Australian
Private Hospitals
Association

Mental Health and Suicide Prevention Agreement Review

CONSULTATION SUBMISSION

July 2025

Contents

Introduction

Purpose

This document is intended to provide a response to the consultation on the review of the National Mental Health and Suicide Prevention Agreement (NMHSPA) (Productivity Commission, 2025). It highlights the current state of mental health and suicide prevention, the role of private hospitals in the delivery of mental health related services, and necessary reforms to the NMHSPA.

The information provided in this document must be handled in accordance with Australian Government best practice for sensitive and commercial sensitive information.

Introduction

The 2023 National Report Card published by the National Mental Health Commission (NMHC) noted that in 2020-2022, just over 1 in 5 people (21.5%) in Australia aged 16-85 years experienced a mental disorder in the previous 12 months. This represents a very significant section of the population.

Australia's private acute psychiatric hospitals provide services for patients suffering from moderate-to-severe mental health issues. They complement the public psychiatry hospital system, which treats a different caseload mix - meaning they are not interchangeable, nor do community clinics and out-patient services meet the same acute needs. When private psychiatric hospitals close, wind down services or have empty beds, a huge need in the community goes unmet.

According to the Australian Institute of Health and Welfare, over 2023-24 private acute psychiatric hospitals accounted for 61% of all acute mental health admissions - a decline of 0.4% to 217,047 (down from 217,851 the previous year). Mental health care in Australia is under immense strain from funding and workforce availability that are unable to keep pace with rising caseloads and an increasing complexity of cases. These challenges are crippling the national health system and the ability of the public and private sectors to continue to serve all those that need care.

The 2024 Private Hospital Financial Viability Health Check (the Health Check) undertaken by then-Department of Health and Aged Care highlighted declining mental health as a critical concern for the government and the viability of private hospitals. Despite providing 61% of all separations for mental health in 2023-24, the ever-increasing pressure has brought the sector to its breaking point.

The closure of Toowong Private Hospital in Brisbane in June 2025 underscores the issues around viability and sustainability. The Health Check confirmed chronic underfunding of private hospitals by health insurance companies. It cited that one-third of private hospitals were/are operating at losses. Of the remainder, most were breaking even and just a few who were making margins were recording 1-2% profits. An EY study for the Australian Government showed private hospitals must make a minimum 5% to be able to invest in procedures, treatments, technologies, service and staffs to maintain quality.

More recent data from the Australian Bureau of Statistics (ABS) has shown a fall from $298 million in operating profit before tax in 2022-23 to $-34 million in 2023-24 for the whole private hospital sector.

As mental health continues to deteriorate around the country and the risk of suicide continues to increase with challenges such as the cost-of-living crisis, the loneliness epidemic in young people, global events and international conflict, climate change, and a whole host of other issues, it essential to have in place a sound, robust, and well-resourced mental health ecosystem.

The NMHSPA

The 2022 NMHSPA was an important step (succeeding the Heads of Agreement) intended towards defragmenting this nation's mental health and suicide prevention architecture and putting on paper, the principles, roles, objectives, and strategy for improving mental health outcomes in Australia.

It also cemented the Commonwealth's agreement to support and regulate private hospitals and the private health insurance sector to enable a viable, sustainable and cost-effective private sector.[1] The overall agreement is unique in that it places emphasis on funding for mental health and suicide prevention services and the need for greater and more relevant data collection to support better policy outcomes.

While the NMHSPA set out to substantially reform and improve the state of mental health and suicide prevention in Australia, the Productivity Commission has argued that it has not succeeded in doing so. The Australian Private Hospitals Association (APHA) supports and endorses this conclusion. There continue to be pervasive issues that include those relating to the mental health workforce and funding for private hospitals.

Australian governments must move beyond consultations and strategic plans to actually delivering for their constituents. Even if the NMHSPA was instrumental in the setting up of more bureaucratic structures, it has only further fragmented the national health framework, increased red tape, placed a greater cost burden on the taxpayer, and further eroded transparency and accountability in our system of health governance.

The APHA Position on Mental Health and Psychiatry in Australia

1. Viability of, and funding for, psychiatric hospitals
    a. Workforce shortages
        i. Australia's psychiatry workforce continues to face severe shortages, causing extended wait times and increased strain on professionals.
        ii. Many psychiatrists report experiencing burnout, with excessive caseloads and inadequate support systems, exacerbating access blocks and deteriorating mental health outcomes. To address these challenges, national efforts have focused on expanding training programs, recruitment initiatives, and workforce retention strategies.
        iii. Policymakers are working to improve access to psychiatric care, particularly in rural areas where shortages are most severe.

[1] National Mental Health and Suicide Prevention Agreement, cl 37(e).

iv. Despite these efforts, concerns remain about the uneven distribution of professionals and long-term sustainability of the mental health sector. Ongoing discussions emphasise the need for systemic reforms and increased investment to ensure adequate psychiatric care for communities across Australia.

b. Resignations of psychiatrists from the public system
    i. Some 200 individual senior NSW psychiatrists have indicated their intention to resign from the workforce.
    ii. With public hospitals overwhelmed, record waiting lists and many psychiatrists refusing to take any new patients at all, Australians are being denied the mental health care they urgently need, due to bureaucratic red tape and ministerial intransigence.
    iii. With the NSW Government seeking to accommodate mental health needs in private psychiatric hospitals, the availability of more psychiatrists is paramount.
    iv. The moratorium restricts overseas-trained doctors from practising in most private hospitals, limiting their activity to areas of designated workforce shortage. This definition ignores the ongoing critical need with respect to private in-patient psychiatric services that have arisen post-pandemic.
    v. With the backlog of patients needing in-hospital care exploding, the critical workforce demand for treatment of moderate-to-severe mental illness is most definitely apparent in private hospitals. The government's historical approach to moratorium setting is redundant and requires immediate correction.
    vi. APHA has repeatedly emphasised to the Australian Government the critical need to lift the 10-year moratorium on overseas trained health professionals, including psychiatrists. Lifting the moratorium will provide immediate relief, helping both public and private healthcare providers to manage patient load and reduce strain on hospital staff.

2. Admissions data and trends and the Private Psychiatric Hospital Data Reporting and Analysis Service (PPHDRAS)
    a. Private psychiatric care shows declining trends in numbers of patients in care, overnight separations, and average service days per bed, while same day separations have increased. CPI-adjusted charges have dropped, and many hospitals face closure, risking a significant loss of private psychiatric beds.
3. Telehealth services
    a. The shortage of psychiatrists available to admit patients has resulted in private psychiatric hospital beds being left empty, while people needing urgent admission have had nowhere to go. Government have mistakenly emphasised out-patient care via community clinics as a solution. This does not meet the needs of the acute cases being untreated and finding their way into general hospital emergency departments only to, ultimately, be released back into the community.
    b. Many unwell Australians have missed out on care they urgently needed because psychiatrists could not utilise telehealth for private hospital inpatients.
    c. The 2024-25 Federal Budget introduced temporary Medicare Benefit Schedule items to allow the admission and some subsequent consultation of inpatients in private hospitals to be undertaken by psychiatrists via video.
    d. A new trial to fund telehealth for psychiatric inpatient consultations should result in better access to psychiatric care for Australian patients. This has been implemented since 1 November 2024 for an initial period of two years.

e. APHA had been campaigning for this change for over 12 months. The Australian Government has recognised the need to address the significant barriers to accessing care in the private psychiatric hospital sector, due to lack of an admission pathway.
f. The measure has provided MBS items for a psychiatrist to admit a patient to a private hospital as well as a subsequent video consultation each week of admission. This will enable inpatients to be admitted and better supported, while ensuring they are still seen face-to-face.
g. Though the causes of the wider crisis in mental health care are complex, this measure will have a direct impact on the ability of psychiatrists working in the private sector to provide timely access to care.

4. Ambulatory care in private psychiatric hospitals
    a. The current situation in private hospital psychiatric care has led to a crisis within which many people in urgent need of private hospital psychiatric care are going untreated. One reason for this is a shortage of psychiatrists available to admit people for inpatient care.
    b. A default benefit for ambulatory care could significantly improve patient access to acute psychiatric care at a time when the availability of psychiatrists to provide inpatient care is limited and diminishing.
    c. A default benefit for private hospital run multi-disciplinary mental health care programs could help to address this crisis by easing pressures on psychiatrists working in the private hospital sector by reducing the burden of pre- and post-discharge care.
    d. Ambulatory care would potentially reduce the risk of relapse during the post-discharge period by enabling prompt interventions, including mental health and allied health interventions in the home and, where necessary, prompt readmission to acute care. Prompt intervention would likely minimise the extent of intervention required even if readmission to acute care occurred.
    e. It would ensure continuity of care in periods of high risk and streamline transition into lower-intensity community care provided by patients' GPs or other community services.
    f. PPHDRAS data shows an increasing trend in the prescription of antipsychotic drugs as GPs, already under immense pressure, encounter more and more patients with moderate-to-several mental health conditions for which there are no available psychiatrists to refer to.
    g. There is currently a pronounced gap in the availability of private hospital-run multi-disciplinary mental health care outreach programs.
    h. APHA has recommended that government implement a 12-month trial of a default benefit for private hospital-run multi-disciplinary mental health outreach programs (ambulatory outreach) and that government convene an industry-wide group to monitor the trial and develop a national guideline for the ongoing funding of ambulatory outreach psychiatric care in the private hospital sector.

APHA Submission

SUBMISSION

1.0 Draft recommendation 2.1 Deliver key documents as a priority

1.1 APHA supports the Commission's recommendation to prioritise the delivery of key documents under the National Mental Health and Suicide Prevention Agreement.

1.2 Timely access to foundational documents is essential to enable coordinated planning, service delivery, and reform implementation across all sectors.

1.3 APHA recommends that the following documents be prioritised and made publicly available:

- 1.3.1 Regional Mental Health and Suicide Prevention Plans, including service mapping and gap analysis.
- 1.3.2 Funding Allocation Schedules, with clarity on Commonwealth and state contributions.
- 1.3.3 Evaluation and Outcome Frameworks, to support consistent data collection and benchmarking.
- 1.3.4 Workforce Development Strategies, including private sector roles and training pathways.

1.4 APHA further recommends the development of a renewed agreement that includes specific, measurable, achievable, relevant, and time-bound objectives, with clear links to actions and funding.

2.0 Draft recommendation 4.1: Developing a renewed National Mental Health Strategy

2.1 APHA strongly supports the Productivity Commission's recommendation to develop a renewed National Mental Health Strategy.

2.2 The current agreement has not delivered the systemic reform required to address fragmentation, funding gaps, and service inequities across Australia's mental health system.

2.3 A renewed National Mental Health Strategy must detail the role of private hospitals, overnight in-patient care, telehealth, ambulatory care, and other associated matters.

2.4 The national mental health system cannot function without any of the above.

- 2.4.1 In-patient care provides an integrated treatment that covers both pre- and post-admission care, ensuring a tailored approach that offers continuity of care, monitoring, and provides access to a much broader range of treatments than are available through other means.
  - 2.4.1.1 This is effectively the foundation for all other types of care and central to the maintenance of a healthy mental health system.
  - 2.4.1.2 It is also, in many cases, the first appropriate source of treatment for people suffering from severe mental illness or disorders, and can later be followed by outpatient care or hospital-in-the-home models.
- 2.4.2 Hospital ambulatory outreach services are services delivered in a person's home or other community setting but delivered to the same standard as if it took place in the hospital, and by appropriately qualified staff as advised by the treating medical practitioner.
  - 2.4.2.1 Chronic disease management programs and other services offered out of hospital by community providers or health insurers play an essential role in the spectrum of services required by

people with a mental health condition, but they do not meet the standards or intensity required for people at high risk of relapse or hospital readmission.

2.4.2.2 The specific benefits of ambulatory outreach care being provided by a private hospital include clinical governance , intensive specialist treatment, more accessibility, and responsive care.

3.0 Draft recommendation 4.2: Building the foundations for a successful agreement

3.1 APHA supports Draft Recommendation 4.2, which outlines the essential components for developing a more effective and enduring national agreement.

3.2 We particularly welcome the emphasis on co-design, extended negotiation timeframes and a clear theory of change, all of which are critical to ensuring the next agreement delivers meaningful reform across the mental health and suicide prevention system.

3.3 Private hospitals, as major providers of inpatient and specialised mental health care, must be recognised as essential partners in this process.

3.4 APHA also supports the proposal to extend the current agreement until June 2027, allowing sufficient time to:

3.4.1 Develop a renewed National Mental Health Strategy.

3.4.2 Align with the National Suicide Prevention Strategy.

3.4.3 Build consensus across jurisdictions and sectors.

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

4.1 To ensure that the next agreement has stronger links to the broader policy environment, it should clearly articulate, and where appropriate, include provisions from other national health frameworks and agreements such as the National Health Reform Agreement (NHRA).

4.2 APHA supports the need to ensure that the next agreement has stronger links to the broader policy environment.

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

5.1 APHA supports Draft Recommendation 4.4, which calls for immediate action to address the significant service gap in psychosocial supports for people who do not qualify for the National Disability Insurance Scheme (NDIS).

5.2 While the NDIS delivers tailored, long-term support for people with significant functional impairments, it does not cover the whole group of people with psychosocial disabilities.

5.3 This gap affects many Australians living with moderate to severe mental illness, many of whom rely on private hospitals for clinical care but lack access to the non-clinical supports essential for recovery and community participation.

5.4 Access to NDIS relies on the severity and permanency of a person's disability, whereas non-NDIS supports are currently fragmented between different levels of government, difficult to understand and access, and generally variable across different jurisdictions on matters of funding, availability, and eligibility criteria.[2]

5.5 NDIS modelling in the 2020 Mental Health Inquiry Report by the Productivity Commission has indicated that only about 10% of people with a severe mental illness would meet NDIS criteria, leaving a vast majority of people that need care, unable to access it.[3]

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[2] Shelby-James, T., Rattray, M. The Future of Psychosocial Supports in Australia– Are the Recommendations from the National Disability Insurance Scheme Review the Answer?. Community Ment Health J (2025). https://doi.org/10.1007/s10597-025-01467-8

[3] Inquiry report - Mental Health - Productivity Commission

5.6 Governments must address the matter of both general and targeted support for people who require access to psychosocial supports outside the NDIS scheme, as a matter of priority and utilise private hospital expertise, experience, and service delivery to expand access to services that are appropriate.

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

6.1 APHA supports Draft recommendation 4.5. The next agreement should clarify responsibility, at the various levels of government, to fund and support carer and family participation in mental health and suicide prevention efforts.

6.2 The agreement should also delineate a role for private hospitals in delivering these supports.

6.3 The next agreement must also state, in clear terms, the triggers, amounts, and methods of disbursement of funding for these supports.

6.4 Carer and family supports should be embedded in bilateral funding agreements, with measurable outcomes and reporting requirements. Private hospitals should be eligible to deliver or partner in delivering these supports.

6.5 The next agreement should also provide funding for carer liaison roles within private hospitals, to facilitate communication, education, and involvement in care planning.

7.0 Draft recommendation 4.6: Increase transparency and effectiveness of governance arrangements

7.1 APHA supports Draft Recommendation 4.6, which calls for improved governance arrangements under the next National Mental Health and Suicide Prevention Agreement.

7.2 However, we emphasise that transparency and effectiveness must be underpinned by inclusive structures, clear accountability, and meaningful engagement across all sectors, including private providers.

7.3 APHA further supports the establishment of the National Mental Health Commission as an independent statutory authority to monitor and report on progress and outcomes to support effective operation of the agreement's governance arrangements.

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

8.1 APHA supports and endorses Draft recommendation 4.7.

8.2 The Australian, state and territory governments should address barriers to the effective involvement of people with lived and living experience in the governance of the next agreement.

8.3 This should include limiting the use of confidentiality agreements with lived and living experience representatives, opening greater opportunities for communication between lived and living experience working groups, other working groups and the senior officials group, and appropriately remunerating lived experience representatives.

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

- 8.4.1 adequate representation of people with lived and living experience at each level of governance
- 8.4.2 balanced representation between people with lived and living experience of mental ill health and lived and living experience of suicide
- 8.4.3 governance roles for carers are commensurate with the significant role they play in Australia's mental health and suicide prevention system. The next agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance

arrangements. These bodies should be adequately resourced to fulfil these roles.

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

9.1 APHA strongly supports Draft Recommendation 4.8, which calls for a greater role for service providers and the broader mental health and suicide prevention sectors in the governance of the next national agreement.

9.2 However, APHA urges the Productivity Commission to ensure that this inclusion is meaningful, structured, and sustained, rather than symbolic or consultative.

9.3 Private hospitals are responsible for a substantial share of mental health service delivery in Australia. Despite this, private hospitals have historically been excluded from mental health and suicide prevention governance.

9.4 This limits the sector's ability to contribute to system reform, coordinate care, and align with national priorities.

9.5 There must be greater formal, funded, and supported involvement from private hospitals and better data collection and reporting to reflect the key role played by private hospitals.

9.6 Forums such as joint regional planning councils, mental health reform advisory boards, corporate agencies with a health focus within Australian governments, and other similar bodies can be useful to increase participation from the private hospital sector in governance.

10.0 Draft recommendation 4.9: Share implementation plans and progress reporting publicly

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

10.2 An Independent Inspector-General for National Mental Health and Suicide Prevention (The Inspector-General) should be appointed and empowered to assess and report on progress independently, using information beyond what is reported by governments. The Inspector-General should publish national progress reports as they are finalised, without requirements for jurisdictions' sign-off.

10.3 Australian governments must engage with private hospitals through a new forum such as the National Mental Health and Suicide Prevention Forum to ensure consistent feedback from stakeholders and quality improvement instead of conducting long drawn-out consultation processes that delay the provision of appropriate help to those that seek and need it.

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

11.1 APHA supports Draft recommendation 4.10 and submits that the next agreement should formalise the role of the National Mental Health Commission as the entity responsible for ongoing monitoring, reporting and assessment of progress against the agreement's outcomes.

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

11.2 The National Suicide Prevention Office should be given formal authority to monitor and report on the next agreement and the separate suicide prevention schedule.

11.3 A live dashboard to monitor progress and visualise data would be helpful to stakeholders and ensure greater transparency and accountability. APHA recommends that this be hosted with the Australian Institute of Health and Welfare (AIHW) as it is the more authoritative and user-friendly health statistics reporting body in government.

11.3.1 The AIHW could receive data from the National Mental Health Commission and state and territory agencies to ensure completeness.

11.3.2 The Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS) may be a useful entity from which to also collect and collate data.

11.4 Government must ensure that private hospitals are represented in NMHC advisory and governance structures to support inclusive reporting and policy development.

11.5 The dashboard must include information on:

11.5.1 Public patients being admitted in private psychiatric hospitals

11.5.2 Private patients being admitted in public psychiatric hospitals

11.5.3 Funding, including the public-private split

11.5.4 Workforce, disaggregated by state and territory

11.5.5 Share of telehealth consultations, in-patient admissions, emergency admissions

11.5.6 Shortfalls in public and private funding and workforce in line with economic modelling

12.0 Draft recommendation 4.11: Survey data should be routinely collected

12.1 APHA supports Draft Recommendation 4.11, which proposes that the Australian Government fund the routine collection of national mental health and wellbeing survey data.

12.2 These surveys are essential for understanding population needs, service gaps, and the impact of reforms.

12.3 Survey data provides critical insights that complement administrative and clinical data. For private hospitals, this information is vital to understand emerging trends, benchmark service delivery, inform planning and investment in new models of care, and support quality improvement.

12.4 However, current survey cycles are infrequent, and private sector-specific insights are often lacking or underreported.

12.5 APHA encourages Australian governments to routinely collect survey data that is both public and private sector-specific and disaggregated by public vs private use, urban vs regional locations, and by demographics.

12.6 The Australian Government should fund the routine collection of the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing Study, running the surveys at least every two (2) years.

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

13.1 APHA supports Recommendation 4.12, which calls for funding arrangements in the next agreement to empower Primary Health Networks (PHNs) to better meet the mental health needs of their communities.

13.2 However, for this to be effective, PHNs must be supported to work collaboratively with private hospitals, which are key providers of mental health care across Australia.

13.3 To ensure PHNs can meet local needs effectively, APHA recommends that:

13.3.1 The next agreement require PHNs to engage private hospitals in regional planning and commissioning processes

13.3.2 PHNs be given flexibility to commission services from private hospitals where appropriate, support innovative models, and fund services that have demonstrated positive outcomes, regardless of provider type where appropriate.

13.3.3 Australian governments introduce national consistency in reporting requirements across PHNs and jurisdictions and put in place

procurement and contracting processes to reduce administrative burden and improve transparency.

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

14.1 With more Australians seeking mental health support, there is a clear need to grow and strengthen the mental health workforce to ensure that it is skilled, sustainable, and available where and when people need it most.

14.2 Action on mental health and suicide prevention is not possible without a well-resourced and staffed health system. The National Mental Health Workforce is at the frontlines of the delivery of mental health and suicide prevention services. Therefore, for any agreement or plan to be effective, it must consider workforce issues.

14.3 The National Mental Health Workforce Strategy 2022–2032 acknowledges the significant shortage in psychiatrists, particularly in rural and regional areas.

14.4 The June 2025 Psychiatry Supply and Demand Compendium Report found that[4]:

14.4.1 The baseline projections estimate:

14.4.1.1 a current shortfall of 103.7 FTE in 2024 and is projected to peak to 385.4 FTE by 2033. The total undersupply is estimated to be 303.2 FTE by 2048.

14.4.1.2 a current shortfall for the number of psychiatrists (headcount) of 119 in 2024, peaks to 464 by 2033 and then declines to reach 370 psychiatrists by 2048.

14.4.2 The projections considering unmet demand estimate:

14.4.2.1 a current shortfall of 762.7 FTE in 2024, increasing to 1,278.2 FTE in 2033 and to 1,466.4 FTE by 2048.

14.4.2.2 a current shortfall for the number of psychiatrists (headcount) of 868 in 2024, increasing to 1,525 in 2033 and to 1,766 psychiatrists by 2048.

14.5 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has found that the existing psychiatry workforce cannot support the mental health needs of Australians.[5] As part of the inclusion of the National Mental Health Workforce Strategy in the new agreement, APHA encourages Australian governments to consider options to:

14.5.1 Legislate to provide a mandatory minimum private health insurance benefit for private hospital provision of ambulatory care, i.e. psychiatric day programs and outreach programs.

14.5.2 Introduce Medicare Benefits Schedule (MBS) items for the strategic use of telehealth for inpatient consultations to reduce the disincentive for psychiatrists to continue to provide inpatient services due to loss of unpaid time in travel and administration.

14.5.3 Reinstate MBS telehealth items for inpatient psychiatric consultations on a permanent basis for use in emergency circumstances to support continuity in the therapeutic relationship and respond to the impracticality of relying on locum support in emergency situations.

14.5.4 Remove restrictions on overseas trained psychiatrists receiving MBS rebates for the provision of private in-hospital consultations. This measure would not be sufficient by itself to resolve the shortage of in-patient services, but it would assist in enabling the private hospital

[4] https://hwd.health.gov.au/resources/primary/psychiatry-supply-and-demand-compendium-report-june-2025.pdf

[5] https://insightplus.mja.com.au/2023/40/psychiatric-workforce-in-crisis-unable-to-meet-complex-patient-needs/; see also https://onlinelibrary.wiley.com/doi/full/10.1111/ajr.13092.

sector to fulfil its role as an essential part of Australia's mental health system.

14.5.5 Commission an urgent review of the financial and regulatory factors which disincentivise psychiatrists providing acute in-patient care in both public and private sectors.

14.6 To ensure the Strategy is implemented effectively across all sectors, we recommend:

14.6.1 formal inclusion of private hospitals in workforce planning

14.6.2 targeted funding for training and development

14.6.3 clinical placements and scholarships for psychiatry, psychology, and nursing students in private hospitals.

14.6.4 continuing professional development (CPD) subsidies for private sector staff.

14.6.5 peer workforce training and supervision programs tailored to private settings.

14.6.6 support for rural and remote workforce expansion

14.6.7 telehealth infrastructure investment.

14.6.8 workforce data integration

15.0 Draft recommendation 4.14: The next agreement should commit governments to develop a scope of practice for the peer workforce

15.1 APHA supports and endorses Draft Recommendation 4.14, which calls for the development of a nationally consistent scope of practice for the peer workforce. Peer workers, i.e., individuals with lived and living experience of mental ill health or suicide can play a transformative role in recovery-oriented care. Their integration into private hospital settings can lead to promising outcomes, including:

15.1.1 Improved patient engagement and satisfaction

15.1.2 Reduced stigma and isolation

15.1.3 Enhanced continuity of care post-discharge

15.1.4 Support for suicide prevention and relapse reduction

15.2 APHA recommends that the scope of practice for peer workers should:

15.2.1 define core competencies and responsibilities, including support roles in inpatient, outpatient, and suicide prevention settings;

15.2.2 establish training and certification pathways, with options tailored to private sector environments;

15.2.3 clarify collaboration protocols between peer workers and clinical staff;

15.2.4 include safety and risk management guidelines, especially for high-acuity settings;

15.2.5 support career progression, including leadership roles and peer supervision;

15.2.6 ensure cultural safety and inclusion, particularly for peer workers from marginalised communities.

15.3 Australian governments must include private hospitals and associated industry bodies in the co-design of the scope of practice.

15.4 Australian governments must fund pilot programs and evaluations in private hospital settings and support workforce development through grants, and training subsidies.

15.5 A scope of practice for the peer workforce must also identify key risks from the expansion of a peer workforce and provide guidance on risk mitigation where appropriate. It must also provide a streamlined process for private hospitals to engage with governments in relation to the peer workforce.

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

16.1 APHA supports and endorses draft recommendation 4.15 that the next agreement should require timely evaluations to be conducted for all funded services in line with the National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines and require sharing of evaluation findings, including sharing publicly where possible.

16.2 A robust, transparent, and inclusive evaluation system is essential to drive continuous improvement, accountability, and evidence-based reform.

16.3 Despite delivering a significant proportion of mental health care, private hospitals are often excluded from national evaluation processes. Key challenges include:

16.3.1 Limited access to national evaluation tools and frameworks, despite participation in accreditation and quality assurance programs.

16.3.2 Inconsistent data sharing and reporting mechanisms, which hinder benchmarking and system-wide learning.

16.3.3 Lack of integration in outcome measurement initiatives.

16.4 APHA underscores the need for the evaluation framework to include private hospitals for feedback on the effectiveness of government policy and funding and provide opportunities for private hospitals to be involved in any future reform work or work to amend the next agreement where and when appropriate.

17.0 Draft recommendation 5.1: An Aboriginal and Torres Strait Islander schedule in the next agreement

17.1 APHA supports the need to ensure that all vulnerable communities have access to the care they need for both mental health and suicide prevention, this includes providing access to regional and remote Australia and to all Australians.

17.2 APHA agrees that the proposed schedule should:

17.2.1 align with the National Agreement on Closing the Gap and other important documents and include

17.2.2 provide tangible actions, with commensurate funding, to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, including better mental health and suicide prevention outcomes

17.2.3 clarify governance for its design and implementation, including the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues relating to Aboriginal and Torres Strait Islander social and emotional wellbeing

17.2.4 measure progress in a strengths-based way, with community-led evaluation

17.2.5 articulate and embed priorities highlighted by community such as cultural safety in all services, and greater investment in the community-controlled sector and the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce.

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

18.1 According to the Department of Health, Disability, and Ageing, suicide is the leading cause of death for Australians aged 15 to 49 years. It is the third leading cause of premature death from injury or disease. About 1 in 8 Australians has seriously considered suicide at some stage in their life.

18.2 In 2024, *suicide and self-inflicted injuries* were the second leading cause of fatal burden among all Australians, with an estimated 159,800 years of life lost.[6]

18.3 There were close to 24,800 intentional self-harm hospitalisations in 2022–23.[7]

[6] https://www.aihw.gov.au/mental-health/snapshots/suicide-and-self-harm

[7] Ibid.

18.4 Research has indicated that while mental illnesses can be a major risk factor for suicide, they are not the only cause. In 2023, 64% of people who died by suicide had a mental and behavioural disorder recorded as cause of death, with 36% of people who died by suicide with other causes of death.[8]

18.5 There is a need to consider suicide prevention both in its own right and in relation to mental health.

18.6 APHA supports and endorses the inclusion of suicide prevention as a schedule to the next agreement and recommends that it include a roadmap for suicide prevention, providing acute inpatient care for individuals experiencing suicidal distress, telehealth and crisis intervention support, risk assessment, post-suicide attempt care, and collaborative care models with psychiatrists, psychologists and other professionals.

18.7 The schedule must delineate funding pathways for suicide prevention programs and public-private partnerships. It should:

- 18.7.1 recognise the role of private hospitals in suicide prevention service delivery.
- 18.7.2 include funding mechanisms that allow private hospitals to deliver post-attempt care, crisis stabilisation, and suicide-specific therapeutic programs.
- 18.7.3 promote collaborative models between private hospitals, primary health networks, local hospital networks, and community organisations.
- 18.7.4 ensure data sharing and outcome tracking, including suicide attempt rates, readmissions, and recovery outcomes.

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[8] https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#risk-factors-for-intentional-self-harm-deaths-suicide-in-australia