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3 April 2025

Commissioner Stephen King &
Commissioner Selwyn Button
Productivity Commission
C/-GPO Box 1428
Canberra City ACT 2601, Australia

Submitted to: https://www.pc.gov.au/inquiries/current/mental-health-review/make-submission#lodge

Dear Commissioners,

Final Review of the National Mental Health and Suicide Prevention Agreement

The Australian Psychological Society (APS) welcomes the Productivity Commission's Review of the National Mental Health and Suicide Agreement (the Agreement) as a timely opportunity to strengthen the Agreement and improve access to effective, person-centred, and coordinated care—no matter where a person lives. We support a renewed Agreement underpinned by robust, evidence-based and fiscally sustainable initiatives, with clear governance, measurable outcomes and informed by lived experience. Strengthening the Agreement is essential to building a more coherent, equitable and sustainable mental health system for all Australians.

About the APS

The APS is the leading professional association for psychologists in Australia. We are committed to advancing the science, ethical practice and application of psychology to promote mental health and wellbeing, empowering individuals, organisations and communities to reach their full potential. Our work is informed by United Nations human rights treaties and conventions[1] and the United Nations Sustainable Development Goals (SDGs)[2]. We advocate for a fair, inclusive and environmentally sustainable world, recognising the evidence that national and global prosperity, now and in the future, hinges on prioritising the wellbeing of people and the planet[3].

Psychologists are essential to the delivery of Australia's mental health system, providing evidence-based, person-centred care across all levels of need and in diverse settings including primary care, community mental health, hospitals, justice settings, schools and workplaces. As highly trained and regulated professionals, psychologists work with individuals across the lifespan to prevent, assess and treat a wide range of mental health conditions. Psychologists also strengthen the broader mental health system through research, education, supervision, policy development and interprofessional collaboration. Their expertise is critical to ensuring that mental health and suicide prevention services are accessible, culturally responsive and effective.

Please find the APS response on the following pages. We consent to this letter and our response being made publicly available. If any further information is required from the APS, I would be happy to be contacted through the National Office on (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Yours sincerely

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Chief Executive Officer

Australian Psychological Society (APS) Response to the Final Review of the Mental Health and Suicide Prevention Agreement

Research based on survey results and media features have highlighted that the combined impacts of climate change, the cost-of-living crisis and social challenges are contributing to elevated levels of mental distress among Australians, particularly young people (e.g.,[4–7]). This has led to increasing demand for mental health care and high levels of unmet need, placing growing pressure on the broader health system, including GPs, first responders, emergency departments and mental health professionals such as psychologists—and ultimately driving up costs to government and taxpayers[8]. An APS member survey in July 2024 confirmed that cost-of-living pressures and slow progress in mental health reform are preventing Australians from accessing much needed psychology services[9]. Many of our young people are forgoing psychological or other mental health support due to financial reasons[6,10].

Against a backdrop of rising cost-of-living pressures and broader social and economic uncertainty, the APS calls for strategic investment in mental health as a national priority to support both immediate and long-term wellbeing. This review of the Mental Health and Suicide Prevention Agreement (the Agreement) is an opportunity for the Australian, State and Territory Governments to substantially strengthen and build upon previous commitments by making the targeted investments required to deliver meaningful change. Reform is needed across all parts of the system—to promote wellbeing, prevent mental ill-health and suicide, and ensure all Australians have timely access to effective support and care when it is needed.

The APS response to this review focuses on *Terms of Reference item (c) which considers opportunities under the National Agreement to adopt best-practice approaches across Australia, particularly where productivity improvements can be achieved*.

1. Costed, evidence-based steps to strengthen mental health outcomes for all Australians

The APS includes for the Commission's consideration a link to our Pre-Budget submission Accessible mental health and wellbeing: A psychological blueprint for Australia's 2025-26 Budget[11], which presents 10 targeted, costed reform initiatives to improve mental health services for Australians, based on three overarching objectives:

1. Empower victim-survivors of domestic and family violence by providing high quality psychology services,
2. Strengthen the psychology workforce to address Australia's critical mental health and wellbeing needs, and
3. Deliver accessible and affordable psychology services to the whole Australian community.

These initiatives are supported by a Cost Benefit Analysis (CBA) by ACIL Allen, which found that each of **the 10 initiatives deliver strong value for money—with benefit-cost ratios well above one and positive net present values**, even under conservative assumptions. Each initiative is expected to generate economic returns that significantly exceed implementation costs, alongside broader social and economic benefits.

A summary of the initiatives and their Benefit-Cost Ratios (BCRs) is provided in Table 1 on the following page. The full ACIL Allen CBA report[12] is available to the Commission upon request.

Table 1: Summary of APS Pre-Budget Submission 2025-26 Initiatives

Objective 1. Empower		BCR
1. Training for psychologists and other health professionals	Develop trauma-informed, culturally sensitive free online training for health professionals to support women and children facing violence and to identify those at risk of perpetrating it.	3.40
2. Direct access for victim-survivors of DFV	Provide MBS item numbers for family violence victim-survivors to access a psychologist without requiring a GP referral or mental health diagnosis (for both current and past DFV experiences).	2.36
3. APS-led DFV Professional Support	Fund the APS to develop a DFV Professional Support Network, offering specialised training for psychologists to support peers, health professionals, and DFV workers, and creating a volunteer network to provide professional support and welfare checks.	2.63
Objective 2. Strengthen		**BCR**
4. Extend Commonwealth Prac Payment to psychology	Extend the Commonwealth Prac Payment to post-graduate psychology students, including a loading for students on placements in rural and remote areas to prevent placement poverty	2.74
5. Develop a National Psychology Workforce Strategy	Fund the APS to research and develop an evidence-based national psychology workforce strategy to address the FTE gap caused by a predominantly part-time female workforce, ensuring a sustainable increase in FTE.	3.25
Objective 3. Deliver		**BCR**
6. Improving Access to Psychology Services	Introduce higher rebates for all Better Access Initiative psychology services to address affordability and cost of living pressures and insufficient rebate indexing, while improving access to care for disadvantaged patients, especially in rural and remote areas.	2.14
7. Bulk Billing Incentives	Introduce bulk billing incentives for psychologists, equivalent to those provided for GPs, especially in rural and remote areas.	2.18
8. Psychologist-determined support	Allow psychologists to determine the necessary number of Better Access sessions, up to 20 for complex mental health issues and up to 40 for lower prevalence and (higher impact) conditions (such as eating disorders and Post-Traumatic Stress Disorder).	2.71
9. Streamline GP Mental Health Reviews	Shift GP Mental Health Reviews from the current arrangement (after 6 sessions) to the end of treatment or when Better Access session limits are reached.	2.19
10. Youth Access (Medicare safety net)	Introduce a $0 youth mental health 'safety net' threshold for Better Access sessions to ensure young Australians aged 14 to 25 can access psychological care without financial hardship for themselves or their families.	1.67

Recommendation 1
Improve access to effective, person-centred mental health care that delivers strong economic and social returns, the National Agreement by supporting the inclusion of the 10 costed, evidence-based reform initiatives outlined in the APS 2025–26 Pre-Budget Submission.

We take this opportunity below to discuss in more detail the ways in which the Agreement can strengthen access, equity and outcomes across the mental health system and better leverage the full capabilities of the psychology workforce in prevention, early intervention and care delivery.

2. A strategic approach to psychology workforce growth and utilisation

The Agreement recognises that workforce is a key enabler of mental health system reform (Clause 147) and commits all parties to increasing the number of full-time equivalent (FTE) mental health professionals per 100,000 population over the life of the Agreement (Clause 158). Psychologists are specifically identified in the Agreement as a priority workforce requiring urgent action to address critical shortages and strengthen multidisciplinary care (Clause 159).

The APS welcomes the inclusion of these principles and clauses, which acknowledge—across all levels of government—the need to grow and sustain Australia's mental health workforce, including the psychology workforce. We have long advocated for urgent, coordinated action to expand, retain and fully utilise the psychology workforce. Yet despite this, available data demonstrates that the longstanding shortfall and underutilisation of the psychology workforce has persisted. A 2020 analysis estimated that the psychology workforce is meeting only 35%of projected national demand[13,14]. As also highlighted in our 2025-2026 Pre-Budget Submission[11], APS analysis demonstrates that psychologists also have the lowest clinical full-time equivalent (FTE) to headcount ratio of all Ahpra-registered professions, with the ratio declining to just 61.2% in 2023—well below the all-profession average of 80.7%[15].

Thus, an essential inclusion in the Agreement is clearly defined national psychology workforce growth targets —such as defined baselines, FTE clinician numbers, percentage increases, and timeframes to achieve this growth. In the case of psychology, these growth targets should also factor in the breadth and diversity of the profession and consider how to fully utilise the skills of all psychologists across prevention, early intervention and treatment efforts. It must also address regulatory and structural barriers that limit their effective contribution. This includes improving support for training and supervision and correcting persistent misunderstandings about psychologists' scope of practice, which continue to constrain workforce utilisation. (If required, more details about these matters can be found in our recent submissions to the APS Response to the Scope of Practice Review - Issues Paper 1[16] and APS Response to the Scope of Practice Review Survey[17]).

Thus, without clear, measurable commitments across jurisdictions and targeted, profession-specific action that ensures full utilisation of psychologists' scope of practice, the Agreement—and the National Mental Health Workforce Strategy 2022–32 to which it refers—will be insufficient to drive the needed psychology workforce growth required to effectively respond to Australia's mental health care needs in fiscally sustainable way.

Recommendation 2
Drive urgently needed mental health workforce reform, by including clearly defined national psychology workforce growth targets in the Agreement — such as defined baselines, FTE clinician numbers, percentage increases, and timeframes — that account for the full utilisation of psychologists' skills. These should be supported by robust accountability mechanisms to ensure all targets are met.

In the following sections of this submission, we outline strategic initiatives and actions that can harness the full capabilities of psychologists across the mental health system to deliver improved health, social, and economic outcomes for Australia.

Harnessing the psychology workforce for prevention and early intervention

While the Agreement acknowledges the importance of prevention and early intervention in improving mental health outcomes, there are clear opportunities to more fully embed this focus into its design and implementation. Current system structures and workforce as reflected in the Agreement remain heavily skewed toward acute care, with interventions typically activated only after significant deterioration in mental health.

This limits investment in psychologists and other appropriately trained professionals to deliver upstream, evidence-informed interventions that maintain wellbeing and address emerging issues early reducing demand on acute services and alleviating the wider social and economic burden of mental ill-health on individuals, communities and the nation[18,19].

In addition to specific wording suggested in Appendix A, the APS calls for the next iteration of the Agreement to take up the opportunity to take strategic action to address the underutilisation of appropriately trained mental health professionals in delivering prevention and early intervention services.

Psychologists, in particular, are trained not only to treat mental illness, but also to apply prevention science and early intervention models across the lifespan, in a wide range of settings and with diverse populations. Psychologists can identify risk and protective factors, build individual and community resilience, and support early intervention across schools, workplaces and community settings.

Psychologists working in a wide range of settings and are highly skilled in delivering early interventions and population-level mental health programs. Their expertise contributes significantly to prevention and early response efforts that reduce long-term system burden and improve individual and community wellbeing. For example:

- *In educational and developmental settings*, psychologists play a critical role in the early identification of and response to psychosocial distress in children and adolescents, supporting both mental health and learning outcomes.
- *In workplaces*, psychologists promote mentally healthy environments, helping to prevent stress-related illness and support employee wellbeing, productivity and retention.
- *In community settings*, psychologists work with individuals, families and service providers to strengthen local capacity and address social determinants of mental health, such as housing insecurity, social isolation and access to services.
- *In healthcare settings*, psychologists support early intervention for people with, or at risk of, chronic illness by promoting health behaviour change and psychological adjustment, thereby reducing downstream health costs.
- *In primary care*, psychologists provide treatment for emerging mental health concerns, helping to prevent escalation and reduce demand on acute care services.
- *In justice settings,* psychologists contribute to prevention and early intervention by addressing the underlying drivers of offending behaviour, supporting at-risk individuals through early assessment and diversion programs, and designing evidence-based initiatives that reduce recidivism and promote rehabilitation. They also play a key role in strengthening systems through work with police, courts, and correctional services to improve decision-making and outcomes.

These roles, additional to the treatment of mental disorders, are vital to a well-functioning mental health ecosystem and should be resourced accordingly in all jurisdictions. Prevention-focused and early intervention roles and services should not be seen as “optional extras” but as integral to a sustainable, effective mental health system. Greater inclusion of psychologists across all settings — and full use of their training and expertise in mental health promotion, early intervention and treatment — will help to reduce future demand and improve health and economic outcomes.

Thus, the Agreement should include funding and support for roles for psychologists in settings such as schools, community settings and workplaces, as well as increasing training placements and supervision support across these settings of practice. Data collection and reporting mechanisms that track wellbeing promotion activities and the contribution of psychologists beyond clinical treatment settings are also required.

Recommendation 3
The Agreement should realise the full system benefits of prevention and early intervention in mental health by:

- ***Explicitly recognising and investing in psychologists to deliver early intervention and mental wellbeing promotion services across a diverse range of settings.***
- ***Including psychologists in regional and national planning and commissioning processes focused on early intervention and primary prevention.***

- *Improving data collection and outcome reporting on the implementation and impact of mental health promotion and early intervention mental health programs across jurisdictions.*
- *Funding training, supervision and placement pathways for psychologists working in early intervention and preventative settings to support workforce sustainability.*

Invest in more psychologists in schools to support student wellbeing

Schools are one of the most critical settings for mental health promotion and early identification and response to mental health concerns in children and adolescents[20]. All psychologists working in schools, including, but not limited to, educational and developmental psychologists and counselling psychologists, play a vital role in promoting student wellbeing, identifying and intervening early in cases of psychosocial distress and mental health concerns and providing timely, evidence-based support for learning and behavioural needs. Deep integration within school communities allows them to build trusted relationships and provide culturally and developmentally appropriate care in a timely, non-stigmatising environment.

Despite this, access to school psychologists in Australia remains limited, inconsistent and far below recommended levels. The Productivity Commission's 2020 *Mental Health Inquiry Report*[21]recommended a national benchmark of one school psychologist for every 500 students, recognising that school-based services are essential to a well-functioning mental health system. However, current resourcing in many jurisdictions falls well short of this benchmark, with significant variation across states and territories. In some areas, ratios exceed 1:1000 students, depending on location and school type—leaving many schools, especially those in rural and remote locations, without access to sufficient psychological expertise to meet the growing mental health needs of students.

The APS strongly supports the recommended benchmark of one school psychologist per 500 students and continues to advocate for its formal adoption, as outlined in our 2022 *Psychologists in Schools Position Statement*[20]. Evidence shows that building resilience and strengthening mental health early improves quality of life across the lifespan and delivers long-term savings to the health system. According to the National Mental Health Commission, investing early in children's mental health yields a return of $1 to $10.50 for every dollar spent[18]—making this not only a social imperative, but an economic one. The next National Mental Health and Suicide Prevention Agreement presents a critical opportunity to embed the 1:500 school psychologist-to-student ratio and drive consistent national progress toward achieving this target. Achieving this goal will require more than just endorsement by the Federal, State and Territory governments —it will demand sustained investment, coordinated workforce planning and movement toward national consistency in how school psychology services are delivered.

Recommendation 4
Embed a national commitment to improving access to psychologists in schools in the Agreement by:
- *Committing to a national school psychologist-to-student ratio target of 1:500, as recommended by the Productivity Commission in 2020.*
- *Ensuring dedicated funding and workforce planning across jurisdictions to support the creation and distribution of school psychologist roles, with particular attention to rural, remote and underserved areas.*
- *Increasing access to placements and supervision for provisional and early-career psychologists within school settings to build future workforce capacity.*
- *Supporting national data collection and reporting on the provision of psychology services in schools to monitor progress and guide future reform.*

Unlocking the full potential of the psychology workforce in public mental health

While there is variation across states and territories in the availability of psychology roles and the types of psychologists employed in public health, current work awards, conditions and work practices frequently restrict psychologists from working to their full scope. This results in the underutilisation of their skills, further exacerbating the impact of workforce shortages and ultimately limiting access to effective psychological care for those Australians who need it most. This is especially important in rural and remote locations where it is even more difficult to attract psychologists to the health workforce.

Examples of these limiting awards, conditions and practices as described by our members (e.g.,[22]) include:

- *Underutilisation of registered psychologists* - All Ahpra-registered psychologists are qualified to assess, diagnose and treat mental health conditions and are registered as general psychologists. However, public sector recruitment practices often limit the contribution of psychologists with general registration (non-endorsed), or areas of practice endorsement (AoPE) other than clinical or clinical neuropsychology (e.g. counselling, health, educational and developmental), despite their relevant competencies and applicability to public health roles. These practices unnecessarily restrict access to a highly trained workforce, exacerbate shortages and reduce system capacity. In addition, provisional psychologists and those on the 5+1 pathway are underutilised, despite their potential to contribute meaningfully under appropriate supervision—representing a missed opportunity to support community access to mental health care and workforce sustainability.
- *Psychologists working predominately as case managers* – Psychologists working in the public health sector are often grouped with other allied health or mental health workers under a generic public sector award which fails to recognise that they are highly trained (often Masters and Doctoral level) and their distinct and full scope of practice. Even when employed in designated psychologist roles, they are generally limited to providing 'case management' or 'clinical management' within a largely biomedical model of care. Our members report that, as a result, patients often have very limited (or no) access to treatment by a psychologist in the public mental health system.
- *Treatment and recovery are deprioritised* – Within the stretched public mental health system, psychological treatment is often deprioritised despite strong evidence of its effectiveness for supporting recovery[23,24]. The focus instead shifts to facilitating patient discharge from hospital to community settings—often in the context of insufficient supports to meet the immediate and ongoing needs of newly discharged patients with complex mental health care needs.
- *Limited opportunities to increase operational efficiency* – Current caseloads and high demand for care means there are limited opportunities to identify cost and process efficiencies in public health settings. APS members report a high burden from administrative tasks which could be streamlined if the opportunity and resourcing were afforded, allowing practitioners to redirect this time to effective psychological treatment.
- *Lack of support for placements and supervisors* – Student psychologists working under qualified and experienced psychologists during placements are critical to the training and registration of psychologists nationally. There are currently a number of barriers which disincentivise potential supervisors from undertaking this crucial training and mentoring role. This includes the high demand and lack of time available for such tasks, as well as the mandatory training which supervisors need to undertake using their own funds and in their own time.
- *Loss of talent from the public system* – As described, the challenging working conditions facing psychologists in the public health system, has led to a movement of the workforce out of the public sector into private practice. In private settings, psychologists are better remunerated and are typically able to choose their own hours, work to their full scope of their practice and training which is more rewarding and helps them to manage burnout and work-life balance. Loss of talent to the private sector places additional strain on the psychologists who remain. They are overwhelmed by the demand for care which can ultimately affect the quality and timely delivery of health services, increase their risk of stress and burnout and hastening their exit from the public health system.

A more consistent, coordinated, and strategic approach is needed to ensure that psychologists—across all areas of practice and career stages—can contribute fully to improving mental health outcomes for Australians accessing public mental health care. While states and territories are primarily responsible for public mental health care employment conditions, the Federal Government must also play a leadership role in requiring cross-jurisdictional consistency of awards and conditions and enabling psychologists in the public sector to work to their full scope of practice throughout Australia—ensuring their skills are not underused at a time of critical service demand.

Recommendation 5
The Agreement should include mechanisms that improve Australians' access to effective, person-centred mental health care in the public mental health by:

- *Redesigning public sector psychology roles to ensure psychologists are recognised, supported, and employed in line with their qualifications and full scope of practice, with a focus on delivering evidence-based psychology services rather than generic case management functions.*
- *Enabling broader and more flexible employment of the psychology workforce.*
- *Expanding funded placements, supervision incentives and career pathways for provisional and early-career psychologists to strengthen entry points into the public mental health workforce.*
- *Promoting cross-jurisdictional consistency in public sector awards, working conditions and career structures to improve portability, support workforce mobility, and strengthen the ability to attract and retain psychologists in the public system.*
- *Removing disincentives for experienced psychologists in the public health system to provide supervision by ensuring access to funded supervisor training requirements, protected time for supervision and appropriate workload relief.*
- *Introducing rural loadings, relocation allowances and ongoing CPD and peer support for psychologists who choose to work in rural, regional and remote locations.*
- *Expanding telehealth infrastructure to support distributed workforce models.*
- *Addressing system-level drivers such as workload, burnout and job satisfaction by supporting flexible work options, improving clinical governance and ensuring career progression pathways within the public system.*

Summary

This submission outlines evidence-informed recommendations to strengthen the National Mental Health and Suicide Prevention Agreement, ensuring it delivers improved access, equity and outcomes for all Australians. We emphasise the urgent need for strategic investment in prevention, early intervention and timely care—underpinned by workforce reform that fully recognises and utilises the skills of psychologists across all settings.

Our recommendations include adopting costed, high-impact initiatives from the APS 2025–26 Pre-Budget Submission, setting clear national psychology workforce growth targets, embedding psychologists in prevention-focused roles, expanding access to psychologists in schools, and addressing structural barriers to effective workforce use in public mental health services. Together, these reforms offer a fiscally sustainable path to a more effective, person-centred mental health system and a stronger return on investment for governments and communities alike.

The APS would like to acknowledge and sincerely thank the members who so kindly contributed their time, knowledge, experience and evidence-based research to the development of this submission.

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Appendix A

Suggested Amendments to the Mental Health and Suicide Prevention Agreement (the Agreement)

1. Reference – Specific section and paragraph number of the Agreement
2. Feedback – Identified opportunity for improvement and rationale
3. Recommended wording changes

Reference	Feedback	Recommended Wording Changes
Overview (point 1)	The APS suggests avoiding language that will date the document. In addition, limiting the reference to natural disasters to drought and bushfires is problematic given recent significant flood events.	2. The Parties recognise the need to improve Australia's mental health and suicide prevention system is amplified by the profound impact of the COVID-19 pandemic and various natural disasters on mental health and wellbeing in Australia. ~~, as well as other recent challenges such as drought and bushfire~~.
Overview (point 9)	An explicit focus on "mental ill-health" is problematic. The importance of the lived experience of preventative well-being focused interventions should be acknowledged.	9. Implementation of this Agreement and associated reform activities should be informed by the specific needs and experiences of those with lived experience of wellbeing promotion, mental ill-health and suicide, and those who care for them and utilise associated services.
Principles (20,a)	The APS suggests focusing on suicide prevention, and the *prevention* of mental ill-health emerging in the first place. Intervening only after pathology emerges is an unnecessarily limiting and risks not addressing the root cause of issues. Phrasing in the current document could be misinterpreted to refer to consumers of suicide (not suicide prevention services). We suggest a small adjustment to address this.	(a) Work together to build a better people-centred wellbeing, mental health and suicide prevention system for all Australians, with lived experience of wellbeing promotion, mental ill health and/or suicide prevention services for ~~of~~ consumers and their families and carers embedded in the design, planning, delivery and evaluation of services;
Principles (20,c)	As noted above, the APS suggests an increased focus on wellbeing promotion as a way of preventing mental ill-health emerging in the first place.	(d) Support and enhance the capability of the wellbeing promotion, mental health, suicide prevention and broader health and related workforce to meet current and future needs, particularly in rural, regional and remote communities and priority populations;
Principles (20,l)	As above.	(l) Improve transparency and accountability of wellbeing promotion, mental health and suicide prevention outcomes, including through clear roles and responsibilities for government, improving data

		collection, linkage and analysis that is shared publicly, and a commitment to develop an evaluation framework, to be formally agreed through this Agreement;
Objectives (22)	As above, the APS suggests broadening the reference to natural disasters.	22. This Agreement acknowledges the significant, and often cumulative, challenges for people living in Australia including ~~drought, bushfires~~ the impact of natural disasters (e.g., drought, bushfires, floods) and COVID-19. These challenges have amplified the need to improve our mental health and suicide prevention system to address the increased impact on mental health, increased levels of mental illness, and increased levels of suicidal risk, self-harm and distress.
Objectives (24)	In line with previous comments, the APS suggests broadening the objectives to ensure that consumers clearly have access to preventative, wellbeing promoting initiatives.	24. The Parties will work together in partnership to ensure that all people living in Australia have equitable access to the appropriate level of wellbeing promotion and mental health and suicide prevention care they need, and are able to access this care when and where they need it.
Objectives (25,c)	The APS applauds the focus on preventative intervention. We suggest adding a reference to wellbeing that ensures this paragraph is not misinterpreted to focus on the prevention only of severe and enduring mental health conditions as per the phrasing at the end of the paragraph.	(c) prioritise further investment in wellbeing promotion, prevention, early intervention and effective management of severe and enduring mental health conditions.
Governance and Implementation (55)	As per our earlier comments, the APS again emphasises the importance of ensuring that there is a focus on wellbeing promotion. This necessitates consulting with those who are consumers of wellbeing promotion services (not just those seeking to prevent ill-mental health from emerging).	55. To ensure a people-centred wellbeing promotion, mental health and suicide prevention system for all people living in Australia the Parties commit to ensuring people with lived experience of wellbeing promotion, mental ill health and/or suicide and their families and carers are consulted throughout implementation of this Agreement. The Parties will seek advice and provide opportunities for people with lived experience of wellbeing, mental health and/or suicide, other experts including representatives for the priority populations identified in Clause 111 [refer Priority populations list], and community groups to influence matters of service design, planning,

		implementation, evaluation, data and governance.
Variation of this Agreement (60)	The APS contends that it seems highly unusual to allow the Commonwealth Government, or any of the State or Territory Governments to terminate their participation in this agreement with simply by notifying all the other Parties in writing. If the objective is to build a *"*unified and integrated" system, then all parties should have confidence that nobody can opt-out with limited notice.	60. A Party to this Agreement may terminate their participation in this Agreement at any time by notifying all the other Parties in writing and providing X months notice of their intent to terminate.
Improve data collection and data sharing (88)	Given the need for serious and committed efforts to ensure investement in preventative measures, as a minimum any wellbeing initiatives that are being implemented across the country should be accounted for with appropriate data collection. The APS suggests an additional bullet point to be inserted between 88,a and 88,b to measure this area.	Maintain and improve measurement of wellbeing promotion activities in all jurisdictions.
Improve data collection and data sharing (89)	If there is to be a focus on preventative wellbeing promotion activities, it will be important for the states and territories to measure and share relevant data.	89. The States will continue to collect and share state and territory delivered wellbeing promotion data and mental health service data, including hospital, specialised mental health services and other mental health program data, and consumer outcome data, and continue to develop and refine those collections to improve system coverage and national consistency where not over-burdensome or duplicative.
Strengthening evaluation culture to measure the impact of programs (97 to 103)	The focus of these clauses appears to be on *"people with mental health issues".* If reporting and transparency is only to focus on this population, then it is unlikely that the system used to promote wellbeing and prevent mental ill-health will be improved over time. The APS suggests a slight change to point 98, and there may also need to be an additional clause somewhere in this section if preventative efforts are to be truly prioritised.	98. The Parties agree that a robust information and evidence base is needed to improve programs, policies, and outcomes for both people with mental health issues and those consuming wellbeing promotion services, including those at risk of or experiencing suicidal distress, and their families and carers. The Parties will support improvements across the whole mental health and suicide prevention system by:...
Suicide Prevention and Response (heading)	The APS suggests a change to the title of this heading in order to truly focus on preventing mental ill-health, not only suicide.	Wellbeing Promotion, Suicide Prevention and Response

Suicide Prevention and Response (122)	Aligned with the suggestion above regarding the heading of this section, the APS further suggests a change to 122.	122. This Agreement recognises that the Parties have a shared responsibility for wellbeing promotion, suicide prevention and that collaboration is required to provide a more effective system-based approach to meet the needs of people at risk of suicide.
Suicide Prevention and Response (123)	As above to 123.	123. The Parties recognise that wellbeing promotion, suicide prevention is complex as there are many contributing factors which can increase an individual's risk of suicide including behaviours, environmental characteristics and psychosocial factors such as a history of self-harm, relationship problems, legal issues, financial pressures, unemployment or homelessness.
Suicide Prevention and Response (124, a)	As above to 124 a.	(a) Seek to improve wellbeing, plus reduce suicide deaths, suicide attempts, and self-harm towards zero.
Suicide Prevention and Response (124, c)	As above to 124 c.	(c) Develop wellbeing promotion and suicide prevention services and programs in collaboration with communities and people with lived experience to identify gaps in service provision and to gain insights into individual experiences.
Suicide Prevention and Response (124, d)	As above to 124 d.	(d) Improve joint regional planning for wellbeing promotion, suicide prevention to drive development of evidence-based services in areas of identified need to address gaps in service provision.
Suicide Prevention and Response (124, e)	As above to 124 e.	(e) Improve the quality of wellbeing promotion and suicide prevention services by establishing standards either developed specifically for the program or by an external organisation to improve outcomes of service provision nationally.
Suicide Prevention and Response (124, f)	As above to 124 f.	(f) Incorporate wellbeing promotion and suicide prevention training into service modelling to develop skills for building capacity and fostering suitably skilled workers that are empathetic to the needs of people in suicidal distress.
Suicide Prevention and	As above to 124 g.	(g) Build competency within the wellbeing promotion and suicide prevention workforce, including the

Response (124, g)		peer workforce, through evidence informed training.
Workforce (144 to 154)	Finally, the APS suggests the addition of this point be in the Workforce section.	The Parties acknowledge that there are opportunities to improve the quality and standardisation of training provided to this workforce. The Parties also acknowledge the lack of a formal registration in place for some occupations in this workforce, and the critical need to protect the public through appropriate regulatory mechanisms.