The Next National Mental Health and Suicide Prevention Agreement

A dedicated Suicide Prevention Schedule to drive forward the National Suicide Prevention Strategy

Suicide Prevention Australia

Summary: National Mental Health and Suicide Prevention Agreement

- Suicide remains one of Australia's most serious public health challenges, with 3,307 lives lost in 2024 and an annual economic cost of $30 billion.
- The National Suicide Prevention Strategy provides a clear national roadmap, but its implementation has been constrained by the limitations of the current Agreement, which the Productivity Commission found did not advance system reform, with most actions unfunded and outcomes too broad to measure.
- The Commission called unambiguously for a new policy architecture, including a dedicated Suicide Prevention Schedule to improve its structure, funding and accountability.
- With the National Suicide Prevention Strategy launched, but with no specific funding, the next Agreement provides a critical opportunity to drive implementation forward.
- The current Agreement has been extended by 12-months, and that window must be used purposefully to design a new National Agreement that responds directly to the Commission's findings and delivers long-overdue reform in-line with the National Suicide Prevention Strategy.
- Suicide Prevention Australia is seeking Government commitment to use this window to develop a new Agreement with a dedicated Suicide Prevention Schedule that enshrines funded commitments, establishes genuine intergovernmental accountability and drives measurable reductions in suicide.

#1 Continued Investment in Critical Services *Aftercare | Postvention | Distress Brief Intervention*	Bilateral funding for aftercare and postvention as non-negotiable baseline commitments, with both extended to universal coverage, while providing a pathway for national roll-out of Distress Brief Intervention post-evaluation.
#2 Stronger Governance and Accountability *NSPO independence | Outcomes framework | Lived experience*	An independent NSPO with a mandate for system oversight, supported through embedding of lived experience, sector representation, clarified roles and responsibilities, transparent reporting, long-term funding, improved data collection and accreditation standards.
#3 Targeted Services for Priority Groups *Men | First Nations | LGBTQIA+ | Veterans*	A $100m Priority Populations Innovation Fund, jointly funded by all jurisdictions, to commission co-designed, culturally safe services for groups most at-risk of suicide and growing the evidence base of what works, for who and when.
#4 A National Network of Peer-led Safe Spaces *Peer-led spaces for people in suicidal distress | Non-clinical | Drop-in*	Jointly-funded investment to establish peer-led Safe Spaces within reach of every person in need, delivered through integration within the broader commissioning framework for mental health and suicide prevention.
#5 A National Suicide Prevention Workforce Initiative *Competencies | Training | Frontline capability*	A National Suicide Prevention Workforce Initiative under the Suicide Prevention Schedule and led by the National Suicide Prevention Office, with dedicated implementation funding to build competency and capability for a national suicide prevention workforce

Context: The Challenge and the Opportunity

Suicide remains one of Australia's most serious public health challenges. The extension of the current National Agreement creates a critical window to shape a stronger successor, with a dedicated Suicide Prevention Schedule taking effect 1 July 2027 and accelerating implementation of the National Suicide Prevention Strategy.

3,307
people died by suicide in Australia in 2024

79%
of people became more distressed in the last 12 months

330
ambulance attendances for suicide/self-harm every day

54,000
estimated number of suicide attempts in Australia per annum

$30b
annual economic cost of suicide to Australia

The Opportunity

- The current National Mental Health and Suicide Prevention Agreement has been extended by 12 months.
- This window of time must be used to create a stronger successor agreement, one that has long term vision while adequately responding to a moment when distress among Australians is so high.
- In November 2025, the Productivity Commission released its review of the current Agreement. It found the Agreement 'did not advance system reform' and that new policy architecture is needed, including through the inclusion of a dedicated Suicide Prevention Schedule.
- **Recommendation 1:** The new National Mental Health and Suicide Prevention Agreement must include a Suicide Prevention Schedule that outlines objectives, outcomes, activities, funding and governance arrangements that are unique to suicide prevention.

What a Dedicated Suicide Prevention Schedule Can Achieve

- Ensure that suicide prevention receives sufficient attention and does not get lost in the broader mental health system.
- Drive forward the National Suicide Prevention Strategy with funded, measurable commitments that respond directly to the Productivity Commission's findings.
- Safeguard existing funding commitments and create national consistency in access to life-saving services including aftercare, postvention and crisis support.
- Reduce fragmentation across Commonwealth, State and Territory responsibilities through clear roles and accountability.
- Establish stronger governance through an independent National Suicide Prevention Office with a genuine mandate for system oversight
- Drive intergovernmental accountability, reduce system fragmentation, elevate best practice, promote collaboration and ultimately save lives.

Priority #1: Continued Investment in Critical Suicide Prevention Services

Aftercare, postvention and distress brief intervention are evidence-based, life-saving services that must be embedded and expanded in the new National Agreement

INVESTING IN CRITICAL SERVICES

- In the current Agreement three key services – Aftercare, Postvention and Distress Brief Intervention – were committed to in some but not all jurisdictions, with implementation also inconsistent. Universal access has not been achieved, with demand outstripping supply.
- **Aftercare**: Support following a suicide attempt or crisis. Services such as the Way Back Support Service and HOPE provide 12 weeks of personalised follow-up.
- **Postvention**: Support programs for anyone bereaved by suicide, including family, friends, colleagues, first responders and witnesses e.g. Standby Support.
- **Distress Brief Intervention**: An innovative short-term therapeutic response for people in crisis, currently in a promising national trial phase.

WHY IS IT IMPORTANT?

- 15-25% of people who attempt suicide will attempt again with risk the highest in the first three months (Department of Health, 2021).
- Coordinated Aftercare reduces future suicide attempts by 19.8% (Bliokas et al., 2019). Yet around half of Australians discharged from hospital after an attempt receive no follow-up treatment.
- 1 in 5 Australians will be bereaved by suicide in their lifetime. People bereaved are themselves at significantly elevated risk of suicide. Postvention is prevention. (Andriessen et al., 2017).
- The Productivity Commission found that most current Agreement actions were unfunded and that Aftercare and postvention remained under-resourced despite strong evidence.

HOW THE AGREEMENT CAN DELIVER

- **Recommendation 2:** Enshrine bilateral funding for aftercare and postvention as non-negotiable baseline commitments in a suicide prevention schedule. Funding should reflect the true cost of service delivery, including workforce development and supervision, data/reporting, partnership work, service promotion and governance.
- **Recommendation 3:** Commit to a pathway for a full national rollout of distress brief intervention, with a clear decision gate pending trial completion.
- **Recommendation 4:** Mandate universal geographic coverage across all jurisdictions, with data-driven benchmarks for access set by the NSPO, and progress on targets reported publicly, modelled on the National Health Reform Agreement (NHRA).

Priority #2: Stronger Governance and Accountability

The new Agreement and Suicide Prevention Schedule must not only invest more, but must establish a robust accountability architecture with the NSPO at its centre.

GOVERNANCE AND ACCOUNTABILITY

- The Productivity Commission found the current Agreement 'did not advance system reform', its outcomes were too broad to measure, most actions had no funding attached and lived experience integration was limited.
- A National Agreement should clarify Commonwealth, State and Territory leadership roles to reduce fragmentation and duplication, elevate best practice through national consistency, and promote collaboration.
- The National Suicide Prevention Office (NSPO), the National Suicide Prevention Strategy, and the National Suicide Prevention Outcomes Framework form a policy environment that can be given sufficient attention through a Suicide Prevention Schedule.

HOW THE AGREEMENT CAN DELIVER

- **Recommendation 5:** Enshrine the independence of the NSPO within the Agreement.
- **Recommendation 6:** Give the NSPO a mandate for outcomes reporting and system oversight, with accountability to Parliament, not just to Government. This should include a requirement to publicly report each year on progress on the Agreement against the Suicide Prevention Outcomes Framework, using jurisdictional trend data, and modelled on the independent monitoring arrangements within the National Agreement on Closing the Gap. In addition there should be a mid-term full review of the agreement.
- **Recommendation 7:** Strengthen lived experience participation across all governance structures, embedded and remunerated in the MHSPSO and relevant intergovernmental fora.
- **Recommendation 8:** Embed sector representatives, including peak bodies, in key National Agreement governance structures.
- **Recommendation 9:** Clarify the roles and responsibilities of jurisdictions, similarly to the National Health Reform Agreement (NHRA).
- **Recommendation 10:** Commit to a specific financial contribution and monitor expenditure, as in the National Agreement on Social Housing & Homelessness.
- **Recommendation 11:** Require all jurisdictions to publish implementation plans with measurable milestones and reporting consequences, modelled on the NHRA.
- **Recommendation 12:** Enshrine minimum five-year funding contracts across all jurisdictions, modelled on the National Disability Agreement, to enable workforce development, long-term planning, and sustained service quality. Contracts should include appropriate indexation and be finalised 6 months prior to commencing delivery.
- **Recommendation 13:** Commit Commonwealth, States and Territories to nationally consistent data collection. Standardise and improve NGO suicide prevention data collection and reporting, to ensure holistic system monitoring and accountability.
- **Recommendation 14:** Once funded, require Government-commissioned services to meet suicide prevention accreditation standards

Priority #3: Targeted Services for Priority Groups

Some populations carry a disproportionate burden of suicide. The Suicide Prevention Schedule must enable co-designed, culturally safe services that meet specific needs

TARGETTING PRIORITY POPULATIONS

- A Priority Populations Innovation Fund of $100 million, jointly funded by Commonwealth, State and Territory Governments, to commission targeted, co-designed services for groups disproportionately impacted by suicide.
- Flexible, place-based funding enabling PHNs, service providers, researchers and the lived experience workforce to develop and test new models of care.
- Targeted services for priority cohorts including co-designed aftercare, crisis support and postvention services are proven models for suicide prevention.
- Co-design and genuine lived experience partnerships are essential. Top-down service design for communities, without engaging those with lived experience have failed to deliver for those who need it most.

WHY IS IT IMPORTANT?

- The Productivity Commission found the current Agreement failed to adequately address the needs of groups disproportionately impacted by suicide which were left underfunded.
- 75% of suicide deaths in Australia are men. (ABS, 2024a)
- Aboriginal and Torres Strait Islander peoples experience age-standardised suicide rates more than twice the national average, with young men most acutely affected (AIHW, 2023a).
- LGBTQIA+ people are significantly more likely to experience suicidal thoughts and behaviours, with young people at particular risk (ABS, 2024b; AIHW, 2023b)

HOW THE AGREEMENT CAN DELIVER

Recommendation 15: Establish a Priority Populations Innovation Fund of $100m through the suicide prevention Schedule, that includes Commonwealth-State cost-sharing. The Schedule should require Commonwealth, State and Territory jurisdictions to:

- Mandate lived experience and community leadership in service design, governance and evaluation; drawing on co-design modes in other National Agreements; and
- Establish outcome metrics using the National Suicide Prevention Outcomes Framework with public reporting disaggregated by priority group and jurisdiction.

Priority #4: A National Network of Peer-led Safe Spaces

People in distress deserve a caring, community-based alternative. The Suicide Prevention Schedule must fund a national network of Safe Spaces.

NATIONAL NETWORK OF SAFE SPACES

- Peer-led, in-person options for people in distress have now been established as an important part of the suicide prevention service continuum.
- Different models of Safe Spaces and Safe Havens exist (referred to collectively here as Safe Spaces). These different models have aspects in common that make them distinct from non-peer-led services (e.g. Medicare Mental Health Centres).
- No referral or appointment is needed. Safe Spaces are welcoming, judgement-free, strengths-based and trauma-informed. They are staffed by peer workers and provide immediate connection, practical support, warm referrals into other supports and community connection.
- Safe Spaces must be located separately from hospitals. A strength is their provision of non-clinical support, with models differing based on the degree of clinical involvement. 'Community-led Safe Spaces' for example are entirely lived experience-led.

WHY IS IT IMPORTANT?

- Emergency departments are often the wrong environment for people in suicidal crisis. Time pressure, lack of privacy and the medicalisation of distress can be counter-therapeutic and deter future help-seeking (Rheinberger et al., 2022).
- Safe Spaces can both redirect people from emergency departments, and reach those who would choose not to attend ED.
- Safe Spaces have been shown to reduce distress, improve patient experiences, increase community connection, and create cost savings by reducing more expensive hospital admissions (Taylor Fry/ARTD independent evaluation, 2024). Safe spaces have shown a return of $2.45 for every $1 spent (Nous Group, 2025)
- The Productivity Commission identified crisis system investment as a priority for the new Agreement.

HOW THE AGREEMENT CAN DELIVER

Recommendation 16: Within a suicide prevention schedule, commit to jointly fund the establishment of a national network of peer-led Safe Spaces within reach of every person in need, with a minimum network of sites agreed between the Commonwealth and all jurisdictions. Safe Spaces should be:

- Positioned within the broader mental health and suicide prevention commissioning framework as the key community-based alternative to emergency departments.
- Co-designed and implemented alongside communities.
- Funded for ongoing evaluation with findings reported to the NSPO and used to continuously improve models.

Priority #5: A National Suicide Prevention Workforce Initiative

The Suicide Prevention Schedule must include a National Suicide Prevention Workforce Initiative with dedicated implementation funding and leadership

NATIONAL WORKFORCE INITIATIVE	WHY IS IT IMPORTANT?	HOW THE AGREEMENT CAN DELIVER
• A strong workforce is a critical enabler of suicide prevention, and prioritising the workforce in the next National Agreement will support its success. • As recommended in SPA's Helping the Helpers workforce report (2025) a National Suicide Prevention Workforce Initiative would address workforce needs by articulating national, regional, and local strategies for accessibility, capability, skills, supply, retention, sustainability, support and workforce safety, with dedicated funding allocations for implementation. • The Initiative should also focus on the creation and expansion of lived experience and peer work roles across the suicide prevention sector.	• SPA's State of the Nation report (2025) found 62% of organisations have insufficient staff or volunteers and 84% support a fully funded national workforce initiative. • The suicide prevention and mental health workforces overlap but are also distinct in important ways. The suicide prevention workforce is broad, reflecting a whole-of-community approach. Suicide-specific capability is required with suicide literacy, safety planning, trauma-informed practice, cultural safety and lived experience integration. • Workforce challenges affect service quality, and drive burnout, compassion fatigue and vicarious trauma. • This responds to Recommendation 4.6 of the Productivity Commission's review of the National Agreement.	**Recommendation 17:** Fund implementation of a National Suicide Prevention Workforce Initiative through a suicide prevention schedule to address workforce needs. The Initiative should: • Align with the National Suicide Prevention Strategy and work already underway in the National Suicide Prevention Office (NSPO), with the NSPO tasked to progress this work and hold funding. • Set aside dedicated implementation funding to turn the initiative into tangible workforce uplift. • Create and expand lived experience and peer work roles.

Alignment: the National Suicide Prevention Strategy

Suicide Prevention Australia's recommendations for a new National Mental Health & Suicide Prevention Agreement support targeted national efforts to reduce suicide, in line with identified critical enablers and actions under the National Suicide Prevention Strategy

- **Recommendation 1:** The new National Mental Health and Suicide Prevention Agreement must include a Suicide Prevention Schedule that outlines objectives, outcomes, activities, funding and governance arrangements that are unique to su**icide prevention** **(NSPS Critical Enabler: Improved governance)**

- **Recommendation 2:** Enshrine bilateral funding for aftercare and postvention as non-negotiable baseline commitments in a suicide prevention schedule. **(NSPS Actions 5.2f, 8.2a & 8.2c)**
- **Recommendation 3**: Commit to a pathway for a full national rollout of distress brief intervention, with a clear decision gate pending trial completion. **(NSPS Action 6.2b)**
- **Recommendation 4:** Mandate universal geographic coverage across all jurisdictions, with data-driven benchmarks for access set by the NSPO, and progress on targets reported publicly, modelled on the National Health Reform Agreement (NHRA). **(NSPS Actions 11.2a & 11.3a)**

- **Recommendation 5:** Enshrine the independence of the NSPO within the Agreement. **(NSPS Critical Enabler: Improved Governance)**
- **Recommendation 6:** Give the NSPO a mandate for outcomes reporting and system oversight, with accountability to Parliament, not just to Government. **(NSPS Critical Enabler: Improved Governance)**
- **Recommendation 7:** Strengthen lived experience participation across all governance structures, embedded and remunerated in the MHSPSO and relevant intergovernmental fora, not advisory or tokenistic. **(NSPS Actions 11.2a, 12.1a, 12.2a, 12.3a & 12.3b)**
- **Recommendation 8:** Embed sector representatives, including peak bodies, in key National Agreement governance structures. **(NSPS Critical Enabler: Improved Governance)**

- **Recommendation 9:** Utilise the service responsibility mapping model used in the NHRA to reduce fragmentation and duplication. **(NSPS Critical Enabler: Improved Governance)**
- **Recommendation 10**: Commit to a specific financial contribution and monitor expenditure, as in the National Agreement on Social Housing & Homelessness. **(NSPS Critical Enabler: Improved Governance)**
- **Recommendation 11:** Require all jurisdictions to publish Bilateral implementation plans with measurable milestones and reporting consequences, modelled on the NHRA. **(NSPS Actions 11.1a, 11.2a, 13.1a & 13.3a)**
- **Recommendation 12:** Enshrine minimum five-year funding contracts across all jurisdictions, modelled on the National Disability Agreement, to enable workforce development, long-term planning, and sustained service quality. **(NSPS Actions 11.2a, 11.3a, 13.2a, 13.3a, 13.4a & 13.4c)**
- **Recommendation 13:** Commit Commonwealth, States and Territories to nationally consistent data collection. **(NSPS Actions 8.3a, 11.2a, 13.1a, 13.1b, 13.1c, 13.3a, 13.4a, & 13.4c)**
- **Recommendation 14:** Once funded, require government-commissioned services to meet suicide prevention accreditation standards. **(NSPS Critical Enabler: Improved Governance)**

- **Recommendation 15:** Establish a Priority Populations Innovation Fund of $100m through the Suicide Prevention Schedule, that includes Commonwealth-State cost-sharing. The Schedule should require Commonwealth, State and Territory Jurisdictions to:
  - Mandate lived experience and community leadership in service design, governance and evaluation; drawing on co-design modes in other National Agreements;
  - Establish outcome metrics using the National Suicide Prevention Outcomes Framework with public reporting disaggregated by priority group and jurisdiction.

  (NSPS Actions 5.2f, 11.2a, 13.1b, 13.3a & 13.3b)

- **Recommendation 16:** Within a suicide prevention Schedule, commit to jointly fund the establishment of a national network of Safe Spaces within reach of every person in need, with a minimum network of sites agreed between the Commonwealth and all jurisdictions. Safe Havens should be:
  - Positioned within the broader mental health and suicide prevention commissioning framework as as the key community-based alternative to emergency departments.
  - Co-designed and implemented alongside communities
  - Funded for ongoing evaluation with findings reported to the NSPO and used to continuously improve models.

  (NSPS Action 7.2b)

- **Recommendation 17:** Fund implementation of a National Suicide Prevention Workforce Initiative through a suicide prevention schedule to address workforce needs. The Initiative should:
  - Align with the National Suicide Prevention Strategy and work already underway in the National Suicide Prevention Office (NSPO), with the NSPO tasked to progress this work and hold funding.
  - Set aside dedicated implementation funding to turn the initiative into tangible workforce uplift.
  - Create and expand lived experience and peer work roles.

  (NSPS Critical Enabler: Capable and integrated workforce)

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