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SUBMISSION

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Submission to the Productivity Commission Mental Health and Suicide Prevention Agreement Review

Final review of the National Agreement

Overview of the Australian mental health and suicide landscape

The Australian Medical Association (AMA) is committed to the ensuring all Australians have access to necessary mental health services at times when they need it most. The burden of mental illness is underestimated. A study by psychiatrists in Boston estimated mental illness to be a distant first in global burden of disease in terms of Years Lived with a Disability (YLD), and level with cardiovascular and circulatory diseases in terms of Disability-Adjusted Life Year (DALY)[1]. Alarmingly, the rise of mental ill health in young people, and particularly young females (from 28.5 per cent in 2007 to 45.5 per cent in 2020–2022),[2] is a warning to all governments to reform existing mental health investments, rather than doing the same thing repeatedly and expecting different results.

The AMA's most recent 2024 Public hospital report card — Mental health edition confirmed major cracks in Australia's public mental health system. Public hospital emergency departments are seeing more patients with mental ill health, and they're sicker than ever before, with 60 per cent of those people presenting through an emergency services vehicle. However, the number of specialised mental health beds is at its worst per-patient, per-person capacity on record (at 27 beds per 100,000 people). Additionally, the report card showed we are then leaving our sickest patients for longer than is necessary in our emergency departments. The average wait time for a mental health bed is now seven hours. That is two hours longer than it was two years ago. One in 10 patients are now waiting more than 23 hours in a noisy, loud, crowded emergency department for a mental health bed.

[1] Vigo, D. et al (2016) Estimating the true global burden of mental illness. The Lancet Psychiatry 3 (2) 171-178

[2] https://www.aihw.gov.au/mental-health/overview/australias-mental-health-system

The National Mental Health Commission's National Report Card 2023 also found no evidence of improved capacity to provide effective care.[3] Private psychiatric hospitals provide 32 per cent of mental health beds for children and 45 per cent of adult general psychiatric beds in Australia.[4] Alarmingly, mental health admissions in private hospitals are becoming increasingly difficult due to wards closing. The collapse of private practice psychiatry will place immense strain on public services, with public emergency departments bearing the burden of more complex cases. Encouragingly, both the AMA and National Mental Health Commission report cards did show modest improvements in the follow-ups of patients after a discharge. The rate of community follow-up for people within the first seven days of discharge from an inpatient psychiatric unit increased from 60.6 per cent (2012–13) to 75.2 per cent (2021–22).

The National Mental Health and Suicide Prevent Agreement (National Agreement) came into effect in March 2022 and is due to expire in 2026. A key objective of the National Agreement was to reduce fragmentation in the mental health system. While significant investment has been made into mental ill health under the National Agreement, there has been limited funding for clinicians and critical bolstering of the mental health workforce through either federal or state and territory governments and is falling significantly short of what is required. The current mental health services and programs under the National Agreement are also failing to improve mental ill health and suicide risk in priority populations, specifically Aboriginal and Torres Strait Island peoples, LGBTQIA+SB people, those with disability, and people who are (or were previously) in contact with the criminal justice system.

A new National Agreement in 2026 can be improved in several key areas:

1. **Increase investment in mental health services** by expanding the capacity of mental health wards in both public and private hospitals, including both the number of beds and the workforce needed to support them.

2. **Provide greater support for general practitioners**, who play a crucial role in delivering most of the mental healthcare. GPs are vital in preventing the deterioration of patients' mental health and managing complex, chronic conditions.

3. **Allocate more resources to mental healthcare** across the full spectrum of needs, ensuring these investments are guided by evidence-based practices.

4. **Improve mental health governance and reduce complexity** to keep as many individuals healthy and out of hospital as possible, promoting proactive care in local settings.

[3] https://www.mentalhealthcommission.gov.au/publications/national-report-card-2023

[4] Australian Private Hospitals Association. Mental Health — crisis and solutions, a private hospital perspective. April 2023.

Mental health professions shortage

The National Agreement provides a good framework for improving the mental health and wellbeing of Australians. However, federal, state and territory governments need stronger collaboration in developing and funding sustainable training models that will expand the domestic mental health workforce pipeline. The AMA understands the federal government is working through its National Mental Health Workforce Strategy,[5] which outlines the need to train, retain and support people to build the mental health workforce. Psychiatrists, GPs, mental health nurses, psychologists, paediatricians, school counsellors, social workers, and alcohol and other drugs support staff are key to a patient-centred mental health system. However, severe workforce shortages and/or inadequate staffing, complexity of patient presentations, and increasing patient loads are contributing to an under-resourced mental health system. Future national agreements must provide a roadmap for meaningful reform of the mental healthcare system and a plan to build the mental health workforce of the future. While there are commitments from the federal, state and territory governments to work together, clear definitions of governmental responsibility for funding and workforce development are necessary to ensure accountability and the successful implementation of the National Agreement. Without clear and co-ordinated efforts from both levels of government, workforce shortages and capacity limitations will continue to undermine the mental health system's ability to meet increasing demand.

The ability to retain and support a mental health workforce to ensure sustainability must be a priority of the National Agreement. A survey conducted by the Royal Australian and New Zealand College of Psychiatry found seven in ten psychiatrists had experienced symptoms of burnout in the past three years and this burn-out was exacerbated by workforce shortages and overstretched mental health services.[6] More than 90 per cent of respondents highlighted that workforce shortages and burnout were having a negative impact on patient care.

Investing in evidence-based care delivered in public and private settings

Australia's mental health system does not need further complexity but rather should return to evidence-based care delivered in public and private settings. The last stocktake of mental health and suicide prevention programs and services was conducted by the Productivity Commission in 2021.[7] This stocktake confirmed the complexity, fragmentation and duplication of mental health services, with roles and responsibilities split between federal, state, and territory public and private, and community and acute services. Other government departments that encompass the social determinants of health and intersect with mental health, such as justice, education and training, housing and homelessness, employment and income support, disability, family violence (FV), and alcohol and other drugs (AOD) are not well integrated, and funding is difficult to identify. Large non-governmental organisations further complicate this picture, increasing fragmentation in an

[5] https://www.health.gov.au/resources/collections/national-mental-health-workforce-strategy-2022-2032

[6] https://www.ranzcp.org/getmedia/f1e48356-bfa6-46b6-a068-e383bbbe2683/ranzcp-workforce-report-feb-2024.pdf

[7] Productivity Commission Final Report: Mental health and suicide prevention stocktake April 2021

already poorly integrated national mental health system. The current fragmentation in the system means people cannot always access the care they need when they need it, increasing mental distress for people in need and placing additional pressure on carers and the health system. This level of complexity is not seen in any other branch of medicine.

In the AMA's most recent Mental Health and Wellbeing Position Statement 2024, a strong call was made for all levels of governments and non-governmental organisations to work co-operatively to design a mental healthcare system that is patient-centred, and needs-based, informed by evidence and research, with adequate investment and sustainable funding. The AMA acknowledges consumer-led input, including the development of multidisciplinary team care, community services, and holistic care, forms a key part of mental health interventions and healthcare innovation. However, greater investment into well-designed, medically governed multi-disciplinary teams is more likely to result in better overall health outcomes.

The AMA acknowledges the release of the national-suicide-prevention-strategy. In our submission to the National Suicide Prevention Office on the draft strategy, we urged the government to reprioritise the enablers of the strategy and prioritise training and support for psychiatrists and GPs. This was not reflected in the final strategy. The General Practice: Health of the Nation report found 71 per cent of specialist GPs reported psychological issues in their top three reasons for patient presentations.[8] Australian GPs conduct more mental health consultations per year than any other specialty or clinician. For some people, mental health conditions must be managed consistently throughout their whole life. Although the severity of mental health conditions can fluctuate, some are often persistent in nature. General practice is the most accessible service for those who require mental health care and, in rural areas, it is often the only service available.[9] Individuals exhibiting suicidal behaviour often visit their GP in the weeks or days leading up to a suicide attempt. GPs are well placed to identify signs of suicidality, even in patients who may not openly express their distress. High-quality GP care has been proven to significantly reduce suicide deaths and attempts, especially when incorporated into a multifaceted suicide prevention program.[10] GPs need to be better equipped to provide and co-ordinate care for people experiencing mental ill health. Successive underfunding of GPs over decades has put enormous financial pressure on general practice and those with mental health concerns and complex care requirements will continue to be underserviced. The AMA recently launched its Modernise Medicare plan to support GPs to spend the time they need with their patients.

Review before funding renewal/discontinued

The National Mental Health Commission's National Report Card 2023 states: "Not much is known about nationally funded initiatives." Less than 10 per cent of mental health programs and facilities and

[8] https://www.racgp.org.au/general-practice-health-of-the-nation

[9] https://lifeinmind.org.au/news/the-role-of-gps-in-suicide-prevention-in-rural-australia

[10] Black Dog Institute. An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring. Sydney: Black Dog Institute, 2016.

their outcomes are measured.[11] The Productivity Commission also noted many government investment decisions for mental healthcare were not based on evidence of effectiveness or cost effectiveness.[12] To ensure a robust and equitable mental health system, implementing measurable and auditable accountability standards is crucial. Developing a comprehensive national database that monitors workforce distribution, service demand, and patient outcomes is recommended. Such measures would help identify gaps, optimise resource allocation, and reduce disparities in care delivery across urban, rural, and remote regions. Data-driven decision making by creating nationalised registers that document and track a patient's "mental health life cycle" offers a transformative approach to measuring outcomes and ensuring accountability in mental healthcare. Such registers, integrated with mental health management care (MHMC) systems, would centralise patient information across all providers (GPs, psychologists, psychiatrists, and allied health professionals) to foster a co-ordinated and evidence-based approach.

Benchmark reporting must be implemented within every intervention, before funding and scale-up occur. Transparent evaluation of prioritised mental health and suicide prevention programs that are funded by federal, state and territory governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors, is needed. Without rigorous evaluation, cost-effectiveness and the assurance that programs are contributing positively to mental health and wellbeing cannot be assumed. Lessons can also be learned and included in future program delivery. Integrated data — where mental health data is linked with broader health, social, and economic datasets to provide a holistic view of mental health determinants and outcomes — is critical. Further resources and support should also be provided to the Australian Institute of Health and Welfare (AIHW). Data linkage within the AIHW will be essential to understanding where the gaps in patient access are in the community, and how to better engage with populations at high risk of mental health and suicidality.

Improved mental health governance with the National Agreement

The Productivity Commission recommended the creation of an interjurisdictional, special-purpose mental health council (SPMHC) of federal, state and territory government health (or mental health) ministers, plus ministers of selected social policy portfolios, on 18-month rotations. The SPMHC would report annually to governments on progress against the National Mental Health Strategy and prioritised actions in integrating mental healthcare between health and non-health agencies. Unlike health ministers who come together regularly for the Health Ministers' Meeting (HMM) and have a direct reporting line to the National Cabinet, the ministers and/or assistant ministers responsible for mental health rarely meet. In fact, July 2024 was the first time in years mental health ministers were invited to join the health ministers. This was in response to the Westfield Bondi stabbing incident in Sydney, which resulted in seven deaths. It is now apparent the man who stabbed and killed six people and injured a further twelve, before being fatally wounded by an intervening police officer, had stopped his medication for schizophrenia and experienced a deterioration in his mental state. The communique that followed the meeting detailed assurances that the governments would work

[11] https://www.mja.com.au/journal/2022/217/8/latest-evidence-casts-further-doubt-effectiveness-headspace

[12] Productivity Commission. Mental Health. Canberra: Australian Government, 2020

together to improve access to mental health services across Australia through a re-affirmed commitment to delivering on the National Agreement.[13] In addition, there was an agreement to meet twice a year. To date, this commitment has not transpired.

As per Annex A of the National Agreement, the federal government co-funds its contribution to the Primary Health Networks (PHNs), with the states and territories to provide their contribution directly to the Local Health Districts (LHDs). The most recent review of PHNs by the Auditor General[14] concluded that PHNs delivery model is not achieving its two objectives: improving the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes; and improving the coordination of health services and increasing access and quality support for people. The Auditor General's report provided eight recommendations (seven recommendations were agreed in full by the Department of Health and Aged Care, with one recommendation agreed in principle). The eight recommendations centred on improving transparency, performance measures and public reporting of all PHN efficiencies. A recent RACGP newsGP poll, with more than 1,200 respondents, showed more than 50 per cent rated the value provided by their PHN as poor or very poor.[15] Mental health services and programs commissioned by PHNs could be greatly improved through better engagement with the GPs and medical services working within the LHNs.

PHNs have a unique opportunity to create comprehensive wrap around services with GPs and allied health professionals working under one roof. In 2022, the Danish Government identified mental health as a public health challenge. With inspiration from the cancer area, the government established multidisciplinary and cross-sectoral groups to deliver overall health and social care services aimed at providing longitudinal support for people with mental illness.[16] The AMA is supportive of bolstering investments to develop co-ordinated models of care that are appropriate for the needs of communities and regions. The AMA recommends specific investment in developing capacity in mental health support services within GP and private psychiatrist practices, such as embedding accredited mental health nurses and social workers. These wrap-around services have the potential to offer better return on investment and health outcomes rather than investing in siloed service delivery models, particularly in rural, regional, and remote areas.

Linkages with other agreements

National Health Reform Agreement Amendment 2020–25 (the NHRA)

A key action from the mid-term review of the Addendum to the National Health Reform Agreement (NHRA) 2020–21 to 2024–25 called for the new Agreement to be one that is broader than hospital

[13] https://www.health.gov.au/resources/publications/joint-health-and-mental-health-ministers-meeting-communique-16-august-2024?language=en

[14] https://www.anao.gov.au/sites/default/files/2024-03/Auditor-General_Report_2023-24_19b.pdf

[15] https://www1.racgp.org.au/newsgp/professional/racgp-calls-for-phn-overhaul

[16] https://healthcaredenmark.dk/national-strongholds/mental-health/

funding. The mid-term review recommended the assignment of functions and actions for mental health and for mental health strategies to be integrated into optimal models of care, financing, innovation and performance elements of a new Agreement.[17] The new Agreement presents an opportunity for real reform to incorporate shared models of care, focus on prevention, and shift models to keep patients out of hospital. Instead, discussions surrounding a new NHRA (2025-30) have stalled between the federal, state and territory governments. On 5 February 2025, all states and territories signed a one-year agreement, which saw the total federal funding contribution to state- and territory-run public hospitals increase by 12 per cent ($33.91 billion for 2025–26). This is disappointing and the AMA urges governments to get back to the discussion table as soon as possible.

National Agreement on Closing the Gap

New data released by the Productivity Commission shows very clearly that the current approach to reduce the rate of suicides in Aboriginal and Torres Strait Islander peoples is not working.[18] The suicide rate for Aboriginal and Torres Strait Islander peoples is the highest since data has been collected (30.8 per 100,000 people in 2024). Indigenous leadership in policy and program development must be embedded in mainstream organisations and government departments as part of systemic and structural change. Under the agreement and following extensive consultation with Aboriginal communities in South Australia and the South Australian mental health sector, the Nunkuwarrin Yunti Mental Health and Wellbeing Centre will open towards the end of 2025 to enhance access to mental health and wellbeing services that are culturally sensitive and interdisciplinary in nature.

Concluding remarks

In conclusion, our review of the National Mental Health and Suicide Prevention Agreement highlights several critical areas for improvement to ensure a robust and effective mental health system in Australia. The AMA calls for a diversion of proposed future funding back to public sector mental health services where there is better evidence for improved outcomes. Sustainable training models are urgently required to expand the domestic mental health workforce pipeline and clear definitions of governmental responsibility for funding and workforce development are needed. The AMA also calls for reduced complexity to the mental health system and improved governance to keep individuals healthy and out of hospitals, promoting proactive care in local settings. To improve mental health and wellness outcomes for priority groups, such as Aboriginal and Torres Strait Islander peoples, Indigenous leadership must be embedded in the policy and program development. And finally, different agreements must not work in isolation. The next five years of the NHRA provides opportunity for significant reform. By addressing these key areas, the National Mental Health and Suicide Prevention Agreement can be significantly enhanced to better meet the needs of all Australians, ensuring a more integrated, effective, and sustainable mental health system.

[17] https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf

[18] Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing - Dashboard | Closing the Gap Information Repository - Productivity Commission

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