MHLET: experience knowledge change

MENTAL HEALTH LIVED EXPERIENCE TASMANIA

*Submission in response to*

# Productivity Commission's National Mental Health and Suicide Prevention Review: Interim Report

July 2025

## Acknowledgement of Country

Mental Health Lived Experience Tasmania (MHLET) respectfully acknowledges the palawa, the original custodians of the lands and seas of lutruwita (Tasmania) on which we live and work. We pay our respects to elders, past and present.

We acknowledge the significant ongoing and pervasive harmful impacts of colonisation and respect the resilience of First Nation's Peoples and their retained strong connection to Country, culture, and community.

We recognise that sovereignty was never ceded. This was, is, and will always be Aboriginal land.

## About MHLET

MHLET is a not-for-profit organisation dedicated to empowering Tasmanians with lived experience of mental health challenges. By advocating for, and with, Tasmanians, we amplify the voices of people with lived experience to create meaningful systemic change in mental health services for the Tasmanian community. MHLET provides training opportunities, peer connections and collaboration with policymakers and service providers.

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## Terminology

References made within this submission to the terms 'consumer' and 'lived experience' specifically refer to mental health consumers with lived experience of mental health challenges and/or suicidality. MHLET uses these as blanket terms due to their shared understanding and acceptance within the broader community, but understand that different people may identify with, and/or prefer, different terms. Within this submission, these terms do not necessarily consider nor convey the levels of need (i.e., low, medium, or high) of consumers unless specified.

MHLET does not represent family, carers, kin, or the bereaved within the organisation, as such they are not included in the definitions of 'lived experience' or 'consumer' within this submission.

## About this submission

The *National Mental Health and Suicide Prevention Agreement*, and the state bilateral agreements set out the shared intention of the Commonwealth, state, and territory governments to work in partnership to improve the mental health of all Australians, reduce the rate of suicide toward zero, and ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system[1].

In March 2025 MHLET responded to the request from the Productivity Commission for feedback on the *National Mental Health and Suicide Prevention Agreement*. MHLET provided a submission that contained their concerns about the existing agreements and their efficacy. MHLET also included several recommendations on how certain aspects of these agreements may be improved in future iterations to better meet the needs of mental health consumers.

This submission is in response to the Productivity Commission's findings and subsequent recommendations illustrated in the *Mental Health and Suicide Prevention Agreement Review: Interim Report*[2] (Interim Report). It pertains primarily to the findings that relate to the recommendations made by MHLET in their earlier submission for the *National Mental Health and Suicide Prevention Agreement* review.

[1] Federal Financial Relations N.D., The National Mental Health and Suicide Prevention Agreement, Australian Government, <https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement>.
[2] Productivity Commission 2025, Mental Health and Suicide Prevention Agreement Review, Australian Government, <https://www.pc.gov.au/inquiries/current/mental-health-review/interim>.

## Introduction

MHLET commends the commitment the Productivity Commission has had to the full analysis of the efficacy of the *National Mental Health and Suicide Prevention Agreement* (Agreement) and the bilateral agreements. The thorough approach that has been taken to the review, through the surveys, broad submission requests, and meetings undertaken with stakeholders, has provided greater opportunities for Australian mental health consumers to have their voices heard.

Consumers and organisations alike may feel validated with the findings of the review thus far, in that the Productivity Commission has found that the current Agreement is not efficacious at delivering significant or measurable outcomes. In its current iteration, the Agreement does little to promote or include the voices of those it claims to represent, nor does it progress systemic change that may promote the wellbeing of Australian mental health consumers.

## Response to Interim Review Recommendations

### Draft Recommendation 4.2

#### Delay next Agreement negotiation

MHLET supports the supports the Productivity Commission's recommendation of a 12-month delay in negotiation of the new Agreement. This will ensure that all the draft recommendations in the Interim Report[3] are able to be put in place prior to negotiations.

As recommended, this will provide the time to:

1. Ensure extensive co-design negotiation, development, and governance processes of the Agreement from those with lived and living experience of mental health challenges. This includes the growth of existing State/Territory Peak bodies (STPs) to facilitate this process to ensure co-design beyond tokenistic levels.
2. Work with the national and state/territory data reporting organisations to ensure new data collection mechanisms are in place to capture data relevant to the interests of people with lived experience of mental health challenges.
3. This includes removing deficits-based language in measurement tools and looking beyond the clinical outcomes of the Agreement.
4. Ensure the Mental Health Commission is an independent statutory body.

[3] *ibid*

## Draft Recommendation 4.7

### Lived experience

MHLET fully supports the Productivity Commissions findings of the lack of significant or meaningful lived experience involvement in the current Agreement. MHLET strongly supports the recommendations for the inclusion of the lived experience of mental health consumers at all levels, including development, implementation and governance of the next Agreements.

The recognition of the lack of lived experience in the design of the current iteration of the Agreement is vital to the lived experience community. It validates their experience and highlights the ongoing need for their voices to be heard in the mental health service design, delivery, evaluation, and governance. Furthermore, it emphasises the need of the prioritisation of the consumer voice over other stakeholders such as service providers to ensure the autonomy and self-determination of mental health consumers.

MHLET endorses the recommendation of the embedding of state and national lived experience peak bodies in governance arrangements. Additionally, to ensure lived experience involvement in the commissioning and negotiation process, MHLET recommends that lived experience STPs are funded appropriately, and that funding is protected. The STPs must be able to be honest and fearless in this governance work, and able to call out failings without fear of funding being at risk.

### Co-design

MHLET supports the Productivity Commission's recommendation of the inclusion of co-design throughout the entirety of the Interim Report. To ensure people with lived experience of mental health challenges are truly included, the Agreement must reflect actual co-design which shares decision-making power; it is crucial that previous tokenistic consultations with consumers, ones that occur after key decisions have been made, are avoided. Outcomes reached without the inclusion of lived experience consumers' recommendations should be completely transparent with a full explanation provided as to how and why those decisions were made.

### Peer workforce

MHLET welcomes the Productivity Commission's interim report and its recognition of systemic challenges within Australia's mental health framework. However, we emphasise that meaningful reform requires the promotion and inclusion of the peer workforce as essential, as peer workers bring incomparable insights, skills, and connections that complement, rather than compete with, clinical approaches.

Australia's mental health system remains dominated by clinical models despite mounting evidence that many consumers prefer peer-led, community-based supports[4]. The Interim Report correctly highlights deep consumer dissatisfaction with crisis responses centred on emergency departments, which frequently prove unsafe, retraumatising, or actively harmful. We strongly support expanding non-clinical, peer-led alternatives with long-term funding commitments to ensure service certainty for users.

MHLET endorses calls for stronger system-wide accountability for peer role integration to prevent tokenism and clinical gatekeeping that diminishes the peer workforce's contributions. This approach will elevate peer work as a standalone profession with distinct value and expertise, further enhanced by the previously proposed establishment of a Professional Peer Workforce Association[5].

## Draft Recommendations: Multiple

### Data

MHLET highlighted in an earlier submission the need for consistent reporting procedures and data transparency regarding targeted outcomes to ensure that the initiatives outlined in the agreement are both effective and accountable to the communities they are intended to serve.

Highlighted consistently throughout the Productivity Commission's Interim Report was that mental health and suicide prevention policies and programs can only be genuinely effective if they are informed by clear, accurate, and transparent data. Therefore, MHLET recommends the following in the development of the new Agreement:

**a) The incorporation of lived experience data**

The data collection processes must not only focus on clinical or demographic statistics but must also incorporate lived experience data. The voices of people with lived experience provide critical insights into the effectiveness of programs, barriers to access, and emerging needs that traditional clinical data might overlook. This lived experience data must be systematically gathered and integrated into both state and national-level reporting frameworks.

**b) Accessible and clear data**

Data must be made publicly accessible in a way that is relevant and accessible to the public, including those with lived experience of mental health challenges. People should be able to track how funding is allocated, the outcomes of various programs, and the impact of the broader mental health strategy.

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[4] Byrne, L, Wang, L, Roennfeldt, H, Chapman, M, Darwin, L, Castles, C, Craze, L & Saunders, M 2021, *National Lived Experience (Peer) Workforce Guidelines*, National Mental Health Commission.
[5] Department of Health and Aged Care 2024, *2024-25 Budget Communication Pack*, Australian Government, <https://www.health.gov.au/sites/default/files/2024-05/budget-2024-25-stakeholder-pack.pdf>.

Clear, consistent, and robust reporting procedures are crucial for understanding the progress of mental health and suicide prevention initiatives. MHLET recommends the inclusion of the following:

**a) Transparent data sharing**

Transparent data sharing between federal and state governments, as well as mental health service providers and lived experience organisations, is essential to ensure that the right resources are being allocated effectively, and that the needs of consumers are being met.

**b) Co-designed reporting**

Existing reporting practices lack input from those with lived experience. It is essential that mental health consumers are provided the opportunity to help design the metrics that matter most to their wellbeing and recovery, ensuring that reports reflect the true impact of mental health care and service provision.

## Conclusion

MHLET commends the Productivity Commission for its thorough review of the current *Mental Health and Suicide Prevention Agreement*. The report's recognition of the complexities surrounding mental health and suicide prevention is a crucial step toward creating a more integrated and responsive system. We appreciate the emphasis on the need for systemic reform and the inclusion of diverse perspectives, which provides a solid foundation for future progress.

MHLET strongly agrees with the Productivity Commission's recommendation of a 12-month delay in the negotiation of a new agreement to ensure that the voices of people with lived experience, co-design processes, and the peer workforce are fully integrated into the framework. This additional time will allow for more comprehensive consultation and ensure that the agreement reflects the real-world needs of those it aims to serve.

Furthermore, MHLET strongly advocates for the inclusion of improved reporting procedures and data transparency as central pillars of any new agreement. Without accountable reporting and clear, accessible data, it will be impossible to accurately measure progress and ensure that resources are being effectively allocated to the areas of greatest need. Transparent, standardised data collection should be structured around the lived experience of individuals, ensuring that the programs and services funded under this agreement are genuinely meeting their goals.

MHLET remains committed to supporting the Productivity Commission's efforts and looks forward to continuing to elevate the voice of Tasmanian mental health consumers in advancing a more transparent, inclusive, and effective mental health and suicide prevention system.

## Recognition of Lived Experience

MHLET deeply values the insights and wisdom of individuals with lived experience of mental health challenges. We believe that those who have navigated these struggles are not only the experts of their own journeys, but also vital contributors to creating a more effective and compassionate mental health system.

We acknowledge that lived experience provides unique and essential perspectives that must be actively integrated into mental health policy, service design, and suicide prevention strategies.

People with lived experience offer invaluable insights into what works, what needs improvement, and what services are truly meaningful. Their voices must be central to the decision-making processes that shape mental health care.

MHLET is committed to fostering an inclusive mental health system where lived experience is not only recognised but empowered. By valuing the voices of those with lived experience, we can create services that are truly person-centred, accessible, and effective for all.

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