, guided by strong leadership and a shared vision, is essential to building a care system that meets the needs of all Australians, now and into the future.

Contents

Item	Page number
Our list of recommendations	6
Chapter 2: What has the National Agreement achieved?	9
Chapter 4: Towards an effective agreement	11
Chapter 6: Suicide Prevention	36

Our list of recommendations

Recommendation 1: That the Australian Government prioritises the release of the National Guidelines on Regional Commissioning and Planning to realise greater productivity gains through strengthening the capability and collaboration of key commissioning bodies with the sector.

Recommendation 2: That the renewed National Mental Health Strategy clearly align with broader health reform agenda, and outline how it will be integrated with existing jurisdictional mental health and wellbeing plans. As part of this, the Strategy should be supported by the following:

- A comprehensive action plan that consolidates federal-level initiatives, minimising duplication and promoting coordinated efforts across governments and sectors;
- Clear assignment of roles and responsibilities for each initiative, ensuring accountability and transparency in implementation; and
- A structured approach to sector consultation, enabling diverse voices and perspectives to shape the Strategy and ensure it reflects the needs of all stakeholders.

Recommendation 3: Ensure the next National Agreement includes a clear transition plan for ongoing initiatives between the current National Mental Health Strategy and the National Suicide Prevention Strategy, to maintain continuity, minimise disruption, and support sector readiness for future reforms.

Recommendation 4: Ensure that an interim solution to address funding gaps is designed and implementation within parameters of the National Health Reform Agreement (NHRA) should the current National Agreement inclusive of its funding commitments be extended to June 2027.

Recommendation 5: Building on from lessons learnt of the current National Agreement, the next National Agreement should include clear terms of reference for stakeholder collaboration and co-design.

Recommendation 6: Expand Draft Recommendation 4.4 so that:

- State and Territory governments lead the design and implementation of psychosocial support services given their proximity to local health service systems and communities; and
- The Australian Government provides dedicated funding to cover the current shortfall in psychosocial supports through a grant funding scheme with defined eligibility criteria and embedded outcome measures to ensure alignment with shared national reform objectives.

Recommendation 7: Further to Draft Recommendation 4.5, the next National Agreement should identify State and Territory governments as the appropriate level of government to hold responsibility for planning and funding carer and family support services. This approach acknowledges the importance of jurisdictional legislative frameworks and the capacity of local governments to engage with people with living and lived experience in designing meaningful supports.

To ensure this recommendation is implemented effectively, it should be aligned with Draft Recommendation 4.2. This alignment is critical to fostering genuine collaboration between stakeholders, underpinned by recognised incentive structures established by the Australia Government that promotes shared responsibility and coordinated action.

Recommendation 8 Drawing on findings from this Review, the Productivity Commission develop a draft governance framework as part of the Final Report to enhance the transparency and effectiveness of the next National Agreement. This framework should clearly define the

interactions between key stakeholder groups, with a strong emphasis on collaboration, transparency, and accountability. It should also outline mechanisms for reporting and evaluation to ensure ongoing oversight and continuous improvement

To support a comprehensive and inclusive approach, Draft Recommendation 4.6 could be simplified to broadly reference broader sector representation in governance forums, including, but not limited to, people with lived and living experience.

Recommendation 9: Ensure the National Agreement is adequately resourced and funded to support its core administrative functions. This includes enabling effective governance, facilitating timely and coordinated information-sharing, and addressing cultural and organisational barriers that may hinder implementation and collaboration across jurisdictions.

Recommendation 10: To strengthen the principles outlined in Draft Recommendation 4.7, explicitly reference the need for transparent recruitment processes of people with lived and living experience to participate as subject matter experts on relevant forums to provide strategic oversight and input. As part of this, emphasise the development of the next National Agreement as an opportunity to role-model meaningful codesign, setting the precedent for jurisdictions, and the sector more broadly, to adopt inclusive, transparent, and accountable engagement practices beyond the life of the National Agreement.

Recommendation 11: Findings from sector responses to Information Request 4.2 could be reflected in an evaluation framework to assess the extent and quality of engagement of people with lived and living experience of mental ill-health and suicide in relevant governance forums:

- Self-reported satisfaction with the engagement process (e.g. via surveys or feedback)
- Perceived influence on decision-making
- Clarity and transparency of communication
- Timeliness and responsiveness of follow-up actions
- Evidence of impact, such as changes to policies or decisions that reflect stakeholder input

Recommendation 12: Ensure that governance arrangements under the next National Agreement include broader sector representation that reflects the realities of the mental health and suicide prevention system, particularly the interdependencies between public and private service providers.

Recommendation 13: The next National Agreement should establish a streamlined regulatory and reporting framework, which could include:

- development of national accreditation standards to guide consistent mental health and suicide prevention service quality
- a centralised reporting system to consolidate data requirements and reduce duplication
- clear articulation of how accreditation standards align with reporting templates and structures, including shared objectives and indicators
- a clear, transparent reporting structure that is meaningful, consultative, and promotes shared accountability.

Recommendation 14: That the NMHC's responsibilities are consolidated under a single recommendation — Draft Recommendation 4.10 — so that its full role in monitoring, reporting, and supporting implementation of the National Agreement is clearly articulated in one section.

Recommendation 15: In alignment with Draft Recommendations 4.9 and 4.10, the NMHC should be responsible for managing centralised data sources from jurisdictions and overseeing the maintenance of the public dashboard. To support this function, the NMHC should work in partnership with the AIHW to collate, analyse, and publish dashboard data that tracks progress against the objectives and outcomes of the next National Agreement.

Recommendation 16a: Expand Draft Recommendation 4.10 to "Clarify and formalise the role and functions of the NMHC within the next National Agreement" and include a consolidated version of proposed changes to the NMHC's responsibilities as articulated in previous draft recommendations.

Recommendation 16b: As part of this consolidation, articulate how the role of the National Suicide Prevention Office will work alongside the revised role of the NMHC in monitoring and reporting on progress of the next National Agreement.

Recommendation 17: Revise Draft Recommendation 4.11 so that the surveys are implemented "at least every three years" instead of "every five years" to ensure data collected can meaningfully reflect changes in the mental health system and support timely policy responses.

Recommendation 18: Strengthen national consistency in mental health commissioning by providing dedicated resourcing and funding for Primary Health Networks (PHNs) to embed collaborative commissioning as a core operational function. This should include support for enabling frameworks, data infrastructure, and the flexibility to design and implement early intervention and preventative care initiatives tailored to local community needs. PHNs should also be expected to engage public and private providers to make full use of system capacity. Successful local models should be evaluated and scaled nationally to drive consistency and equity.

Recommendation 19: Include explicit wording in the next National Agreement to articulate its interactions with the National Mental Health Workforce Strategy, including future iterations. This may include explicit provisions within the National Agreement requiring that the Strategy be developed in consultation with the sector. Additionally, the National Agreement should commit to shared funding responsibilities and workforce reforms to address critical workforce shortages across public and private settings.

Recommendation 20a: To ensure peer workers are recognised as essential members of a multidisciplinary mental health workforce, the development of a nationally consistent scope of practice should include the following actions:

- Engage with the national professional association for peer workers (once established) to ensure sector-led input and representation.
- Evaluate the impact of PHN-GP partnerships in commissioning peer worker services, focusing on their effectiveness in meeting care needs across the sector.
- Identify and address barriers to workforce entry and career progression within the peer workforce, ensuring inclusive and sustainable pathways.

Recommendation 20b: Ensure that the development of a nationally consistent scope of practice for the peer workforce is embedded within the National Mental Health Workforce Strategy. This will enhance alignment with broader mental health and care workforce planning efforts, including integration with the National Skills and Capability Framework and Matrix, and support the long-term sustainability of the peer workforce.

Recommendation 21: Similar to the treatment of jurisdiction-specific mental health and wellbeing plans, there should be clear guidance on how discrepancies between the National Mental Health and Suicide Prevention Evaluation Framework and jurisdiction-specific evaluation frameworks should be treated. Clear requirements for public sharing of evaluation findings should also be included in the evaluation framework.

Submission

Chapter 2: What has the National Agreement achieved?

Findings from the interim report, alongside the National Mental Health Commission's National Report Card, underscore the significant pressures facing Australia's mental health and wellbeing system. The system continues to struggle to meet rising demand and deliver improved outcomes for those in need. The interim report also identifies persistent data gaps and challenges in understanding the current state of the mental health and suicide prevention system, which have made it difficult to assess the progress achieved since the National Agreement was signed. This is a matter of deep concern for CHA and its members, who believe that genuine reform requires a comprehensive, whole-of-government approach that spans awareness, prevention, treatment, and recovery.

The National Agreement represents a critical step forward in fostering collaboration between the Australian, state, and territory governments to improve mental health outcomes and ensure the sustainability of the mental health and suicide prevention system. CHA acknowledges the progress made in initiating systemic, coordinated, and compassionate reform. However, further work is needed to overcome persistent barriers to effective collaboration, particularly fragmented funding models that impede the implementation of innovative, integrated approaches to care. Addressing these challenges is essential to achieving a truly person-centred and responsive mental health system for all Australians.

Recommendation 2.1 Deliver key documents as a priority

Draft recommendation 2.1 By the end of 2025, the Australian Government should publicly release:

- the National Stigma and Discrimination Reduction Strategy
- detailed National Guidelines on Regional Planning and Commissioning that meet the needs of primary health networks and local hospital networks

As outlined in Table 2.1 of the interim report, most national outputs identified in the National Agreement have been delivered. CHA notes that majority of the outputs have been iteratively delivered since the signing of the National Agreement, and therefore, will require sufficient timeframes to assess the effectiveness of these outputs in contributing towards the broader goal of a sustainable, person-centred mental health and suicide prevention system. The interim report provides detailed commentary on this matter, which have been outlined in Table 2.2.

Specific items that have yet to be delivered include:

- the National Stigma and Discrimination Reduction Strategy, including an associated action or implementation plan; and
- the National guidelines on regional commissioning and planning.

Release of the National Stigma and Discrimination Reduction Strategy

CHA finds the lack of clarity around the status of the National Stigma and Discrimination Reduction Strategy and associated plans for action concerning. In line with our commitment to caring for the most vulnerable members of the community, CHA strongly supports draft Recommendation 2.1 to publicly release the Strategy. Doing so will lay the groundwork for further policy development aimed at addressing stigma and discrimination, which are key drivers of adverse care outcomes across the mental health and suicide prevention system. Public

consultation and feedback are essential to ensure the Strategy is fit for purpose, responsive to diverse stakeholder needs, and adaptable to evolving challenges in mental health and suicide prevention.

Release of the National Guidelines on Regional Commissioning and Planning

CHA strongly supports the action for Government to urgently release the National Guidelines on Regional Commissioning and Planning as part of draft Recommendation 2.1. Effective commissioning models, particularly collaborative commissioning, offer a powerful mechanism for improving outcomes, addressing fragmentation, and delivering greater value for investment. These guidelines have the potential to foster meaningful cooperation among government agencies, local health services, community organisations, private providers, and consumers. The delayed release of these guidelines has hindered the ability of health services to meaningfully engage in local and regional mental health planning. By providing a clear framework for collaboration across the care continuum, the guidelines would enable services to be better aligned with individuals' comprehensive needs — physical, mental, and social — thereby reducing duplication, service gaps, and inconsistent care. This is essential given the current challenges facing Australia's mental health and suicide prevention system.

For these guidelines to be effective, they must recognise the different roles played by providers across the continuum of care — not only Primary Health Networks (PHNs) and Local Health Networks (LHNs), but also community-managed organisations, and private and not-for-profit services. In addition, while some variation is necessary to reflect local community needs, a unified approach would enhance the effectiveness of key commissioning bodies, such as PHNs. Through the establishment of consistent guidelines, commissioning bodies would be better positioned to optimise resource allocation, respond to priority health needs in a timely manner, and promote interoperable data systems and knowledge-sharing across regions. These productivity gains would be further supported by strengthened capabilities in population health tracking, outcome reporting, and service coordination, thereby addressing many of the challenges identified in the interim report regarding the effectiveness and achievements of the current National Agreement.

Moreover, the guidelines offer a valuable opportunity to lay the foundation for integrated care in emerging domains, such as virtual care. By enabling more seamless collaboration across the care continuum, they would help overcome persistent barriers to accessing safe, high-quality care in the right place and at the right time.

Recommendation 1: That the Australian Government prioritises the release of the National Guidelines on Regional Commissioning and Planning to realise greater productivity gains through strengthening the capability and collaboration of key commissioning bodies with the sector.

Chapter 4: Towards an effective agreement

Recommendation 4.1 Developing a renewed National Mental Health Strategy

Draft Recommendation 4.1 Developing a renewed National Mental Health Strategy A National Mental Health Strategy is needed to articulate a clear vision, objectives and collective priorities for long-term reform in the mental health system over the next 20–30 years. The National Mental Health Commission should oversee the development of this Strategy and undertake a co-design process with people with lived and living experience, their supporters, families, carers and kin. The National Mental Health Strategy should take account of the objectives and actions included in the National Suicide Prevention Strategy, which was released in early 2025. The next National Mental Health and Suicide Prevention Agreement should include actions governments will take over the agreement's term that are aligned with the long-term objectives articulated in the strategies.

CHA overall supports draft recommendation 4.1 as the key considerations to guide the development of a renewed National Mental Health Strategy.

CHA supports the next National Agreement being explicitly aligned with both the renewed National Mental Health Strategy and the existing National Suicide Prevention Strategy. Establishing a consistent and coordinated framework is essential to clarify roles and responsibilities, streamline initiatives, and unify objectives across jurisdictions. Anchoring the sector's efforts in a shared source of truth will enable more effective collaboration and drive progress toward a more integrated, responsive, and outcomes-focused mental health and suicide prevention system.

The renewed National Mental Health Strategy should clearly align with the broader health reform agenda, including its integration with existing jurisdictional mental health and wellbeing plans. To ensure coherence and effectiveness, the Strategy should include:

- **a comprehensive action plan** that consolidates federal-level initiatives, minimising duplication and promoting coordinated efforts across governments and sectors
- **clear assignment of roles and responsibilities** for each initiative, ensuring accountability and transparency in implementation
- **a structured approach to sector consultation**, enabling diverse voices and perspectives to shape the Strategy and ensure it reflects the needs of all stakeholders.

CHA also supports the recommendation that the National Mental Health Commission lead this work through a codesign process with people with lived and living experience, their families, supporters, and carers. Genuine codesign is essential to ensuring that services respond not only to clinical need but also to the social, spiritual, and cultural factors that shape each person's mental health journey.

A renewed Strategy must also grapple with the systemic drivers of distress, such as trauma, disconnection, poverty, discrimination, loneliness, and injustice. Mental health cannot be treated in isolation from the social conditions that shape it. CHA encourages the Commission to adopt a holistic vide of mental health that reflects this complexity and creates space for cross-sector collaboration, including with housing, disability, justice, and education.

Furthermore, the Strategy should also guide future iterations of national agreements by ensuring that shorter-term actions and investments are clearly aligned with long-term goals. This is crucial for maintaining direction and coherence across government, jurisdictions, and providers. To that

end, the Strategy must include measurable objectives, timelines, and mechanisms for accountability, while allowing space for innovation and local responsiveness.

This approach will help create a unified and strategic foundation for reform, supporting a more integrated and responsive mental health and suicide prevention system.

Recommendation 2: That the renewed National Mental Health Strategy clearly align with broader health reform agenda, and outline how it will be integrated with existing jurisdictional mental health and wellbeing plans. As part of this, the Strategy should be supported by the following:

- A comprehensive action plan that consolidates federal-level initiatives, minimising duplication and promoting coordinated efforts across governments and sectors;
- Clear assignment of roles and responsibilities for each initiative, ensuring accountability and transparency in implementation; and
- A structured approach to sector consultation, enabling diverse voices and perspectives to shape the Strategy and ensure it reflects the needs of all stakeholders.

The next National Agreement should clearly outline how ongoing initiatives will be transitioned between the current National Mental Health Strategy and the National Suicide Prevention Strategy. Without defined transitional arrangements, there is a risk of confusion, duplication, or disruption in service delivery and policy implementation. A well-articulated transition plan will help ensure continuity, prepare the sector for new priorities or frameworks, and support stakeholders in adapting to changes effectively. This clarity is essential for maintaining momentum, safeguarding existing progress, and enabling a smooth evolution toward a more integrated and coordinated mental health and suicide prevention system.

Recommendation 3: Ensure the next National Agreement includes a clear transition plan for ongoing initiatives between the current National Mental Health Strategy and the National Suicide Prevention Strategy, to maintain continuity, minimise disruption, and support sector readiness for future reforms.

Recommendation 4.2 Building the foundations for a successful agreement

Draft recommendation 4.2 Building the foundations for a successful agreement

The current National Mental Health and Suicide Prevention Agreement, including funding commitments, should be extended until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy. To support the next agreement:

- the National Mental Health Commission should run a co-design process with people with lived and living experience, and their supporters, families, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes
- the Department of the Prime Minister and Cabinet should convene negotiations with the support of the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities
- commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement rather than a separate schedule. Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration
- the Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention. Implementation plans to develop any new indicators should be in place within 12 months of the agreement being signed.

CHA partially supports draft Recommendation 4.2 to extend the current National Agreement, including its funding commitments, until June 2027. This extension provides a valuable opportunity for robust sector consultation and further policy development to ensure the next Agreement is comprehensive and fit-for-purpose. It is essential that the next National Agreement is closely aligned with the National Health Reform Agreement (NHRA) to support a more integrated and sustainable approach to mental health and suicide prevention.

CHA is concerned, however, that simply extending the existing Agreement without addressing its funding limitations risks entrenching the status quo, at a time when demand is rapidly outstripping capacity. Public mental health services are under considerable strain, characterised by long wait times, limited bed availability, and growing unmet need. This pressure is being felt acutely in emergency departments, community services, and inpatient settings alike.

In this context, private hospitals — many of them not-for-profit, mission-driven providers — are playing a vital complementary role. They provide high-quality mental health care that helps reduce the burden on public services, facilitates more timely access, and prevents deterioration through early intervention. However, the current Agreement does not adequately reflect or fund this contribution, despite the clear system-wide benefit it offers.

If the existing functions and funding commitments are to be extended until 2027, an interim solution must be developed to address these funding and integration caps, particularly through coordination with ongoing NHRA reform work. This may include clearer mechanisms for private sector involvement, more equitable funding flows for mental health services delivered outside the public system, and investment in collaborative models that span both public and private care.

Without these measures, Australia risks missing a critical opportunity to enhance access, reduce fragmentation, and improve outcomes for people living with mental ill health or at risk of suicide. The additional time afforded by an extension must be used not only to design a better agreement, but to bridge the urgent capacity gaps in the current system.

Recommendation 4: Ensure that an interim solution to address funding gaps is designed and implementation within parameters of the National Health Reform Agreement (NHRA) should the current National Agreement inclusive of its funding commitments be extended to June 2027.

Clarity in objectives and intended outcomes

Chapter 3 of the interim report identifies the absence of effective, measurable objectives and outcomes as a key barrier to progress, one that must be addressed in the next National Agreement. CHA welcomes this insight and agrees that the next Agreement presents a critical opportunity to reset and clarify shared goals, demonstrating a unified commitment among stakeholders to building a more person-centred, effective, and efficient mental health and suicide prevention system.

To achieve this, the National Agreement must include clear terms of reference for stakeholder collaboration and co-design. This should outline structured processes for engagement, particularly for people with lived or living experience, ensuring their voices meaningfully shape the vision and objectives of the National Agreement. Such an approach would foster a shared understanding of priorities and enable stakeholders to align their contributions with clearly defined outcomes over the life of the National Agreement. This terms of reference should be part of the drafted recommendation, which outlines that commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the National Agreement as opposed to a separate schedule.

Recommendation 5: Building on from lessons learnt of the current National Agreement, the next National Agreement should include clear terms of reference for stakeholder collaboration and co-design.

Incentivising collaboration across all stakeholders

CHA strongly supports the drafted recommendation for governments to allocate dedicated funding for collaborative initiatives and enablers of collaboration. This funding could be directed toward large-scale, cross-sector initiatives with shared public health goals, such as the development of a National Preventative Health Framework[1] or toward activities that promote the consistent use of the National Mental Health and Suicide Prevention Evaluation framework by relevant bodies.

The mental health sector in Australia encompasses a diverse and complex stakeholder landscape, including public health services, private providers, non-government organisations, community groups, and lived experience advocates. Within this ecosystem, public and private providers should be viewed as complementary partners, each bringing unique strengths and capabilities. Public services often deliver foundational and acute care, while private providers contribute specialised expertise, innovation, and additional capacity.

Collaborative engagement between these sectors is essential to ensure efficient use of resources, reduce service duplication, and improve continuity of care. By working together, stakeholders can better align efforts with shared priorities, streamline service delivery, and achieve more integrated and person-centred outcomes across the mental health system.

[1] Refer to CHA's submission to the Productivity Commission on Pillar 4 – Delivering care efficiently here.

Clear governance and accountability measures

To ensure accountability and strategic resource allocation, it is essential that a clearly designated individual or group oversees the distribution of funding. This is particularly important for enabling effective engagement between the Australian, state, and territory governments on shared priorities, as outlined in draft Recommendation 4.2. Strong governance and leadership are critical to translating collaborative intent into coordinated action and measurable outcomes.

Given the need for cross-government collaboration, the Department of the Prime Minister and Cabinet (PM&C) should lead negotiations for the next National Agreement, supported by advice and input from the National Mental Health Commission (NMHC). PM&C is well-positioned to fulfil this role, given its mandate to coordinate whole-of-government policy development and implementation, and its capacity to align efforts with national priorities.

It is CHA's understanding that a similar approach was adopted for the National Health Reform Agreement (NHRA), and that the processes and lessons learned from that experience could inform the development of the next Agreement.

Measuring outcomes

CHA supports the Australian Institute of Health and Welfare (AIHW) leading the development of a nationally consistent set of outcome measures for mental health and suicide prevention. To ensure these measures are meaningful and actionable, it is critical that they are underpinned by clearly defined outcomes and supported by robust, relevant data indicators. This will enable transparent tracking of progress and inform continuous improvement across the sector.

A clear monitoring and evaluation plan should be embedded from the outset, allowing outcomes to be tracked and measured over a designated reporting period. This ensures that the initiative is not a "set and forget" exercise, but rather a dynamic framework that evolves with emerging evidence and changing needs.

These outcome measures, which may include reductions in suicide rates, improved access to mental health services, and enhanced patient-reported outcomes, should be matched with data sources that are timely, reliable, and capable of capturing both quantitative and qualitative dimensions. This will enable a more nuanced understanding of what works, for whom, and under what circumstances.

To reinforce accountability, structured progress reporting mechanisms should be established. This might include regular reviews at the Health Ministers' Forum, where achievements and progress against these developed outcome measures are discussed. Incorporating formal oversight processes will ensure that mental health and suicide prevention remain high priorities at the national level, and that implementation of these outcome measures are continuously monitored, evaluated and refined.

There is also a strategic opportunity to establish partnerships with agencies such as the Australian Digital Health Agency (ADHA) and the Australian Centre for Evaluation (ACE). These collaborations can help align methodologies, promote interoperability across data systems, and streamline data collection and reporting. Leveraging their expertise will support the development of indicators that are not only evidence-based but also practical and scalable.

Recommendation 4.3 Stronger links to the broader policy environment

Draft recommendation 4.3 The next agreement should have stronger links to the broader policy environment

The next agreement should articulate its role within the policy environment and specify the way it links with other key policy documents. This will require consideration of the interactions with a range of policy areas including housing, justice, disability supports and more. As a starting point, the next agreement should link to:

- the National Health Reform Agreement, which provides much of the funding for the mental health and suicide prevention system
- key policies in relevant non-health portfolios, such as the Better and Fairer Schools Agreement which will support the whole-of-government approach needed to improve mental health and suicide prevention outcomes (draft finding 4.1)
- jurisdictional mental health and suicide prevention policy documents, which should inform the bilateral schedules developed under the agreement
- policy documents related to Aboriginal and Torres Strait Islander social and emotional wellbeing, including the National Agreement on Closing the Gap (draft recommendation 5.1).

CHA supports the key elements of Draft Recommendation 4.3, particularly where they establish a strong foundation for further policy development. These elements are critical to ensuring that the next National Agreement is both fit-for-purpose and effective in delivering on its objectives, most notably, the creation of a person-centred, outcomes-driven mental health system. As a mission-based provider, we are acutely aware that the fragmentation of policy domains often leaves individuals and families navigating disconnected systems at their most vulnerable. We urge governments to treat this recommendation as foundational, not optional, to the success of the next agreement. It is only through sustained, cross-portfolio collaboration that we can build a mental health system that is truly preventative, inclusive and equitable.

CHA particularly supports the proposed linkages with the NHRA. Given the NHRA provides much of the underlying funding for hospital-based mental health care, it is essential that the two agreements work in concert to improve system integration, clarify roles across public and private sectors, and ensure resources are directed toward timely, appropriate care. At present, inconsistencies between the NHRA and the current mental health agreement contribute to fragmentation, inefficiencies, and gaps in service access, particularly where private hospitals are excluded or underutilised despite their significant capacity and capability.

Leverage private capacity

The next National Agreement should look to leverage capacity across public and private mental health care sectors. CHA members' private hospitals are well-positioned and able to support the public system in addressing unmet demand for services. In adopting lessons learnt from NHRA, the next National Mental Health and Suicide Prevention Agreement could include:

- incentives for jurisdiction systems to use private hospital mental health bed capacity, this might include public hospitals receiving additional support from the NHRA and/or the National Agreement to expand existing services
- a national contracting framework to streamline the establishment and operation of public-private partnerships (PPP), reducing administrative burdens and promoting efficiency gains
- full funding pass-throughs from states to private providers, avoiding discounted pricing to enable private providers to maintain quality and viability of services, ensuring fairness

and consistency, and maintains clarity in how public funds are used to address care needs.

To complement these structural reforms, the National Agreement should also ensure that early intervention and preventative care initiatives are appropriately funded. Maintaining hospital avoidance — that is, strategies and programs designed to prevent unnecessary hospital admissions and poorer health outcomes — should remain a policy priority for the Australian Government. This approach not only improves patient outcomes but also enhances system sustainability and cost-effectiveness.

Ensure reforms are appropriately contextualised

CHA strongly agrees that the next National Mental Health and Suicide Prevention Agreement must be better integrated within the broader policy and funding landscape. Mental health does not exist in a vacuum, as it is deeply shaped by social, economic, cultural and environmental factors. A more cohesive and deliberate alignment between mental health policy and other national frameworks is critical to delivering person-centred care and achieving meaningful reform.

While it is important for the next National Mental Health and Suicide Prevention Agreement to establish stronger links to the broader policy environment, it must also ensure cohesion and clarity across fragmented funding models and policy settings in health-adjacent sectors. A one-size-fits-all approach will not be sufficient.

Mental health outcomes cannot be improved without addressing social determinants such as safe housing, access to education, family and domestic violence, justice system involvement, and disability supports. These intersecting needs are common among the people CHA members serve, many of whom face complex disadvantage that places them at elevated risk of both mental ill health and suicide. Initiatives such as the *Better and Fairer Schools Agreement* highlight the potential of a whole-of-government approach to improving mental health and suicide prevention outcomes. However, realising this potential requires a considered and coordinated strategy that accounts for the distinct priorities, operational frameworks, and funding mechanisms across sectors such as education, housing, justice, and social services.

Aged care is a particularly relevant example, where the Australian Government is the primary funder and regulator, and states and territories have limited formal involvement. This creates a unique dynamic in which mental health services for older Australians must be integrated into a system that operates largely outside of jurisdiction-specific health infrastructure. Addressing these nuances is essential to ensure that mental health reform efforts are inclusive, equitable, and responsive to the needs of all population groups.

Further, CHA supports the integration of jurisdictional mental health and suicide prevention policy documents into bilateral schedules developed under the next Agreement. This approach can help bridge gaps between levels of government, reduce duplication, and ensure that each jurisdiction's expertise and responsibilities are recognised in meeting the mental health needs of their communities.

To facilitate this level of cross-sectoral and intergovernmental alignment, PM&C should lead the negotiation process for the next Agreement. As the central agency responsible for whole-of-government policy coordination, PM&C is uniquely positioned to convene stakeholders across jurisdictions and portfolios. Its leadership, supported by expert input from bodies such as the NMHC, will be critical to ensuring that roles and responsibilities are clearly defined, national priorities are reflected, and collaborative intent is translated into coordinated action and measurable outcomes.

Additional Schedule in the next National Agreement - alcohol and other drug use

CHA notes that Information Request 4.1 seeks views on whether an additional schedule should be included in the next National Agreement to address the co-occurrence of problematic alcohol and other drug use, mental ill health, and suicide. While acknowledging the importance of addressing these intersecting issues, CHA cautions that introducing a separate schedule specific to alcohol and other drug use may risk creating further overlap and fragmentation across existing policy frameworks.

Given the complexity of these issues, particularly within the mental health context, where roles and responsibilities often intersect across sectors, it is essential to ensure clarity and coordination. CHA recommends that this subject matter may be more appropriately addressed within a broader public health framework, such as through the NHRA, where cross-sectoral integration is already a focus to further the Government's health priorities.

Instead of a standalone schedule, the next National Agreement could reference and support the National Drug Strategy, aligning with its initiatives and reinforcing a coordinated approach. This would help avoid duplication, clarify jurisdictional responsibilities, and promote more effective integration of services across mental health, alcohol and other drug use, and suicide prevention.

Workforce settings to support increased access to mental health services

An integrated and coordinated national agreement must also be supported by the right workforce policy settings to ensure timely and equitable access to mental health services. Persistent workforce shortages, particularly in psychiatry, are limiting access across both public and private settings, with many patients facing long wait times or substantial out-of-pocket costs. Reforms to migration policy could play a key role in alleviating these shortages; for example, allowing overseas-trained psychiatrists to be linked to private hospitals for inpatient admissions and restricted outpatient consults, without requiring full compliance with the 10-year moratorium, would create a safe and flexible pathway to expand capacity. Additionally, permitting these professionals to work across both public and private sectors on a part-time basis would further enhance service availability and reduce delays in care. Moreover, reviewing telehealth policy settings to enable psychiatrists to more easily diagnose and prescribe via telehealth would strengthen early intervention and support continuity of care.

At the same time, it is important to rebalance incentives away from short telehealth consultations and back toward inpatient care, where workforce shortages are most acute. Increasing the Medicare rebate for inpatient psychiatry services in private hospitals from 75 per cent to 100 per cent of the schedule fee would help retain psychiatrists in inpatient settings, reduce gap fees for patients, and ensure that private hospitals can continue to relieve pressure on the public system. Embedding these policy levers into the next national agreement will be critical to addressing workforce access and achieving a more sustainable, person-centred mental health system.

The next agreement should also support the implementation of a nationally consistent scope of practice for the peer workforce and other emerging roles. Clearly defined and appropriately supported scopes of practice will strengthen multidisciplinary care, promote safe and effective service delivery, and improve workforce sustainability in a system that increasingly relies on both clinical and non-clinical practitioners.

Strengthening private health insurance and supporting the role of private mental health providers

The next National Agreement must acknowledge and address the challenges faced by private mental health service providers, particularly in relation to private health insurance policy settings, which have a direct bearing on access, affordability, and continuity of care. Private hospitals and day programs play a critical role in alleviating pressure on the public system, yet outdated policy frameworks and product limitations continue to create barriers for consumers and providers alike.

A key area for reform is the design of private health insurance products. Many current products offer limited mental health coverage, and there is a pressing need for a review of product structures to ensure mental health treatment is covered in a way that is fit-for-purpose, transparent, and responsive to consumer needs. Reforms should include removal or reduction of waiting periods for people upgrading to access psychiatric care, recognising that people often seek help at a time of crisis and should not face unnecessary delays. In particular, waiting periods for mental health care should be removed for all patients 30 years of age or younger. This policy adjustment would ensure young Australians who are experiencing increasing levels of mental health challenges receive better access to care. In parallel, the extension of default benefit arrangements to include community-based mental health care would support step-down models of care, reduce unnecessary hospital admissions, and enable more sustainable and person-centred service pathways.

Access could also be improved by revising current eligibility criteria for mental health day programs. The requirement for assessment exclusively by a hospital-credentialed psychiatrist can create unnecessary treatment delays. Allowing assessments by appropriately trained and qualified health professionals, such as psychologists or mental health nurse practitioners, would expedite access and better reflect contemporary models of care.

Finally, the next agreement should support a review of risk equalisation settings and broader private health insurance policy architecture to ensure the private sector remains viable and responsive in meeting mental health needs. A reformed risk equalisation system should better reflect age and sex related differences in claim costs, as recommended by the Finity review commissioned by the Department of Health, Disability and Ageing. As part of a genuinely mixed health system, private providers must be recognised and supported as equal partners in delivering mental health services, especially in regions or populations where they are the primary or sole provider.

Recommendation 4.4 Address the unmet need for psychosocial supports outside the National Disability Insurance Scheme

Draft recommendation 4.4 Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme

The Australian, state and territory governments need to immediately agree to responsibilities for psychosocial supports outside the National Disability Insurance Scheme. State and territory governments should be responsible for commissioning services and commence work to address the unmet need. The next agreement should:

- confirm the roles and responsibilities for psychosocial supports and the funding split between the Australian, state and territory governments
- include Australian Government funding to the state and territory governments to help cover the shortfall in support
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030.

Psychosocial supports refer to non-clinical services that help people with mental ill-health live independently and participate in their communities. These supports include assistance with daily living, social connection, and accessing services such as housing, education, and employment. They are essential for long-term recovery and wellbeing, particularly for people with moderate to severe mental illness.

Given the framework and eligibility criteria of the National Disability Insurance Scheme (NDIS), only a small proportion of people with psychosocial disability qualify for support through the scheme. This leaves an estimated 500,000 people without access to psychosocial supports through the NDIS or other programs.

Establishing a coordinated approach to address this unmet need is critical. Psychosocial supports should be made available outside of the NDIS to ensure broader access, particularly for those with episodic or moderate mental illness who do not meet NDIS eligibility. Delivering these supports outside the NDIS would also allow for greater flexibility and regional responsiveness, enabling integration with health and social services tailored to local needs of jurisdictions.

The current lack of clarity around which level of government is responsible for funding and delivering psychosocial supports has led to fragmentation, duplication, and inefficiencies in service provision. This ambiguity has created significant barriers for both consumers and service providers, contributing to service gaps and inconsistent access across jurisdictions.

CHA supports Draft Recommendation 4.4 as a necessary starting point for the next National Agreement to address these longstanding issues. As mission-based providers, CHA members are committed to holistic care and see firsthand the human and social cost of inadequate psychosocial support, especially for individuals who fall through the cracks of existing service systems.

While the NDIS plays a crucial role for a defined cohort, it was never intended to meet the needs of all people with psychosocial disability. Many individuals require structured, long-term support that sits outside the NDIS to maintain their wellbeing, remain connected to their communities, and avoid unnecessary hospitalisation or crisis intervention. The lack of continuity and clarity in responsibility for this group has created a fragmented landscape of care that undermines outcomes and strains hospital and emergency services.

Further action is needed to ensure a sustainable and coordinated approach. Building on this recommendation, CHA proposes that state and territory governments lead the design and implementation of psychosocial support services, given their proximity to local service systems and communities. This would enable a more flexible, regionally responsive approach that integrates psychosocial supports with health and social services at the local level.

To make this feasible, the Australian Government should provide dedicated funding to cover the current shortfall in psychosocial supports. A practical mechanism for this could be a grant funding scheme administered by the Australian Government, enabling jurisdictions to expand and sustain psychosocial support services outside the NDIS. To ensure the effectiveness and equity of such a scheme, further policy development is needed to establish clear operational parameters. This includes defining eligibility criteria, ensuring equitable access across jurisdictions, and embedding specific outcome measures to support transparency, accountability, and alignment with shared national reform objectives, as set out in the next National Agreement.

Recommendation 6: Expand Draft Recommendation 4.4 so that:

- State and Territory governments lead the design and implementation of psychosocial support services given their proximity to local health service systems and communities; and
- The Australian Government provides dedicated funding to cover the current shortfall in psychosocial supports through a grant funding scheme with defined eligibility criteria and embedded outcome measures to ensure alignment with shared national reform objectives.

Recommendation 4.5 Clarify responsibility for carer and family supports

Draft recommendation 4.5 The next agreement should clarify responsibility for carer and family supports

The next agreement should clarify the level of government responsible for planning and funding carer and family support services for supporters, families, carers and kin of people with lived and living experience of mental ill health and suicide.

CHA agrees in principle that the next National Agreement should clarify responsibilities for carers and family supports. As outlined in the interim report, the Mental Health Statement of Rights and Responsibilities affirms key rights for carers, including access to comprehensive information, education, training, and support to enable their care roles. It also recognises, with the consumer's consent and where appropriate, carers' right to participate in treatment and ongoing care decisions.

Given the rights-based nature of this framework, it is essential that these rights and responsibilities are articulated with sensitivity to local contexts and legislative frameworks beyond the scope of the National Agreement. For example, the *Victorian Mental Health and Wellbeing Act 2022* explicitly acknowledges the vital role of families, carers, and supporters of individuals experiencing mental illness or psychological distress. This recognition is embedded within a jurisdiction-specific Statement of Rights that reflects the principles and obligations of the Act.

CHA recommends that the next National Agreement explicitly identify state and territory governments as the appropriate level of government responsible for planning and funding carer and family support services. This approach reflects the distinct legislative frameworks within which each jurisdiction operates and manages mental health services. It also recognises their

capacity to engage meaningfully with people who have living and lived experience, enabling the co-design of responsive and locally relevant supports for carers and families.

Recommendation 7: Further to Draft Recommendation 4.5, the next National Agreement should identify State and Territory governments as the appropriate level of government to hold responsibility for planning and funding carer and family support services. This approach acknowledges the importance of jurisdictional legislative frameworks and the capacity of local governments to engage with people with living and lived experience in designing meaningful supports.
To ensure this recommendation is implemented effectively, it should be aligned with Draft Recommendation 4.2. This alignment is critical to fostering genuine collaboration between stakeholders, underpinned by recognised incentive structures established by the Australia Government that promotes shared responsibility and coordinated action.

Recommendation 4.6 Increase transparency and effectiveness of governance arrangements

Draft recommendation 4.6 Increase transparency and effectiveness of governance arrangements

The effectiveness of the next agreement's governance arrangements should be improved by:

- including a governance framework that emphasises transparency and collaboration, and outlines accountability, reporting and evaluation functions
- embedding and formalising the participation of people with lived and living experience of mental ill health and suicide in the design and implementation of governance arrangements
- clarifying the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues that relate to Aboriginal and Torres Strait Islander social and emotional wellbeing (draft recommendation 5.1).

To support effective operation of the agreement's governance arrangements, the Australian Government should:

- establish the National Mental Health Commission as an independent statutory authority and task it with monitoring and reporting on progress and outcomes
- publish information about the composition and activities of the working groups established under the agreement
- adequately resource the agreement's administrative functions and ensure timely and effective information sharing across working groups.

Improvements to governance arrangements

CHA notes that the second point in Draft Recommendation 4.6 highlights the need to embed and formalise the participation of people with lived and living experience of mental ill health and suicide in governance arrangements. This overlaps with Draft Recommendation 4.7, which more explicitly calls for the next National Agreement to support an expanded role for people with lived and living experience in governance.

While it is appropriate to have separate recommendations addressing the limited participation of these groups, CHA suggests that Draft Recommendation 4.6 be broadened in scope. Specifically, it should focus on enhancing the overall transparency and effectiveness of governance under the next National Agreement by ensuring broader sector representation, including, but not limited to, people with lived and living experience. This refinement would help ensure that the recommendations in the interim report are mutually exclusive in focus yet collectively exhaustive in coverage, avoiding duplication while reinforcing a comprehensive and inclusive governance framework.

To support this, Draft Recommendation 4.6 could be strengthened by referencing a draft governance framework that clearly outlines the interactions between stakeholder groups contributing to broader sector representation. This framework should identify the roles, responsibilities, and relationships among entities such as the Social and Emotional Wellbeing Policy Partnership and other similar bodies. By mapping these interactions in a coordinated and transparent manner, the framework would help ensure that governance arrangements under the next National Agreement are both inclusive and effective.

Recommendation 8: Drawing on findings from this Review, the Productivity Commission develop a draft governance framework as part of the Final Report to enhance the transparency and effectiveness of the next National Agreement. This framework should clearly define the interactions between key stakeholder groups, with a strong emphasis on collaboration, transparency, and accountability. It should also outline mechanisms for reporting and evaluation to ensure ongoing oversight and continuous improvement

To support a comprehensive and inclusive approach, Draft Recommendation 4.6 could be simplified to broadly reference broader sector representation in governance forums, including, but not limited to, people with lived and living experience.

Supporting measures

CHA agrees that, as a priority, the Australian Government should finalise its planned process to establish the NMHC as an independent statutory authority and task it with monitoring and reporting on progress and outcomes on the next National Agreement. Further comments around the specific functions of the NMHC will be discussed in CHA's response to Draft Recommendation 4.9.

CHA supports the commitment to publish information about the composition and activities of working groups established under the National Agreement. To enhance transparency and sector confidence, the interim report could outline practical implementation strategies, such as a dedicated webpage on the NMHC website detailing membership, initiatives, progress, and meeting cadence of each working group. This page could also include an organisational chart to illustrate how working groups relate to one another within the broader governance structure of the National Agreement, making navigation and understanding more accessible.

A project management approach, similar to that used in the operationalisation of the National Health and Climate Strategy, could strengthen the governance arrangements under the next National Agreement. In that Strategy, specific initiatives were assigned priorities and responsibilities, with progress reported to the Climate and Health Expert Advisory Group (CHEAG). A comparable model could be adopted within the scope of the NMHC, ensuring each working group has a clearly defined purpose, responsibilities, and reporting mechanisms. This would support transparency, accountability, and alignment with the overall objectives of the National Agreement.

To ensure effective governance under the National Agreement, its administrative functions must be adequately resourced to support timely and coordinated information sharing across working groups. In addition, cultural and organisational barriers, such as entrenched siloes within government, should be proactively identified and addressed to enable genuine collaboration and strengthen the overall effectiveness of governance arrangements within context of the National Agreement.

Recommendation 9: Ensure the National Agreement is adequately resourced and funded to support its core administrative functions. This includes enabling effective governance, facilitating timely and coordinated information-sharing, and addressing cultural and organisational barriers that may hinder implementation and collaboration across jurisdictions.

Recommendation 4.7 Supporting a greater role for people with lived and living experience in governance

Draft recommendation 4.7 The next agreement should support a greater role for people with lived and living experience in governance

The Australian, state and territory governments should address barriers to the effective involvement of people with lived and living experience in the governance of the next agreement. This should include limiting the use of confidentiality agreements with lived and living experience representatives, opening greater opportunities for communication between lived and living experience working groups, other working groups and the senior officials group, and appropriately remunerating lived experience representatives.

The makeup of governance forums for the next agreement should be reconfigured to ensure:

- adequate representation of people with lived and living experience at each level of governance
- balanced representation between people with lived and living experience of mental ill health and lived and living experience of suicide
- governance roles for carers commensurate with the significant role they play in Australia's mental health and suicide prevention system.

The next agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance arrangements. These bodies should be adequately resourced to fulfill these roles.

Embedding codesign at all stages

CHA agrees the next National Agreement embed codesign with people with lived and living experience at all stages, including within governance arrangements. As noted in CHA's response to Draft Recommendation 4.2, this process must be clear, transparent, and foster genuine collaboration, avoiding perceptions of tokenism.

CHA supports the principles outlined in Draft Recommendation 4.7 and suggests it be strengthened by explicitly referencing the need for transparent recruitment processes. This would help ensure appropriate representation and recognition of the diverse community of people with lived and living experience of mental ill-health and suicide, contributing to more inclusive and effective governance.

Mental ill-health and suicide are complex issues, and while increasing governance roles for people with lived and living experience is essential, it is only one part of addressing the broader barriers to their meaningful participation in national reform. CHA and its members observe that involvement of people with lived and living experience in service design and strategic planning is often treated as optional or symbolic, rather than recognised for its depth, breadth, and value.

To move beyond tokenism, it is critical to understand how people with lived and living experience are currently engaged in service provision planning, and to ensure that future approaches reflect the diversity of their perspectives.

CHA also supports the recommendation to limit the use of confidentiality agreements that unnecessarily restrict the ability of lived and living experience representatives to consult with their communities or share their perspectives. Over-reliance on confidentiality and legalistic approaches can hinder transparency, diminish trust, and isolate representatives from the very networks they are meant to reflect. Instead, governance arrangements should promote open communication, safe collaboration, and strong accountability to the broader lived and living experience community.

In response to Information Request 4.2, an evaluation framework could include the following quality indicators to assess the extent and quality of engagement:

- Self-reported satisfaction with the engagement process (e.g. via surveys or feedback)
- Perceived influence on decision-making
- Clarity and transparency of communication
- Timeliness and responsiveness of follow-up actions
- Evidence of impact, such as changes to policies or decisions that reflect stakeholder input

Additionally, the Australian Government could use the development of the next National Agreement as a role-modelling opportunity, demonstrating how meaningful codesign can be embedded in governance arrangements. This would set a precedent for the jurisdictions, and the sector more broadly, to adopt inclusive, transparent, and accountable engagement practices beyond the life of the National Agreement.

Recommendation 10: To strengthen the principles outlined in Draft Recommendation 4.7, explicitly reference the need for transparent recruitment processes of people with lived and living experience to participate as subject matter experts on relevant forums to provide strategic oversight and input. As part of this, emphasise the development of the next National Agreement as an opportunity to role-model meaningful codesign, setting the precedent for jurisdictions, and the sector more broadly, to adopt inclusive, transparent, and accountable engagement practices beyond the life of the National Agreement.

Recommendation 11: Findings from sector responses to Information Request 4.2 could be reflected in an evaluation framework to assess the extent and quality of engagement of people with lived and living experience of mental ill-health and suicide in relevant governance forums:

- Self-reported satisfaction with the engagement process (e.g. via surveys or feedback)
- Perceived influence on decision-making

- Clarity and transparency of communication
- Timeliness and responsiveness of follow-up actions
- Evidence of impact, such as changes to policies or decisions that reflect stakeholder input

Recommendation 4.8 A greater role for the broader sector in governance

Draft recommendation 4.8 A greater role for the broader sector in governance

The next agreement should support a greater role for service providers and the broader mental health and suicide prevention sectors in governance. Both mental health and suicide prevention providers should take part in governance mechanisms.

Sector participation in governance

Building on previous responses to Draft Recommendations 4.6 and 4.7, CHA strongly supports broader sector representation in governance arrangements, particularly from both public and private mental health providers, to reflect the complexity of service delivery and the consumer care journey. A person-centred mental health system requires input from those who understand the interdependencies across services and funding streams.

Public and private providers play complementary roles within Australia's stepped care model. Private hospitals offer specialised inpatient and outpatient services that ease pressure on the public system, which often faces long wait times and limited capacity. Without access to private care, individuals may experience delayed treatment and poorer outcomes. Further details are available in CHA's position paper on private mental health care in Australia.

Including both public and private sectors in governance arrangements will ensure the next National Agreement is grounded in the realities of service delivery and better positioned to deliver integrated, timely, and effective care. For this to be effective, service provider involvement must be genuine, structured, and adequately resourced, ensuring diverse perspectives are not only heard but actively shape the direction of national mental health strategy. To operationalise this, broader sector representation could be embedded through designated roles in working groups outlined within the National Agreement, or via a dedicated sector taskforce or advisory body. Such mechanisms would help maintain accountability and ensure ongoing input into the implementation and oversight of the National Agreement's initiatives.

Recommendation 12: Ensure that governance arrangements under the next National Agreement include broader sector representation that reflects the realities of the mental health and suicide prevention system, particularly the interdependencies between public and private service providers.

Recommendation 4.9 Share implementation plans and progress reporting publicly

Draft recommendation 4.9 Share implementation plans and progress reporting publicly

The Australian, state and territory governments should publish all implementation plans and jurisdictional progress reports developed under the next agreement.

The National Mental Health Commission should be empowered to assess and report on progress independently, using information beyond what is reported by governments. The Commission should publish national progress reports as they are finalised, without requirements for jurisdictions' sign-off.

Transparency and accountability through public progress reporting

CHA supports the principle of increasing transparency and accountability through the publication of implementation plans and progress reports under the next National Agreement. To address existing fragmentation across jurisdictions, driven by varying mental health and wellbeing plans, reporting requirements, and compliance measures, there is a clear opportunity to establish a streamlined regulatory framework. The next Agreement could include:

- development of national accreditation standards to guide consistent mental health and suicide prevention service quality
- a centralised reporting system to consolidate data requirements and reduce duplication
- clear articulation of how accreditation standards align with reporting templates and structures, including shared objectives and indicators
- a clear, transparent reporting structure that is meaningful, consultative, and promotes shared accountability.

Standardising these elements would reduce complexity, improve comparability across jurisdictions, and support more effective implementation of the National Agreement.

Recommendation 13: The next National Agreement should establish a streamlined regulatory and reporting framework, which could include:

- development of national accreditation standards to guide consistent mental health and suicide prevention service quality
- a centralised reporting system to consolidate data requirements and reduce duplication
- clear articulation of how accreditation standards align with reporting templates and structures, including shared objectives and indicators
- a clear, transparent reporting structure that is meaningful, consultative, and promotes shared accountability.

Role of the National Mental Health Commission

CHA supports the role of the NMHC, as outlined in Draft Recommendation 4.9, to independently assess and report on progress under the next National Agreement. In particular, strengthening the role of the NMHC to independently monitor and report on performance using multiple data sources would improve the credibility and comprehensives of reporting and allow for a ore nuanced understanding of progress across the system. To fulfil this role effectively, the NMHC must be adequately resourced to support jurisdictions in contributing to revised framework and processes for national reporting.

To maintain constructive relationships, jurisdictions should be given the opportunity to provide explanatory notes or contextual feedback on national progress reports, particularly where they have contributed data. Additionally, the NMHC could offer tailored feedback to individual jurisdictions on key progress indicators, enabling targeted improvements and capacity-building, similar to the approach used by the Independent Health and Aged Care Pricing Authority (IHACPA) in its costing studies. Similar lessons learnt from the Aged Care Safety and Quality Commission, and other authorities could be adapted to the context in which the NMHC operates in.

However, to preserve the independence and efficiency of the reporting process, CHA agrees that jurisdictional sign-off should not be required prior to publication. These considerations should be reflected in the interim report to ensure transparency and clarity in the reporting framework.

To ensure clarity and coherence, CHA recommends consolidating the NMHC's responsibilities under a single recommendation — Draft Recommendation 4.10 — so that its full role in monitoring, reporting, and supporting implementation is clearly articulated in one section.

Recommendation 14: That the NMHC's responsibilities are consolidated under a single recommendation — Draft Recommendation 4.10 — so that its full role in monitoring, reporting, and supporting implementation of the National Agreement is clearly articulated in one section.

Public dashboard to track progress

In response to Information Request 4.3, CHA supports the development of a public dashboard to track and report progress against the objectives and outcomes of the next National Agreement. Aligned with Draft Recommendation 4.9, the NMHC's role as an independent assessor and reporting body positions it well to manage centralised data sources from jurisdictions and oversee the maintenance of the public dashboard. This would ensure transparency, support national consistency, and provide a clear mechanism for tracking progress against the National Agreement's commitments.

To ensure consistency and credibility, CHA recommends that the NMHC, working in partnership with AIHW, given their role in developing key outcomes, be responsible for the collation and publication of dashboard data.

Recommendation 15: In alignment with Draft Recommendations 4.9 and 4.10, the NMHC should be responsible for managing centralised data sources from jurisdictions and overseeing the maintenance of the public dashboard. To support this function, the NMHC should work in partnership with the AIHW to collate, analyse, and publish dashboard data that tracks progress against the objectives and outcomes of the next National Agreement.

Recommendation 4.10 Strengthening the National Mental Health Commission's reporting role

Draft recommendation 4.10 Strengthening the National Mental Health Commission's reporting role

The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for ongoing monitoring, reporting and assessment of progress against the National Agreement's outcomes.

The Commission should have legislative provisions to compel information from Australian, state and territory government agencies to fulfil its reporting role.

The National Suicide Prevention Office should be given an advisory role in monitoring and reporting on the next agreement. It should also be responsible for the monitoring and reporting on progress against the separate suicide prevention schedule (draft recommendation 6.1).

Strengthening the National Mental Health Commission's reporting role

CHA recommends consolidating all references to the NMHC's role and functions into a single, comprehensive recommendation within the final report. This would improve clarity, reduce some duplication across the current interim report, and enhance visibility of proposed changes to the NMHC's responsibilities for inclusion in the next National Agreement. Consolidation would also support better alignment with other national bodies, such as IHACPA under the NHRA, by clarifying the NMHC's position within the broader governance and accountability framework of the National Agreement.

A consolidated Draft Recommendation 4.10 should formally establish and clearly articulate the NHMC's role and powers, including:

- the establishment of the NMHC as an independent statutory authority tasked with monitoring and reporting on progress and outcomes under the next Agreement (Draft Recommendation 4.6)
- empowering the NMHC to independently assess and report on the progress under the next Agreement (Draft Recommendation 4.9)
- providing the NMHC with legislative provisions to compel information from Australian, state and territory government agencies to fulfil its reporting role, which includes ongoing monitoring, reporting and assessment of progress against the National Agreement's outcomes. (Draft Recommendation 4.10)
- assigning the NMHC responsibility for overseeing the development of a renewed National Mental Health Strategy, including undertaking a comprehensive codesign process with relevant sector stakeholders (Draft Recommendation 4.1).

Importantly, Draft Recommendation 4.10 does not articulate how the National Suicide Prevention Office is expected to work alongside the National Mental Health Commission given the degree of potential overlap between this complex subject matter. To minimise duplication and ensure coordinated effort, the final report should provide further detail on how these roles are intended to interact based on findings of this Review, particularly in relation to monitoring and reporting on the next National Agreement.

Recommendation 16a: Expand Draft Recommendation 4.10 to "Clarify and formalise the role and functions of the NMHC within the next National Agreement" and include a consolidated version of proposed changes to the NMHC's responsibilities as articulated in previous draft recommendations.

Recommendation 16b: As part of this consolidation, articulate how the role of the National Suicide Prevention Office will work alongside the revised role of the NMHC in monitoring and reporting on progress of the next National Agreement.

Recommendation 4.11 Survey data should be routinely collected

Draft recommendation 4.11 Survey data should be routinely collected

The Australian Government should fund the routine collection of the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing Study, running the surveys at least every five years.

Supporting a robust evidence base

CHA supports the Australian Government's continued funding of the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing Study, as outlined in Draft Recommendation 4.11. These surveys are critical for generating high-quality, population-level data to inform policy and service delivery. Their ongoing implementation should be formally embedded within the next National Agreement to ensure long-term commitment and integration into national planning.

To maximise their impact, there must be strong coordination between these routinely collected surveys and the broader outcome measurement framework being developed by the AIHW, as referenced in Draft Recommendation 4.2. Specifically, the outcome measures developed by AIHW should be directly informed by, and aligned with, the data collected through these surveys. This alignment will ensure that survey outputs contribute meaningfully to national accountability mechanisms and performance monitoring under the National Agreement.

A clear implementation plan is needed to map how the agreed outcomes relate to specific survey questions across both studies. This will help ensure that the data collected is fit for purpose, supporting transparency, enabling streamlined reporting, and providing actionable insights for continuous improvement.

Furthermore, survey design should be guided by a broader national data collection strategy, which promotes consistency, reduces duplication, and supports interoperability across systems. This strategic approach will help ensure that mental health and suicide prevention efforts are underpinned by reliable evidence and remain responsive to emerging needs.

Finally, the timeframe for administering these surveys should align with other health indicator-related surveys conducted by AIHW and the Australian Bureau of Statistics (ABS). CHA recommends that the frequency of these surveys be increased to at least every three years, to ensure that the data collected can meaningfully reflect changes in the mental health system and support timely policy responses.

Recommendation 17: Revise Draft Recommendation 4.11 so that the surveys are implemented “at least every three years” instead of “every five years” to ensure data collected can meaningfully reflect changes in the mental health system and support timely policy responses.

Recommendation 4.12 Funding should support primary health networks to meet local needs

Draft recommendation 4.12 Funding should support primary health networks to meet local needs

The next agreement should emphasise national consistency in areas where there are efficiency gains, including standardising reporting requirements across primary health networks (PHNs) and jurisdictions where possible and investigating ways to standardise procurement and data collection processes.

Funding arrangements in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services or support existing services where they have been positively evaluated. National service models should not limit the ways in which PHNs meet their communities’ needs.

Collaborative Commissioning

As outlined in Draft Recommendation 4.12, the next National Agreement presents a timely opportunity to strengthen national consistency in mental health commissioning, driving efficiency, productivity, and improved outcomes. A key lever for achieving this is a dedicated focus on embedding collaborative commissioning across jurisdictions.

Collaborative commissioning is a critical enabler of integrated, person-centred mental health care, and PHNs are uniquely positioned to lead this transformation. As regional system stewards, PHNs possess the mandate, local intelligence, and cross-sector relationships needed to convene stakeholders across health, social care, and community services.

Through co-design, joint funding, and coordinated service delivery, PHNs facilitate a unified approach that aligns services around the full spectrum of individual needs — physical, mental, and social. This reduces fragmentation, enhances continuity of care, and ensures services are responsive to local priorities and lived experience.

PHNs also play a central role in embedding shared accountability frameworks and leveraging data to monitor outcomes, identify service gaps, and drive continuous improvement. By streamlining service pathways and minimising duplication, collaborative commissioning generates operational efficiencies. These efficiencies can be reinvested in addressing the broader social determinants of health, such as housing, nutrition, and social connection, which are foundational to long-term mental wellbeing.

In addition to integration, PHNs are strategically placed to lead investment in early intervention and preventative care.[2] Their deep understanding of local community needs enables evidence-informed, place-based decision-making that targets resources where they are most effective.

To support this, future funding arrangements under the next Agreement could enable PHNs to pilot enhanced preventative care initiatives. This could include the development of an integrated data platform that links prevention programs with broader care economy datasets, spanning primary care, community services, and government-held indicators of health system performance. Such a platform would address critical data and evaluation infrastructure gaps by enabling continuous outcome measurement, real-time monitoring, and predictive modelling.

These pilots would also trial advanced evaluation frameworks to better capture the diffuse and long-term benefits of prevention, beyond direct financial metrics, supporting more strategic and informed government investment decisions. Importantly, this work should align with existing national wellbeing frameworks, such as *Measuring What Matters*, to ensure coherence and maximise policy impact.

The next Agreement must also recognise that PHNs operate within a mixed health system. There should be an explicit expectation that PHNs engage across public and private sectors when planning and commissioning mental health care. This includes private hospitals, general practices, and community-based providers, ensuring that available capacity and clinical expertise are leveraged efficiently.

CHA also recommends the National Agreement include provisions to evaluate and scale successful local initiatives nationally where appropriate, ensuring that good practice is not only recognised but also meaningfully disseminated across jurisdictions. A flexible yet accountable commissioning framework is critical to supporting equitable access to high-quality mental health care across all parts of Australia.

Ultimately, PHNs are not just facilitators but strategic leaders in building a more equitable, efficient, and person-centred mental health system, through both collaborative commissioning and forward-looking investment in prevention.

Recommendation 18: Strengthen national consistency in mental health commissioning by providing dedicated resourcing and funding for Primary Health Networks (PHNs) to embed collaborative commissioning as a core operational function. This should include support for enabling frameworks, data infrastructure, and the flexibility to design and implement early intervention and preventative care initiatives tailored to local community needs. PHNs should also be expected to engage public and private providers to make full use of system capacity. Successful local models should be evaluated and scaled nationally to drive consistency and equity.

[2] Further information on our position regarding early intervention and preventative care is available in our submission to the Productivity Commission's 5 Pillars Inquiry – which can be accessed here.

Recommendation 4.13 Support the implementation of the National Mental Health Workforce Strategy

Draft recommendation 4.13 The next agreement should support the implementation of the National Mental Health Workforce Strategy

The next agreement should support the implementation of the National Mental Health Workforce Strategy.

This should include:

- clear commitments to, and timelines for, priority actions under the National Mental Health Workforce Strategy
- an explicit delineation of responsibility and funding for workforce development initiatives.

National Mental Health Workforce Strategy

CHA supports Draft Recommendation 4.13 and recognises its importance in addressing the workforce challenges facing the mental health sector. To ensure meaningful impact, the National Agreement should clearly articulate how it will complement the National Mental Health Workforce Strategy, including future iterations. This could include explicit provisions within the National Agreement requiring that the Strategy be developed in consultation with the sector, consistent with CHA's feedback on Draft Recommendations 4.3 and 4.8.

Clear commitments and defined timelines for priority actions under the Strategy are essential to ensure sector-wide alignment on workforce planning efforts. This will also help identify synergies across existing initiatives, reduce duplication, and enhance efficiency. A strong example of effective planning is the National Allied Health Digital Uplift Plan, which outlines specific timelines, roles, and responsibilities for each priority area. Embedding similar planning and accountability mechanisms within the Strategy will be critical to its success and to the broader goal of strengthening Australia's mental health workforce.

The National Agreement should explicitly outline responsibilities for workforce development, training, and funding, across both public and private sectors, and support innovative models of care and scope-of-practice reforms to make the best use of available clinical capacity. It should also recognise the critical role of the nursing workforce, particularly mental health nurses, and include targeted strategies to recruit, retain, and support this workforce as demand for services grows.

Further comments in relation to the peer workforce and how it interacts with the National Mental Health Workforce Strategy is found in our response to Draft Recommendation 4.14.

Recommendation 19: Include explicit wording in the next National Agreement to articulate its interactions with the National Mental Health Workforce Strategy, including future iterations. This may include explicit provisions within the National Agreement requiring that the Strategy be developed in consultation with the sector. Additionally, the National Agreement should commit to shared funding responsibilities and workforce reforms to address critical workforce shortages across public and private settings.

Recommendation 4.14 Scope of practice for the peer workforce

Draft recommendation 4.14 The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce.

The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce, in consultation with the peer workforce, that:

- promotes safer work practices for peer workers
- contributes to better outcomes for people accessing mental health and suicide prevention peer support
- improves public understanding of the profession, allowing for greater recognition of peer workers'
- capabilities and contributions.

Peer workforce

CHA recommends that the final report include a clear and consistent definition of the peer workforce to support the effective implementation of Draft Recommendation 4.14 in the development of the next National Agreement.

To guide the development of a nationally consistent scope of practice for the peer workforce, the following considerations should be taken into account:

- The 2024–25 Federal Budget includes a $7.1 million investment over four years to strengthen the lived experience peer mental health workforce. This funding will support the establishment of a national professional association for peer workers, facilitate a workforce census, and explore expanded training pathways. This national professional association should be a key stakeholder in the development of a scope of practice for the peer workforce.
- The 2024-25 Federal Budget also includes a commitment to increase funding for PHNs, working in partnership with GPs, to commission services from mental health nurses, counsellors, social workers, and peer workers should be evaluated for its effectiveness. These services are critical in providing ongoing, wraparound care and care coordination for individuals with complex needs, particularly between GP visits and specialist appointments.
- Importantly, the scope of practice must address existing barriers to entering and advancing within the peer workforce. This requires comprehensive stakeholder engagement to ensure the scope is relevant, practical, and aligned with the needs of the sector.

These activities should be embedded within the National Mental Health Workforce Strategy, a key component of the National Agreement, to support the growth and sustainability of the peer workforce. In practice, this means the finalised scope of practice must be integrated with broader mental health and care workforce planning efforts, including the ongoing development and implementation of the National Skills and Capability Framework and Matrix. Aligning these initiatives will help ensure that peer workers are recognised as essential members of a multidisciplinary mental health workforce, which itself forms a vital subset of the broader care workforce.

Recommendation 20a: To ensure peer workers are recognised as essential members of a multidisciplinary mental health workforce, the development of a nationally consistent scope of practice should include the following actions:

- Engage with the national professional association for peer workers (once established) to ensure sector-led input and representation.
- Evaluate the impact of PHN-GP partnerships in commissioning peer worker services, focusing on their effectiveness in meeting care needs across the sector.
- Identify and address barriers to workforce entry and career progression within the peer workforce, ensuring inclusive and sustainable pathways.

Recommendation 20b: Ensure that the development of a nationally consistent scope of practice for the peer workforce is embedded within the National Mental Health Workforce Strategy. This will enhance alignment with broader mental health and care workforce planning efforts, including integration with the National Skills and Capability Framework and Matrix, and support the long-term sustainability of the peer workforce.

CHA notes that **Information Request 4.4** is seeking examples of best practice with regards to integrating peer workers in clinical mental health and suicide prevention settings. As such, CHA has provided a case study that could be adopted in other organisations.

Case study: Peer Workers at St Vincent's Hospital Sydney

St Vincent's Hospital Sydney actively employs Mental Health Peer Workers who draw on their own lived experience with mental health challenges to provide empathetic, authentic support to individuals currently navigating mental illness. These peer practitioners play a vital role within the hospital's mental health services by offering one-on-one consultations that foster trust and understanding, as well as facilitating group sessions designed around recovery-oriented principles such as hope, empowerment, self-determination, and building meaningful social connections. Their unique perspective allows them to connect with patients in ways that complement clinical care, providing practical insights and emotional validation that enhance the healing journey. Working collaboratively alongside psychiatrists, nurses, social workers, and other clinicians, peer workers help bridge the gap between traditional medical treatment and community-based, peer-led support systems, ensuring care is more holistic, person-centred, and responsive to the individual's lived realities. This integration enriches the multidisciplinary team's approach, improving patient engagement, reducing feelings of isolation, and promoting sustained recovery beyond the hospital setting.

Recommendation 4.15 Evaluation framework and guidelines

Draft recommendation 4.15 The next agreement should build on the evaluation framework and guidelines

The next agreement should require timely evaluations to be conducted for all funded services in line with the National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines and require sharing of evaluation findings, including sharing publicly where possible.

Monitoring and evaluation

CHA supports Draft Recommendation 4.15, which proposes that the next National Agreement should contribute to and build upon the National Mental Health and Suicide Prevention Evaluation Framework (the National Evaluation Framework) and its associated guidelines. CHA strongly endorses the principle of transparency and the value of consistent progress reporting to build accountability and drive system-wide improvement.

Robust monitoring and evaluation are essential to understanding what works, for whom, and in what context. They provide the evidence base needed to inform continuous improvement, guide investment decisions, and ensure that mental health reforms outlined in the next Agreement delivers meaningful outcomes for the sector.

However, it is important to consider how jurisdiction-specific evaluation frameworks will interact with the National Evaluation Framework. In cases where discrepancies arise, there must be clear guidance on how these differences will be reconciled to maintain coherence and comparability across jurisdictions. Alignment between national and local evaluation efforts will be critical to ensuring that data is meaningful, actionable, and contributes to a shared understanding of system performance.

CHA also encourages the inclusion of clear requirements for public sharing of evaluation findings to promote transparency, facilitate sector-wide learning, and support evidence-based policy and practice. Additionally, evaluations should meaningfully incorporate perspectives from people with lived experience and frontline providers to capture the full impact of services and identify opportunities for refinement.

Recommendation 21: Similar to the treatment of jurisdiction-specific mental health and wellbeing plans, there should be clear guidance on how discrepancies between the National Mental Health and Suicide Prevention Evaluation Framework and jurisdiction-specific evaluation frameworks should be treated. Clear requirements for public sharing of evaluation findings should also be included in the evaluation framework.

Chapter 5: Services for Aboriginal and Torres Strait Islander people

CHA has no comments on Draft Recommendation 5.1 in relation to the inclusion of an Aboriginal and Torres Strait Islander schedule in the next Agreement.

Chapter 6: Suicide Prevention

Recommendation 6.1 Suicide prevention as a schedule to the next agreement

Draft recommendation 6.1 Suicide prevention as a schedule to the next agreement

The next agreement should include a separate schedule on suicide prevention. This schedule should be developed through a process of co-design with people with lived and living experience of suicide, their supporters, families, carers and kin and service providers.

The schedule should:

- only include actions in policy areas of suicide prevention that are distinct from mental health
- reflect a clear link between the short-term objective and outcomes of the schedule and progress
- towards the long-term objectives of the National Suicide Prevention Strategy
- align with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- include monitoring and reporting indicators that align with the forthcoming National Suicide Prevention Outcomes Framework
- require the National Suicide Prevention Office be responsible for the monitoring and reporting of the schedule.

Distinguish suicide prevention from mental health

CHA supports the development of a distinct schedule on suicide prevention as part of the next National Agreement. While suicide prevention is closely linked to mental health, it also encompasses broader systemic and social determinants — including poverty, trauma, social isolation, substance use, family breakdown, homelessness, and discrimination — that require a cross-sectoral, whole-of-government response. A dedicated schedule offers the opportunity to take a more holistic, coordinated, and proactive approach to suicide prevention, ensuring that investment and action extend beyond the health system alone.

We strongly support the recommendation for genuine co-design with people with lived and living experience of suicide, including families, carers and kin, and Indigenous communities. As a Catholic organisation committed to human dignity and the sanctity of life, we believe that suicide prevention efforts must be underpinned by compassion, connection, and respect for the inherent worth of each individual. Suicide prevention initiatives must also be culturally safe and responsive, and we welcome the recommendation that the schedule be aligned with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. This alignment is particularly critical in light of the disproportionate burden of suicide experienced by First Nations communities and the need for community-led and culturally grounded approaches to healing.

We support the proposed inclusion of short- and long-term objectives, outcomes, and indicators that align with the National Suicide Prevention Strategy and the forthcoming Outcomes Framework. These should guide investment in evidence-informed and locally appropriate actions, support transparent monitoring and evaluation, and enable continuous learning and improvement. However, further clarity is needed on the respective roles of the National Suicide Prevention Office and the NMHC to ensure coordination, avoid duplication, and provide a clear governance structure for monitoring and accountability under the National Agreement, as outlined in CHA's previous responses in this submission. Strengthening collaboration between

these bodies will be essential to delivering a nationally consistent yet locally responsive suicide prevention system.

Finally, CHA emphasises that suicide prevention is everyone's responsibility. Hospitals, aged care, community organisations, schools, workplaces, and faith-based institutions all play a vital role in fostering belonging, hope, and resilience. The schedule should recognise the contribution of non-government, faith-based and community-based providers in providing compassionate care and wraparound support, particularly for people in distress who may not engage with traditional mental health services.