Mental Health Australia

Sector priorities: National Mental Health and Suicide Prevention Agreement

Mental Health Australia is pleased to provide the following priorities for the next National Mental Health and Suicide Prevention Agreement to support governments' consideration.

July 2026

The National Mental Health and Suicide Prevention Agreement is the foundation for an effective, integrated national mental health and suicide prevention system. Mental Health Australia called for and welcomed delivery of the inaugural Agreement, to facilitate collaboration across all Australian governments, the community and the sector to improve mental health.

However, as the Productivity Commission review found, **the current Agreement is not fit for purpose** – with ineffective governance structures, monitoring and accountability. The review found the Agreement does not address key barriers to reform – including system fragmentation, insufficient collaboration, a lack of flexibility in funding arrangements and workforce shortages.[1]

It is imperative that these challenges are addressed to ensure effectiveness of the next Agreement. Mental health challenges are now the leading global cause of living with poor health or 'non-fatal burden of disease'.[2] **Mental health challenges are one of the biggest threats to population wellbeing, the ongoing sustainability of Australia's health systems, and our national productivity**.

There are clear and practical actions governments should take to improve mental health outcomes through the next Agreement – through investing in priority reform areas, addressing system foundation shortfalls, and improving ongoing commitments.

Mental Health Australia is pleased to provide the following advice to Health and Mental Health Ministers on priorities for the next Agreement. This advice builds on extensive insights Mental Health Australia has received through our membership, including through consultations at Members Policy Forums (in June 2025, November 2025 and May 2026), consultations open to all members through webinars and networks, and targeted consultations with members and stakeholders on specific areas of subject matter expertise.

Mental Health Australia is the national, independent peak body for the mental health sector. We unite the voices of the mental health sector and advocate for policies that improve mental health. Mental Health Australia represents nearly 160 members, including organisations representing people with lived experience of mental health challenges, family, carers and kin, service providers, professional bodies, researchers and state and territory peak bodies.

Priorities

Invest in priority reform areas

1. **Address identified unmet need for psychosocial support outside the NDIS** – funded through the Foundational Supports Agreement and governed by the National Mental Health and Suicide Prevention Agreement.
2. **Improve access to mental health supports for children and their families,** by expanding the network of Medicare Mental Health Kids Hubs and reviewing the National Mental Health Service Planning Framework for children to support delivery of a connected care system.
3. **Integrate prevention as a core focus of the Agreement** by increasing access to perinatal and infant mental health and wellbeing programs, scaling mental health and wellbeing programs within schools and early learning services, boosting local mental health promotion capability, and embedding prevention in national reporting.
4. **Grow and strengthen the mental health workforce** by implementing and updating the National Mental Health Workforce Strategy, and embedding supported student placements and graduate engagement across all multi-disciplinary adult, child and youth service models under the Agreement.

Address system foundation shortfalls

5. **Fix governance arrangements** to improve transparency and accountability, by continuing to embed lived experience; including sector representation; strengthening accountability to ensure culturally safe supports for Aboriginal and Torres Strait Islander people; strengthening the role of the National Mental Health Commission; and committing to a mid-term review of implementation progress.
6. **Improve efficiency and stability of services** under the Agreement through default longer term (five-year) contracts, indexation that includes mandated wage increases and a minimum 6-month notice period for contract adjustments.
7. **Address national data gaps** by developing and delivering a national approach to measuring the impact (activity, outcomes and consumer and carer experiences) of mental health services delivered by non-government organisations, led by the Data Governance Forum.
8. **Improve commissioning and system integration** by developing a standardised mental health support taxonomy and national directory, and trialling and evaluating collaborative commissioning approaches to support future expansion.

Improve ongoing commitments

9. **Continue to deliver and improve existing National Agreement commitments** – informed by immediate public release of evaluations, and implementation of strategies to improve supports for culturally and linguistically diverse and LGBTQI+SB people.

Contents

Invest in priority reform areas

1. Address unmet need for psychosocial support

Problem:

Nearly half a million people are missing out on critical psychosocial supports outside the National Disability Insurance Scheme,[3] with this gap likely to grow with upcoming changes to NDIS eligibility.

Solution:

Address identified unmet need for psychosocial support outside the NDIS – funded through the Foundational Supports Agreement and governed by the National Mental Health and Suicide Prevention Agreement.

Background:

Psychosocial supports are a core element of an effective mental health service system – assisting people to achieve meaningful personal and community participation outcomes, preventing escalation and crises, reducing the need for more intensive supports and improving connection and effectiveness of other supports. However, **over 80% of the hours of psychosocial support required are not available**.[4]

Governments have made some progress towards addressing this critical gap under the current Agreement – by developing a common definition of psychosocial supports, undertaking a detailed analysis of unmet need for psychosocial support and confirming joint responsibility between the Commonwealth and State and Territory Governments for psychosocial support services for people not supported through the NDIS. However, the community is still waiting for action to address this unmet need. The gap in access to psychosocial supports outside the NDIS is now even more urgent, with the Australian Government announcing an intended reduction in NDIS participants from the previously forecast 900,000 to 600,000 participants by 2030.[5]

Mental Health Australia welcomes governments' commitment to address unmet psychosocial support needs as one of the central priorities for the next National Mental Health and Suicide Prevention Agreement.[6] As Ministers have also acknowledged – there is a unique opportunity now to consider psychosocial supports in the next stage of work on Foundational Supports outside the NDIS.[7]

To support governments' consideration, Mental Health Australia and our members have developed Fundamental Principles to guide the design of psychosocial supports outside the NDIS. We refer governments to this document for more detailed principles to guide system architecture, service design, commissioning and workforce development for psychosocial supports.

2. Expand infant, child and family mental health supports

Problem:

The prevalence of mental health challenges among young people is growing far faster than any other age cohort[8] – yet Australia's systems to prevent and support children and young people experiencing mental health concerns are not equipped or scaled to meet this challenge. There are particular gaps in supports for infants, children and families.

Solution:

Expand the network of Medicare Mental Health Kids Hubs to increase access to free mental health supports for children and their families.

Review the National Mental Health Service Planning Framework model for mental health support for children 0-11, to support delivery of a connected care system.

© Everymind/Salty Dingo

Background:

The commitment from Health and Mental Health Ministers that "*children and young people (0-25 years) will remain a priority population in the next National Mental Health and Suicide Prevention Agreement*" is very welcome, as is Ministers' renewed focus on the **National Children's Mental Health and Wellbeing Strategy**.[9]

While essential progress is being made through the current National Agreement and Australian Government initiatives to expand mental health support for young people 12-25, **there remains a critical gap in supports for infants and children 0-12.**

An estimated 13% of children in Australia are experiencing a mental health condition, and one-in-five children show vulnerability to mental health challenges in their first year of primary school.[10] Existing supports are inequitably distributed, with regions with the highest child and infant mental health need often having the lowest availability of services and workforces.[11]

The next National Agreement must improve access to mental health supports for infants, children and families, building on the foundations of the current Agreement and guided by the National Children's Mental Health and Wellbeing Strategy. To change the trajectory of mental health for children and young people, the commitments delivered by health portfolios under the National Agreement must be complemented by action across governments to address the social determinants of mental health.

EXPAND MEDICARE MENTAL HEALTH KIDS HUBS

Governments should continue to expand the network of Medicare Mental Health Kids Hubs to increase access to free mental health supports for children (0-12) and their families.

These hubs are critical to addressing gaps and inequity in access to child and infant mental health support, and deliver the cornerstone recommendation of the National Children's Mental Health and Wellbeing Strategy.

Through the current Agreement, governments have established a national network of multi-disciplinary child mental health hubs, with 14 of 17 hubs active as of May 2026.

These mental health-specific supports for infants and children are critical for mental health early intervention and prevention, and are not provided by other supports focused on developmental delay.

Continued expansion of Medicare Mental Health Kids Hubs should be informed by the evaluation of the initial hubs, and support increasing integration with other support systems including in education and early learning, youth mental health care, primary healthcare and disability supports. Innovative models to support equitable access across large metropolitan and regional areas should also be explored – such as hub and spoke, or local mental health and wellbeing roles connected to Hubs or other existing services.

It is important to continue to ensure consistent delivery of these supports in a family-inclusive approach – measures of family engagement, family experience and family wellbeing within evaluation and outcomes frameworks should be incorporated to monitor implementation fidelity over time.

UPDATE THE NATIONAL MENTAL HEALTH SERVICE PLANNING FRAMEWORK

The landscape of mental health supports for infants and children is scarce, confusing and disjointed – leaving families and caregivers to navigate between rare, disconnected or sometimes duplicative programs in their area. An agreed outline for Australia's child mental health support system is needed to provide clarity on care pathways, accountability for ensuring local regions have access to the range of supports required, and a mechanism to address duplication and fragmentation.

The National Mental Health Service Planning Framework outlines the benchmark mental health supports required to meet population need across the continuum of care. **Governments already use this model to guide mental health service planning, coordination and resourcing – however it is outdated for the mental health needs of children (grouped under the Framework for ages 0-11), with the last substantive update to care profiles for this age cohort in 2016.** Work is also needed to incorporate the needs of children living in families affected by mental health challenges – where children may be a young carer or significantly impacted by a parent, sibling or other family member's mental health challenges and benefit from early support.

Governments should update the Framework for mental health supports for children 0-11 to inform delivery of a cohesive infant and child mental health support system. This review should be undertaken in partnership with people with lived experience, carers, families and kin and the sector, to ensure the framework reflects contemporary evidence, lived experience expertise and the realities of service delivery and commissioning.

An updated Framework would provide clear direction for governments, planners and commissioners to address service gaps and duplication, support improved local commissioning and accountability, and integration of commonwealth and state and territory services. Updating the Framework could also provide clarity on distinction and connection of child mental health supports to broader evolving service systems including Thriving Kids, and reflect the role of education, early childhood and family service systems alongside health services.

3. Integrate prevention as a core focus

Problem:

Mental health challenges are the leading global cause of living with poor health. Australia has effective programs to prevent mental health challenges, however they are not yet at the scale required to shift population outcomes. Without rebalancing the system to integrate prevention, people and communities will continue to experience significant and avoidable mental health challenges and health services will face unsustainable pressure.

Solution:

Establish prevention as a core activity of the Agreement by increasing access to perinatal and infant mental health and wellbeing programs, scaling mental health and wellbeing programs within schools and early learning services, boosting local mental health promotion capability, and embedding prevention in national monitoring and reporting.

Background:

Mental health challenges are now the leading global causes of living with poor health or 'non-fatal burden of disease' – with anxiety conditions and major depression the leading mental health related contributors.[12] **A far greater focus on prevention is imperative to addressing mental health challenges as one of the biggest threats to population wellbeing, the ongoing sustainability of Australia's health systems, and our national productivity.**

The current National Agreement includes an objective for governments to work together to "prioritise further investment in prevention" as an area identified for immediate reform, and confirms that mental health promotion, prevention and early intervention is a joint responsibility of governments. While some action to improve perinatal mental health screening and related investments in suicide prevention under the current Agreement have been welcome, far greater action is required in the next Agreement to support a structural shift to include prevention in the continuum of mental health responses.

The next Agreement must increase investment in prevention – in line with Aim 4 of the National Preventive Health Strategy 2021-2030 – to 5% of total national health expenditure.[13] There is a strong and increasing evidence base to guide this investment in effective preventive mental health action and system architecture.[14]

To shift the population mental health trajectory, whole-of-government action is needed to embed prevention as a cross-portfolio commitment; with national governance to drive accountability.[15]

Within the health portfolio, there are key actions that governments must deliver together through the next National Agreement. **These actions should support the integration of prevention as a core, funded commitment of the Agreement, progressing towards 5% of the total mental health budget, and included in national reporting and outcome measures**.

© Everymind/Salty Dingo

Through the next Agreement, governments should:

- increase access to specialised perinatal and infant mental health and wellbeing programs and support stepped perinatal mental health care linked to care complexity
- scale parenting, family and carer supports delivered in community and service settings
- scale existing evidence-based, whole of learning community mental health and wellbeing programs within schools and early childhood learning services to reach all children
- leverage existing health and community service infrastructure (such as Primary Health Networks, Child and Family Hubs, public health units) to build local prevention capacity through designated roles and resourcing for local initiatives
- incorporate prevention in national mental health monitoring and reporting and support consistent tracking of prevention effort and impact across jurisdictions
- embed evaluation of prevention initiatives from the start to support continual development of the evidence base and ongoing translation of research into practice.

4. Grow and strengthen the mental health workforce

Problem:

Australia has severe shortages and maldistribution of key mental health professionals, while other skilled professions remain underutilised – limiting the community's access to supports and governments' capacity to implement reform.

Solution:

Implement and update the National Mental Health Workforce Strategy, including through embedding supported student placements and graduate engagement across adult, child and youth services under the Agreement to support workforce growth and service capacity.

Background:

Severe workforce shortages are impacting the community's access to mental health support, and limiting sector capacity to implement reform. **Australia has an estimated 32% shortfall in mental health workers, anticipated to grow to 42% by 2030 if current shortages are not addressed**.[16] Workforce challenges are even further exacerbated in remote areas of Australia,[17] and by underutilisation of skilled allied health professions.

Ambitious action to address workforce challenges and ensure coordinated national reform must be central to the next National Mental Health and Suicide Prevention Agreement.

The National Mental Health Workforce Strategy 2022-2032 provides an agreed platform and roadmap to guide workforce action. However, implementation progress has been slow, reflecting a lack of clear prioritisation, associated funding and accountability mechanisms.[18]

© Everymind/Salty Dingo

The **National Mental Health Workforce Sector Advisory Group and Network** have previously provided advice to governments on priority actions from the Workforce Strategy for immediate implementation, including:[19]

- Developing initiatives to safeguard the wellbeing of the mental health workforce (Action 3.1.1)
- Addressing critical medical, nursing and allied health workforce shortages with an initial focus on psychiatry, psychology, mental health nursing, and other relevant allied health professions (Action 1.1.1)
- Examining innovative service delivery models that support increased engagement of the Lived Experience (Peer) and First Nations workforces in different contexts (Action 1.1.2)
- Supporting initiatives to grow local mental health workforces, particularly in rural and remote settings, including training and placement opportunities (Action 2.4.4).

The Sector Advisory Group and Network also identified the need for specific actions to grow the community-managed psychosocial mental health workforce, and prioritise the provision of longer-term service contracts to support workforce retention.[20]

Actions to implement the Strategy will support delivery of broader shared health workforce commitments under the National Health Reform Agreement, where governments have committed to developing a shared evidence base to support national workforce planning, overseen by the Health Workforce Taskforce.

Workforce reform should also be informed by the national mental health workforce capability framework, attraction and retention report and mental health workforce data report recently developed for Health and Mental Health Ministers.

In particular, governments should deliver key priorities of the Strategy to attract, train, distribute, support and retain mental health workforces by embedding student placement and graduate support into program funding under the Agreement. The Early Career Program developed by headspace has been found to successfully contribute to the growth of the mental health workforce through resourcing for educator roles to provide supervision, structured education and support positive early career experiences for students and graduates.[21]

This is an effective and scalable model for growing the mental health workforce, which also facilitates important experience in multidisciplinary teams, supports evidence-based practice, and increases service capacity.[22]

This model should be expanded, adapted and embedded across programs under the Agreement to support workforce growth, development and retention - including headspace services, Medicare Mental Health Centres, Kids Medicare Mental Health Hubs and Youth Specialist Care Centres. Embedding workforce development within these services is crucial to support the increasing demand for staff with establishment of new services and models of care.

Further detailed advice for governments on priority mental health workforce reforms will be outlined in an additional statement from Mental Health Australia on behalf of the National Mental Health Workforce Sector Advisory Group and Network.

Address system foundation shortfalls

5. Fix governance arrangements

Problem:

As the Productivity Commission review found, the governance structures of the current Agreement are not effective, and monitoring and accountability are lacking.[23] This has directly contributed to low public trust, and a delayed and ineffective implementation of Agreement commitments.

Solution:

Governments should commit to the following immediate, cost neutral changes to fix the governance arrangements of the Agreement and improve effectiveness, transparency and accountability:

- continue to embed lived experience leadership across all governance structures
- include sector representatives on the Mental Health and Suicide Prevention Senior Officials (MHSPSO) Group and all associated subcommittees
- strengthen system accountability to ensure all services are culturally safe for Aboriginal and Torres Strait Islander people
- commit to a mid-term review to take public stock of Agreement implementation progress and provide an opportunity for course correction
- establish the National Mental Health Commission (NMHC) as an independent statutory agency, and remove the need for jurisdictional approval prior to release of reports on Agreement progress
- publish the membership and meeting outcomes of MHSPSO and each subcommittee.

Background:

LIVED EXPERIENCE LEADERSHIP

People with lived experience of mental health challenges, carers, family and kin must be at the heart of national mental health reform. **Lived experience, carer, family and kin leadership must continue to be embedded throughout the governance structures of the National Agreement.**

SECTOR INVOLVEMENT IN GOVERNANCE

The extensive experience of the non-government sector delivering mental health reform is an essential resource to support the effectiveness of the next Agreement – particularly in addressing the implementation failures of the current Agreement. However, the non-government sector does not have a formal voice in most of the governance structures steering this implementation.

The Productivity Commission found broad support for a stronger role for the sector in governance arrangements, and canvassed potential approaches, concluding "including the perspectives of service providers will strengthen the governance of the next agreement and support the development of a more effective system."[24]

Currently, Mental Health Australia is pleased to provide representation for the mental health sector on the Data Governance Forum and Safety and Quality Group, but such limited sector representation to only two governance subgroups is unacceptable. **Mental health sector representatives should be included on the Mental Health and Suicide Prevention Senior Officials (MHSPSO) Group and all associated subcommittees, to support coordinated oversight and effective implementation of the Agreement.**

AN INDEPENDENT NATIONAL MENTAL HEALTH COMMISSION

The National Mental Health Commission (NMHC) has a unique role in monitoring and reporting on progress under the National Agreement. This is an essential component of an effective and trusted governance system, but the NMHC has been limited in this function to date.[25]

The community and sector are waiting for a now overdue government response to consultation on reforms to strengthen the NMHC and National Suicide Prevention Office (which concluded in November 2024), in response to the findings of the 2023 independent investigation.[26]

Statutory independence of the NMHC is foundational to effectively delivering mental health system monitoring and accountability, and re-establishing trust with the community and sector. Statutory independence is consistent with broader practice and has continually been recommended by the Productivity Commission and supported by the sector. In its recent review of the National Mental Health and Suicide Prevention Agreement, the Productivity Commission concluded "Statutory powers are the norm for bodies tasked with scrutinising public sector performance. For the NMHC to carry out its monitoring role effectively and instil confidence in its oversight, it should be established as an independent statutory body."[27]

Further, the NMHC has been significantly hampered in its monitoring and reporting on the Agreement due to delays in approvals from jurisdictions. **As recommended by the Productivity Commission, the NMHC should be able to publish national progress reports as they are finalised without the requirement for jurisdictions' sign off**. Rather, the NMHC could be required to meet with jurisdictions before publishing to provide a brief on their findings and opportunity to appropriately nuance reporting on different jurisdictions.

CULTURAL SAFETY AND STRENGTHENED GOVERNANCE

The ineffectiveness of current governance approaches is particularly clear in the deplorable lack of progress in improving Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention outcomes.

As outlined by the Productivity Commission review, there has been a lack of alignment between the Social and Emotional Wellbeing (SEWB) Policy Partnership under the Closing the Gap Agreement and the Mental Health and Suicide Prevention Senior Officials group. **Mental Health Australia strongly supports Gayaa Dhuwi (Proud Spirit) Australia's calls for aligned governance mechanisms and clear accountability for mental health system reform to improve outcomes for Aboriginal and Torres Strait Islander people**, including the Social and Emotional Wellbeing Policy Partnership overseeing a dedicated schedule for Aboriginal and Torres Strait Islander Peoples.[28]

Consistent with partnership commitments under the National Agreement on Closing the Gap, the SEWB Policy Partnership should have authority to govern, monitor and evaluate the implementation and outcomes of Aboriginal and Torres Strait Islander SEWB, mental health and suicide prevention commitments under the National Mental Health and Suicide Prevention Agreement. The needs and priorities of Aboriginal and Torres Strait Islander people should be reflected throughout the *entire* Agreement to ensure cultural safety is a priority across all services and systems. The specific SEWB Schedule should provide appropriate governance and accountability for delivery of these agreed actions, reiterating commitments under existing national strategies and frameworks.

Mental Health Australia strongly supports a focus for the next Agreement on improving accountability across the whole system for delivery of culturally safe and accessible mental health and suicide prevention supports for Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people have a right to culturally safe, accessible and effective mental health and suicide prevention care regardless of where they seek support. This is consistent with existing government commitments under the United Nations Declaration of Rights of Indigenous People,[29] and the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan 2025-2035.

The systemic integration of cultural safety standards and elimination of racism in mental health care should be prioritised by the Safety and Quality Group under the Agreement, and governed by the SEWB Policy Partnership.[30]

Eliminating racism and ensuring that all services and supports are culturally safe will require strong accountability and coordinated action across both the government and non-government sector, including education and training, workforce, accreditation and service provider stakeholders.

MID-TERM REVIEW AND INCREASING TRANSPARENCY

There is not yet an effective mechanism for tracking progress of implementation of the Agreement. National progress reports for the current Agreement have been severely delayed and opaque,[31] and program evaluations have not yet been released.

Governments should commit to a mid-term progress review to provide a mechanism for a public stocktake on implementation progress. This would allow an appropriately transparent mechanism to review and course correct if required, in collaboration with lived experience peak bodies and the mental health and suicide prevention sectors as the major delivery partners. Together with improvements to independent monitoring and reporting by the NMHC, this review would provide appropriate checks and balances to support effective implementation of significant public investment over the course of a five-year agreement.

Governments should further improve transparency by addressing the lack of public information on the way the governance of the Agreement operates and the outcomes of governance bodies' work. **Governments should publish the membership and meeting outcomes of MHSPSO and each subcommittee going forward**.

© Everymind/Salty Dingo

6. Service sustainability

Problem:

Unsustainable funding, commissioning and contracting approaches are impacting community access to essential supports, and causing significant instability and job precarity across the sector – diverting and wasting scarce resources through inappropriately short-term contracts and inadequate indexation.

Solution:

Improve efficiency and stability of services under the Agreement through default longer term (five-year) contracts, appropriate indexation that includes mandated wage increases and a minimum 6-month notice period for contract adjustments.

Background:

Chronic short term funding cycles have perpetuated uncertainty and staff retention challenges for mental health services, and instability for people and communities needing mental health support.

Mandated national wage increases are appropriate. However commensurate increases are required in government contracts, otherwise these changes will result in reduced service access – where government funding is the predominant income, and wages the predominant expenditure, of most non-government mental health service providers.

These issues are highlighted in Mental Health Australia's **Sector Sustainability Statement**,[32] which outlines how problematic government funding and commissioning approaches are causing significant issues for mental health service providers including short contract durations; late notice of contract renewals; long delays in the development and execution of new service agreements; and inadequate indexation or inclusion of mandated increases for worker payments. This in turn has negative impacts on individuals' and family's access to and experiences of care.

These issues can be readily resolved through the next Agreement, through changes in government contracting protocols that create efficiencies and reduce costs associated with funding and commissioning processes.

Australian, State and Territory Governments are already making welcome progress to increase government procurement contracts for a range of community and social services (such as 5year contracts, and 3 or 5 year contracts with multiple automatic continuations), including:

- Australian Government **Community Sector Grants Engagement Framework**
- NSW Secure Jobs and Funding Certainty commitment – **Community Services Funding Framework**
- Queensland Government best practice **industry conditions for procurement**
- ACT Government community mental health **Strategic Investment Plan**
- Northern Territory Government **reforms to human services**
- South Australian Government **Response to Review of SA Not for Profit Funding Policy**
- Western Australian Government **Delivering Community Services in Partnership Policy**

The next Agreement should support five-year service contracts for mental health and suicide prevention services as default, in line these with broader changes across social and community services, and Productivity Commission recommendations.[33] Five-year contracts with appropriate notice periods and indexation to cover mandated employment requirements will support certainty for communities, job security for workers and sustainability for providers.

© Everymind/Salty Dingo

7. Data collection and measuring impact

Problem:

While governments invest in significant mental health services for the community delivered by non-government organisations, these services are almost invisible in national monitoring and reporting. This lack of data means the community, government decision makers and the non-government sector itself cannot assess the effectiveness or impact of this investment, nor the mental health system as a whole.

Solution:

Develop and deliver a national approach to measuring the impact (activity, outcomes and consumer and carer experiences) of mental health services delivered by NGOs, led by the Data Governance Forum.

Background:

Governments invest approximately $2.47bn annually in mental health services delivered by non-government organisations (NGO).[34] Yet despite the significant role and impact of these services in preventing and supporting people in Australia experiencing mental health challenges, **mental health services delivered by NGOs are largely missing in national reporting on Australia's mental health system**.

The scarcity of national data on NGO mental health activity and performance limits service and workforce planning, and monitoring of the impact of government investment. Strengthening consistency and national collation of NGO mental health service data is essential to ensure decision-makers have an accurate, systemwide view to inform policy and funding decisions, guide service development and evaluation, and ensure accountability and transparency across the whole mental health system.

There is a key opportunity to address this long-standing gap through the next Agreement, utilising the well-established interjurisdictional Data Governance Forum to lead the development and implementation of consistent data measures, building on initial scoping from the Australian Institute of Health and Welfare. This work should also be informed by initial sector consultation already undertaken by Mental Health Australia for the National Mental Health Commission on increasing NGO data in national reporting.[35]

Implementation will require progressive transition to consistent reporting measures across government contracts, with appropriate resourcing for provider data collection and capability.

8. Collaborative commissioning and system integration

Problem:

Different levels of government are funding mental health services in the same regions, with limited mechanisms or accountability for coordination and often limited involvement of people with mental health challenges and their family, carers and kin. This is a key contributor to the mental health system being fragmented, not responsive to the community's needs, and access to care being disjointed. The lack of integration risks both duplication and service gaps.

Solution:

Develop a standardised mental health support taxonomy and national directory.

Trial collaborative commissioning approaches that embed lived experience representation and include evaluation from the outset, to support expansion of effective collaborative commissioning processes to meet local community needs and support integration.

Background:

Navigating Australia's mental health system to find appropriate support is far too challenging.[36] The complexity and fragmentation of the system impacts people's access to and experience of quality care, and the efficiency of the system.

The Agreement is a unique platform to improve system integration. Moving towards "a unified and integrated" mental health and suicide prevention system is a foundational objective of the current Agreement.[37] However, little progress has been made.

A fundamental barrier has been the lack of shared language or systems to support coordinated service planning, integration or referral. The Digital Navigation Project recommended **development of a federated national mental health directory, with standardisation of mental health taxonomies and data collection**.[38] This would support more accurate connection of people to the supports right for them and smoother connection between services.

It would also enable local system integration through collaborative planning and commissioning between Australian and State and Territory Government entities. Collaborative commissioning was one of three priorities the Productivity Commission examined in their recent review into delivering quality care more efficiently. **The Productivity Commission found enormous benefits of collaborative and place-based approaches in focusing on local needs, reducing fragmentation and fostering innovative models of care**.[39]

The Productivity Commission estimated that embedding system-wide collaborative commissioning between Primary Health Networks and Local Hospital Networks could reduce potentially preventable hospitalisations by 5% and emergency department presentations by 4%, equivalent to $600million per year.

The Productivity Commission pointed to four necessary actions from governments to overcome systemic barriers to broad adoption of collaborative approaches:

1. "provide a more consistent and prescriptive approach to joint regional governance
2 increase the flexibility and certainty of funding
3 provide dedicated funding that incentivises collaboration
4 undertake supporting actions to provide strategic direction and guidance and enable access to data."[40]

Through the next Agreement, governments should pilot collaborative commissioning approaches to deliver particular components of mental health investment in particular locations (such as expansion of psychosocial supports in some states and territories), to develop and test the supporting infrastructure for more expansive collaborative commissioning in the future. **Embedding lived experience representation in collaborative commissioning is core to appropriately responding to local needs and accountability to local communities**. Piloting collaborative commissioning approaches must also improve capability of commissioners to embed lived experience in local commissioning approaches.

Improve ongoing commitments

9. Continually improve ongoing National Agreement commitments

Problem:

The current Agreement has made welcome progress to establish significant national programs, but implementation has been inconsistent and the impact is unclear with a lack of public information and reporting.

Solution:

Governments should continue to deliver and improve existing commitments under the Agreement, including through immediate release of program reviews and evaluations, and implementation of recommendations and strategies to improve supports for culturally and linguistically diverse and LGBTQI+ people.

Background:

The bi-laterals of the Agreement established significant service models and structures that now form essential components of the national mental health prevention and support system – including Medicare Mental Health Centres, Medicare Mental Health Kids Hubs, expansion of headspace youth mental health supports, supports for people at risk of or experiencing eating disorders and national perinatal mental health screening.

These important initiatives must be continued through the next Agreement, and continually adapted and improved to respond to community need and implement learnings and opportunities for innovation. **Independent evaluations form an important part of this continuous improvement cycle, and should be released and responded to in a timely way to support improved effectiveness and efficiency of the Agreement**.

Further, the Agreement includes commitments to consider and support the wellbeing of priority population groups. Ongoing commitments should be strengthened by incorporating recommendations and strategies to improve supports for culturally and linguistically diverse and LGBTQI+ people.

There are particular opportunities to strengthen the existing initiatives established through the Agreement, as outlined below.

SUPPORTS FOR CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES AND REFUGEES

Governments committed that implementation of initiatives under the Agreement would consider and support the mental health and wellbeing of priority population groups, including culturally and linguistically diverse communities and refugees. However, as the Productivity Commission review of the Agreement found – the needs of these 'priority populations' are not reflected in other parts of the Agreement or associated funding, activities or bi-lateral commitments.[41]

The next Agreement should better incorporate and strengthen accountability for responding to the needs of people from culturally and linguistically diverse communities, across both ongoing and new commitments. Australia's cultural diversity is one of our greatest strengths. Our mental health system must reflect this.

The recent **State of Multicultural Mental Health in Australia** report found people born overseas were more likely to delay accessing mental health support for 10 years or more.[42] These findings reflect barriers such as stigma, low mental health literacy, language challenges, difficulties navigating the system, and a shortage of culturally safe services. The report also highlights the limitations of existing national surveys on mental health, with exclusion of individuals with limited English proficiency and constraints around disaggregating data to meaningfully understand the needs and trends across culturally and linguistically diverse population groups.

Stakeholder consultations across multiple communities for this report highlighted that multicultural mental health care must be based on culturally safe, trauma informed and strengths-based principles, and supported by both community engagement and structural reform.

Through the next Agreement, governments should implement the recommendations of this report, to ensure that the needs of culturally and linguistically diverse communities are considered across system funding, planning and commissioning, implementation, evaluation and reporting.

SUPPORTS FOR LGBTIQA+SB PEOPLE

Similarly, the current Agreement commits governments to consider and support the mental health and wellbeing of LGBTQIA+SB people as a priority population group. While welcome, there is minimal reflection of this commitment in funded activities, implementation or monitoring of the Agreement and bi-laterals.[43]

LGBTIQ+ people continue to experience significant health inequities, including nearly three times the rate of experience of mental health challenges compared to the general population (as reported over a one year period), with even higher rates among trans and gender-diverse people.[44] LGBTIQ+ people also have limited access to safe, respectful and inclusive healthcare, with many avoiding services due to stigma and discrimination.[45]

The National Action Plan for LGBTIQA+ Health and Wellbeing 2025–2035 outlines important actions to ensure mental health and suicide prevention services are safe, respectful, inclusive and responsive to the needs of LGBTIQA+ people (Action 11).[46] These actions should be incorporated into the next (National Mental Health and Suicide Prevention) Agreement, including to improve the capacity of mainstream mental health services to offer safe, respectful, inclusive, person-centred and responsive mental health care to LGBTIQA+ people and exploring opportunities to build the capacity of community-led LGBTIQA+ mental health services to meet growing demand.

Ongoing commitments in the bi-laterals should be strengthened to support greater engagement with community-led LGBTIQ+ health and wellbeing sector, alongside further funding to support national leadership and programs that enable safe, appropriate facetoface connection, and consistent national data systems.[47]

MEDICARE MENTAL HEALTH CENTRES

Initial reviews of Medicare Mental Health Centres (MMHCs) indicate these supports are effectively addressing key gaps in mental health care. Co-evaluation of Centres delivered by Neami in 2024 found these Centres were reaching people who would not have sought support elsewhere, providing care and access to multidisciplinary support that is highly valued by consumers, and reducing presentations to hospital and emergency departments.[48]

However, Mental Health Australia members also report challenges in implementation, including sourcing appropriately skilled workforces – particularly in regional and remote areas; inconsistencies across different commissioning agencies causing inefficiencies and diverse KPIs/approaches; lack of connection across Centres; and difficulty embedding within local ecosystems without support or resourcing to do so.

Moving forward, governments should strengthen the national architecture around the Centres, to ensure they fulfil their role consistently and effectively.

As the initial review of the establishment of Medicare Mental Health Centres (then Adult Mental Health Centres) pointed to – there are ongoing challenges to manage future demand and system-level integration in a complex service and funding environment, and opportunities to improve collaboration as a complete 'network' of Medicare Mental Health Centres.[49]

This initial review made recommendations for ongoing improvement to the delivery of these Centres, including that Government should provide greater guidance on the approach to performance measurement and data collection; commissioners should include consistent reporting requirements in contracts, including around service integration; and Centres should be provided with technical support for system integration. It was also recommended that government ensure all Centres have access to appropriate senior clinical expertise, and actively monitor clinical need as the services mature.

Since this review, many more Centres have been established, and Government has undertaken both a clinical needs review led by the Chief Psychiatrist and an independent evaluation. The Australian Government should publicly release the findings of these two recent reviews to inform ongoing improvement, integration and alignment of MMHCs in the next National Agreement.

Emerging priorities from the sector include:

- **Greater national consistency in commissioning and accountability** to address significant variation in contracts, reporting requirements, KPIs, data systems and expectations across commissioning agencies. People should be able to access an equivalent service of consistent quality regardless of which PHN region they live in, and providers should have consistent requirements across multiple regions. While local flexibility remains important, clearer national expectations and greater consistency would reduce inefficiencies and support a more coherent national model.

- **A more sophisticated national outcomes framework,** as current KPIs do not reflect the breadth and value of the work centres undertake. Measures should capture brief and single-session engagements, consumer experience and outcomes, crisis de-escalation, warm connections to other services and the support provided to families and carers. There is also a need for more consistent and usable data across the national network, so the community, providers, PHNs and government can better understand performance, benchmark outcomes and support continuous improvement.
- **Recognition of lived experience practice as a core component of the model**. The integration of lived experience and clinical supports is one of the strengths of the MMHC model. Both peer workers and clinicians bring distinct and complementary expertise, including when supporting people experiencing distress or suicidality. Peer workers should not be viewed simply as a first point of contact before people are escalated to clinical care as their needs become more complex. The integrated role of peer workers as a core component of the service model should be clarified.
- **Resourcing for local integration and service-system development** to ensure MMHCs are embedded within their local ecosystems and can effectively receive and make referrals to other appropriate supports. The essential work of active relationship-building to establish clear pathways with state-funded clinical services, emergency departments, GPs, psychosocial supports, AOD services, housing and homelessness services and suicide-prevention services requires time, support and resourcing.
- **Funding and contracting arrangements that support stability and model maturity** – in line with Priority 6 above, longer term contracting arrangements with appropriate indexation are needed to support ongoing effectiveness and efficiency of MMHCs. Short-term contracts, unclear timelines and inconsistent indexation have made it harder to attract and retain the skilled workforce and create the service-system relationships required.
- **Stronger mechanisms for shared learning across the national network.** Mechanisms including Communities of Practice have supported some shared learning across the network, but this has been limited without nationally consistent data sharing. Stronger national approaches, including publicly available and benchmarked data on MMHC performance and outcomes, are needed to enable the community, providers, PHNs and government to compare performance, understand variation, and identify effective practice.
- **Further development of evidence-based practice for brief and accessible support**. MMHCs create an opportunity to develop and share evidence about how therapeutic approaches can be adapted effectively for a walk-in, low-barrier setting, with brief engagements. Many established therapeutic modalities assume a longer-term engagement. Further work is needed to identify effective brief approaches while retaining the capacity to provide continuity and connection to longer-term support where required.

KIDS MEDICARE MENTAL HEALTH HUBS

Establishment of a national network of Medicare Mental Health Kids Hubs is a key achievement of the current Agreement – implementing a core action of the Children's Mental Health and Wellbeing Strategy to address critical gaps in support for children and their families.

However, implementation of Kids Hubs was slow, with delays in many jurisdictions. As of May 2026, 14 of 17 committed hubs are active.

Government should immediately release the recent evaluation of the Hubs to inform ongoing improvement, as well as any changes to mitigate further delays.

As outlined above, **continued expansion of Medicare Mental Health Kids Hubs should be informed by this evaluation, support increasing integration with other support systems, and consistent implementation of a family-inclusive approach**.

YOUTH MENTAL HEALTH SERVICES

The current Agreement has supported welcome enhancement and expansion of youth mental health services across the country, with commitments in all bi-lateral agreements.

Mental Health Australia understands jurisdictions have taken different approaches in the interpretation, prioritisation and progression of these commitments to strengthen headspace services.

National action to support integration through the next Agreement is required and should be informed by advice from the sector and young people on youth mental health models of care,[50] and the Australian Government's recent consultation to inform development of headspace Plus and Youth Specialist Care Centres.[51]

Ongoing improvement through the next Agreement should focus on improving integration with both primary and tertiary care, particularly given the addition of these two new models of care.

Further, as recommended above, changes are needed to address workforce challenges (Priority 4) and sustainability issues of short-term contracts (Priority 6).

SERVICES FOR PEOPLE EXPERIENCING OR AT RISK OF EATING DISORDERS

The current bi-lateral agreements supported four jurisdictions to establish particular programs to support people experiencing or at risk of eating disorders (Western Australia, Tasmania, Australian Capital Territory and Queensland).

As reported by the National Eating Disorders Collaboration, these services address important gaps in the system of care – responding to priority needs in these jurisdictions aligned with national priorities as articulated in the National Eating Disorders Strategy. **These programs are delivering important early intervention and intensive community support to increase access and comprehensiveness of supports for people at risk of or experiencing eating disorders and their family, carers and kin**.

These commitments have also supported greater alignment between federal and state/territory initiatives through clear funding arrangements and performance targets. However, some initiatives have not been as well integrated into local systems of care as they could have, with a lack of consultation with local leaders and mechanisms for people with lived experience to be part of decisions on funded activities and ongoing oversight.

Governments should continue to build on progress to date, to work towards a comprehensive and integrated system of care for eating disorders within each jurisdiction, utilising the Agreement to address system gaps and clarify responsibilities for state and federal services. **Under the next Agreement, governments should continue existing programs and increase support to other jurisdictions to address gaps in prevention and support, in line with priorities under the National Eating Disorders Strategy 2023-2033**.

This Strategy provides a clear roadmap to guide sector development and policy decision-making. The Strategy and the requisite components of the stepped system of care for eating disorders should be used to guide the development of commitments to address particular gaps in each jurisdiction. Initiatives should be aligned with best practice and the National Strategy, overseen by local advisory groups, and transparently monitored and reported on, including how the initiative fits within jurisdictions' approach to the stepped system of care.

PERINATAL MENTAL HEALTH SCREENING

Investment to expand perinatal mental health screening in six of the bi-lateral agreements was very welcome. However, there is limited information on the rollout of perinatal mental health screening programs under the bilateral agreements, or tracking of how screening and help seeking/referral to supports has changed over the course of the current Agreement.

Mental Health Australia members report there is an ongoing need to provide national perinatal mental health screening, but that there are challenges in ensuring consistent screening, reporting and referral to supports. Embedding screening in care pathways and service touchpoints across public, private and not-for-profit primary, secondary and tertiary care providers is needed to improve reach, consistency and reporting. It will also improve opportunities to connect fathers and non-birthing partners with supports where needed, who may not be identified through tertiary maternity services.

Governments should continue to improve consistent national perinatal mental health screening and reporting through the next Agreement by:

- driving incorporation in screening tools of automatic information on support options to enable immediate connection to supports
- removing barriers to accessing care by broadening referral pathways into specialist services
- increasing availability/use of culturally sensitive screening tools
- standardising screening protocols to ensure consistency for both continuity of care and reporting
- expanding screening programs to primary care professionals in the public, private and not for profit space to capture presentations across the perinatal period, and include dads and non-birthing partners
- ensuring the workforce delivering screenings are trained to do so
- improving indicators in the National Dataset for Perinatal Mental Health.

These changes, along with more transparent national monitoring and reporting, are important to ensure the effectiveness of this important national initiative and that screening results in connection to supports where required.

References

1 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review [Inquiry Report]**, Finding 3.1

2 Santomauro D, Miller P, Shadid J et al. Updated trends in the global prevalence and burden of mental disorders, 1990–2023: a systematic analysis for the Global Burden of Disease Study 2023 The Lancet, 407, 2040-2064

3 Health Policy Analysis (for Australian Governments) (2024) **Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme: Final Report,** 9-10

4 Health Policy Analysis (for Australian Governments) (2024) **Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme: Final Report,** 89

5 The Hon Mark Butler MP, Minister for Health and Ageing, Minister for Disability and the National Disability Insurance Scheme (2026) **Minister Butler speech at the National Press Club – 22 April 2026**

6 Health and Mental Health Ministers (2025) **Joint Health and Mental Health Ministers' Meeting (HMM): Communique: 13 June 2025- Melbourne**

7 Health and Mental Health Ministers (2026) **Health Ministers Meeting (HMM): Communique: 13 February 2026 - Canberra**

8 Australian Bureau of Statistics (2020-2022) **National Study of Mental Health and Wellbeing**; Australian Bureau of Statistics (2007) **National Survey of Mental Health and Wellbeing**

9 **Joint Health and Mental Health Ministers' Meeting Communique** (13 June 2025) Melbourne

10 Goodyear, M., Taylor, E., Marsh, C., Scharling-Gamba, K., Mclean, S., Burn, M., & Morgan, B. (2024). **Scoping child mental health workforce capability: Final report**. Emerging Minds

11 Goodyear, M., et al. (2024). **Scoping child mental health workforce capability: Final report**.

12 Santomauro D, Miller P, Shadid J et al. Updated trends in the global prevalence and burden of mental disorders, 1990–2023: a systematic analysis for the Global Burden of Disease Study 2023 The Lancet, 407, 2040-2064

13 Australian Government Department of Health (2021) **National Preventive Health Strategy 2021-2030**, p73

14 Prevention Coalition in Mental Health (2020) **Primed for prevention: A consensus statement on the prevention of mental disorders**; Prevention Coalition in Mental Health (2022), **Starting upstream: Building a strong and sustainable preventive mental health system for Australia**

15 Wellbeing and Prevention Coalition in Mental Health (2026) **Statement of Priorities: Health and Mental Health Ministers' Meeting**

16 Department of Health and Aged Care (2022) **National Mental Health Workforce Strategy 2022-2032**, p16

17 Australian Institute of Health and Welfare (2023) **Mental health workforce**

18 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review [Inquiry Report]**

19 Mental Health Australia on behalf of the Mental Health Workforce Sector Advisory Group and Network (2025) **Mental health sector guidance on National Mental Health Workforce Strategy 2022-2032 implementation priorities**

20 Mental Health Australia for National Mental Health Sector Workforce Advisory Group and Network (2025) **Mental health sector guidance on National Mental Health Workforce Strategy 2022-2032 implementation priorities**

21 Headspace National Youth Mental Health Foundation (2025) **evaluation of the headspace Early Career Program 2021-2025: evaluation snapshot report**

22 Deloitte independent evaluation of Early Career Program for Department of Health and Aged Care (2023), as cited by headspace (2024) **Pre-budget submission 2024-25**

23 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review [Inquiry Report]**, Finding 3.1

24 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review [Inquiry Report]**, p176

25 Mental Health Australia (2024) **Submission on Reforms to Strengthen the National Mental Health Commission and National Suicide Prevention Office**

26 Department of Health, Disability and Ageing (2024) **Reforms to Strengthen the National Mental Health Commission and National Suicide Prevention Office**

27 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review: Inquiry report** p.178

28 Gayaa Dhuwi (Proud Spirit) Australia (2025) **Submission to the Productivity Commission on the National Mental Health and Suicide Prevention Agreement Review Interim Report**

29 United Nations (2007) **United Nations Declaration on the Rights of Indigenous Peoples**

30 Gayaa Dhuwi (2026) **Submission to the Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs inquiry into racism, hate and violence**

31 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review [Inquiry Report]**, p177

32 Mental Health Australia (2025) **Sector Sustainability Statement**

33 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review: Inquiry report** p.199

34 Australian Institute of Health and Welfare (2026) **Expenditure on mental health-related services.** This figure includes funding to programs managed by the Department of Health, Disability and Ageing and the Department of Social Services, Indigenous Social and Emotional Wellbeing programs and the total State and Territory spending on non-government organisation mental health services for 2023-24.

35 Mental Health Australia for the National Mental Health Commission (2026) [forthcoming] Increasing NGO data in the National Report Card: Final Report

36 Productivity Commission (2020) **Inquiry Report: Mental Health**, Vol 2 pp661-663

37 **National Mental Health and Suicide Prevention Agreement** (2022) Paras 21, 25(a)

38 Green, R., Gelling, A., Jackson, M., Verbeek-Martin, E., Millet, S., Mallet, W., Powell Thomas, G., Bothwell, S., Brideson, T., Brown, T., & Reavley, N. (2025). **Digital Navigation Project Recommendations Report**. SANE and Nous Group.

39 Productivity Commission (2025) **Delivering quality care more efficiently inquiry report**, p33

40 Productivity Commission (2025) **Delivering quality care more efficiently inquiry report**, p41

41 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review [Inquiry Report]**, p118

42 Slewa-Younan S, Blignault I, Chimoriya R, Agho K, Li B, Jorm AF, Salvador-Carulla L, Bagheri N, Renzaho AM (2025). **The State of Multicultural Mental Health in Australia Research Report**, Western Sydney University, for Embrace Multicultural Mental Health, Mental Health Australia

43 Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review [Inquiry Report]**, p118

44 Australian Bureau of Statistics (2024**) Mental health findings for LGBTQ+ Australians**, analysis of National Study of Mental Health and Wellbeing 2020-2022

45 Amos, N., Lim, G., Buckingham, P., Lin, A., Liddelow-Hunt, S., Mooney-Somers, J., Bourne, A., on behalf of the Private Lives 3, Writing Themselves In 4, SWASH, Trans Pathways, Walkern Katatdjin, and Pride and Pandemic teams (2023). **Rainbow Realities: In-depth analyses of large-scale LGBTQA+ health and wellbeing data in Australia**. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.

46 Australian Government Department of Health and Aged Care (2024) **National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025 - 2035**

47 LGBTIQ+ Health Australia (2026) **2026-27 Pre-Budget Submission**

48 ALIVE National Centre for Neami National (2022-2024) **An Implementation Co-Evaluation of four First Wave Medicare Mental Health Centres and the Urgent Mental Health Care Centre (SA)**

49 Nous Group for Australian Department of Health (2022) **Independent Evaluation of HeadtoHelp and AMHCS: Final Evaluation Report**

50 Orygen and partners (2025) **Sector-led advice on new and/or refined youth models of care: Final Advice**; and Batyr (2025) **Youth at the Centre: Young People's Vision for Mental Health Care in Australia**

51 Australian Government Department of Health, Disability and Ageing (2026) **Consultation on draft models of care for headspace Plus and Youth Specialist Care Centres**