The Auditor-General
Auditor-General Report No.23 2025–26
Performance Audit

Suicide Prevention Policy Development and Monitoring

Department of Health, Disability and Ageing

Australian National Audit Office

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5 March 2026

Dear President
Dear Mr Speaker

In accordance with the authority contained in the *Auditor-General Act 1997*, I have undertaken an independent performance audit in the Department of Health, Disability and Ageing. The report is titled *Suicide Prevention Policy Development and Monitoring.* I present the report of this audit to the Parliament.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's website — http://www.anao.gov.au.

Yours sincerely

Dr Caralee McLiesh PSM
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

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Audit snapshot

Auditor-General Report No.23 2025–26

Suicide Prevention Policy Development and Monitoring

Why did we do this audit?

- Suicide is the leading cause of death for Australians aged 15 to 44 years. The suicide rate for Aboriginal and Torres Strait Islander people is increasing.
- Reducing suicide deaths is a public health priority for all Australian governments. Two national agreements establish objectives and intended outcomes for suicide prevention.
- The Department of Health, Disability and Ageing (DHDA) is responsible for administering a national agreement, providing policy advice, and administering specific suicide prevention measures.

Key facts

- From 2022–23 to 2025–26, DHDA administered 41 suicide prevention measures with total Australian Government funding of over $990 million. This audit examined six measures with funding of $560 million.
- The Social and Emotional Wellbeing Policy Partnership was established to support policy development with Aboriginal and Torres Strait Islander people.

What did we find?

- DHDA's development and monitoring of suicide prevention measures is partly effective.
- Policy advice on national strategies and suicide prevention measures is not fully robust. Commitments to partner with First Nations people in policy development are partly met.
- Four to five years after several national agreements, objectives to reduce suicide have not been achieved. While suicide prevention measures are evaluated, there is no framework to support measuring and monitoring the impact of the Australian Government's suicide prevention investment.

What did we recommend?

- There were six recommendations to DHDA aimed at clarifying roles and responsibilities and strengthening planning, policy advice, partnership, and monitoring and reporting arrangements.
- DHDA agreed to three recommendations and agreed in principle to three recommendations.

4 years

Time between public consultation and release of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

5 out of 10

'Strong partnership' elements in the National Agreement on Closing the Gap exhibited by the Social and Emotional Wellbeing Policy Partnership.

None

Grant agreements examined that included performance indicators of effectiveness or efficiency.

Summary and recommendations

Background

1. The Australian and state and territory governments have committed to address suicide through two national agreements.

- The July 2020 National Agreement on Closing the Gap (Closing the Gap Agreement) includes socio-economic outcome 14: 'Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing'; and target 14: a 'significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero'.[1] Under the Closing the Gap Agreement, governments committed to work in full and genuine partnership with Aboriginal and Torres Strait Islander people in policy development including in relation to 'social and emotional wellbeing (mental health)'.
- The March 2022 National Mental Health and Suicide Prevention Agreement (National Agreement) includes the objective to implement whole-of-government approaches to suicide prevention, including beyond the mental health system, to progress the goal of zero lives lost to suicide and to deliver a suicide prevention system that is comprehensive, coordinated, consumer focused and compassionate to benefit all Australians.[2]

2. The Australian Government Department of Health, Disability and Ageing (DHDA) is responsible for administering the National Agreement, providing policy advice on suicide prevention, and administering specific suicide prevention measures.

Rationale for undertaking the audit

3. In 2024, there were more than 3,300 deaths by suicide in Australia. Suicide is the leading cause of death for Australians aged 15 to 44 years. The suicide rate for Aboriginal and Torres Strait Islander people is more than double the rate for non-Indigenous Australians and is increasing.

4. Reducing suicide deaths is a public health priority for all Australian governments. Under the National Agreement, the Australian Government has a national leadership role in suicide prevention. The Closing the Gap Agreement includes a target of a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero. From 2022–23 to 2025–26, Australian Government expenditure on suicide prevention measures was approximately $1 billion.

5. This audit provides assurance to the Australian Parliament over whether Australian Government suicide prevention measures have been informed by robust policy advice and are effectively monitored and evaluated.

1 Australian Government, *National Agreement on Closing the Gap*, Commonwealth of Australia, Canberra, July 2020, available from https://www.closingthegap.gov.au/national-agreement [accessed 24 September 2025].

2 Australian Government, *National Mental Health and Suicide Prevention Agreement*, Commonwealth of Australia, Canberra, March 2022, available from https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement [accessed 24 September 2025].

Audit objective and criteria

6. The audit objective was to assess whether DHDA effectively developed and monitored suicide prevention measures.

7. To form a conclusion against the objective, the ANAO adopted two high-level audit criteria.

- Has DHDA provided robust policy advice on suicide prevention measures?
- Has DHDA effectively monitored and evaluated suicide prevention measures?

Conclusion

8. DHDA's development and monitoring of suicide prevention measures was partly effective. The Australian Government committed to address suicide through two national agreements. DHDA did not fully support these commitments through robust policy development, including in genuine partnership with Aboriginal and Torres Strait Islander people, or effective performance monitoring. While new suicide prevention measures were implemented, DHDA has not established arrangements to determine whether outcomes are being achieved.

9. Policy advice on two national suicide prevention strategies and six suicide prevention measures was not fully robust. Advice lacked consideration of program logics, implementation, stakeholder input, evaluation findings, and performance measurement and monitoring. Policy advice included consideration of how the proposed measures would be evaluated. Australian Government commitments to develop policy in partnership with Aboriginal and Torres Strait Islander people were partly met. A lack of clear roles and responsibilities impacted on policy development effectiveness, including the way in which the policy was developed in partnership with First Nations peoples.

10. DHDA's monitoring and evaluation of suicide prevention measures was partly effective. Nearly four years after the National Mental Health and Suicide Prevention Agreement, and over five years since the National Agreement on Closing the Gap, government objectives to reduce suicide have not been achieved. An appropriate performance measurement framework for suicide prevention agreements, measures and grants was not established. Monitoring and reporting was incomplete, compliance focused, based on unverified performance information and provided little insight into the achievement of intended outcomes. Although evaluations are planned and underway, a lack of fit-for-purpose performance data limits DHDA's ability to conduct robust evaluations of suicide prevention measures. As a result, there is limited information available to DHDA and the public about the extent to which Australian Government investment in mental health and suicide prevention is contributing to reducing suicide.

Supporting findings

Policy advice

11. In 2019 and 2021, the Australian Government committed to developing two national strategies for suicide prevention: the National Suicide Prevention Strategy and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. The National Suicide Prevention Office and Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi), respectively, were responsible for developing the strategies. DHDA did not establish clear roles for all parties in the development

and approval of the strategies, which impacted DHDA's ability to effectively advise government and contributed to delays in the strategies being finalised. DHDA's advice to government on the development of the strategies was not always complete. DHDA's guidance and instructions to the National Suicide Prevention Office were not fully aligned with its advice to government, and its guidance and instructions to Gayaa Dhuwi were unclear or inconsistent with a commitment to work in partnership. The strategies were initially intended to be finalised in 2021 and 2023 but were released in 2024 and 2025 respectively. As at September 2025, there was no implementation plan and DHDA had not provided advice to government on implementation of either strategy. (See paragraphs 2.4 to 2.28)

12. Policy advice on the establishment or expansion of six suicide prevention measures between April 2021 and March 2022 was aligned with government objectives. Advice did not present stakeholder feedback and largely did not present relevant evaluation evidence, options or specific benefits. Regulatory impact statements were completed for each measure and regulatory costs were estimated for five of six measures. Legal and reputational risks were identified, however proposed mitigations were incomplete. Implementation risks were identified for two of six measures. Between April and October 2024, DHDA advised government on possible extension of four of the suicide prevention measures. Despite having access to evaluation evidence for three of the four measures, the advice to extend provided limited evidence from evaluations. (See paragraphs 2.29 to 2.43)

13. DHDA developed program logics for the six suicide prevention measures examined. None were completed in time to inform policy advice to government and the quality of the models was inconsistent. Advice on the six measures contained limited information on how the measures would be implemented. Advice proposed that all six measures would be evaluated and sought evaluation funding. Advice did not include information on how performance would be monitored or how DHDA would measure success. Evaluation plans were subsequently developed for all six measures. (See paragraphs 2.44 to 2.54)

14. The Social and Emotional Policy Partnership (Policy Partnership) was established in part to reduce Aboriginal and Torres Strait Islander suicide rates. DHDA is the lead Australian Government entity for developing and supporting the Policy Partnership. DHDA put in place governance and funding arrangements for the Policy Partnership that were not consistent with the principles of strong partnership and shared decision-making. As at September 2025, DHDA had not effectively ensured that the Policy Partnership was a genuine partner in suicide prevention policy development. A suicide prevention measure, Culture Care Connect, is an advisory arrangement funded under a grant agreement with the National Aboriginal Community Controlled Health Organisation (NACCHO). By helping to build the Aboriginal community-controlled sector, it contributes to the achievement of Closing the Gap Priority Reform 2, however it does not meet the criteria of a policy partnership. (See paragraphs 2.55 to 2.84)

Monitoring and evaluation

15. Performance indicators for suicide prevention activities at the national agreement and enterprise level have improved and are continuing to develop. For the six suicide prevention measures examined, performance indicators were established for four measures. In addition, performance indicators for grantees were established in grant agreements with third-party providers for four measures. Established indicators largely focus on the delivery of activities and

outputs and provide limited information about the impact and effectiveness of that work. Performance indicators in grant agreements are not verifiable due to a lack of a clear measurement and reporting methodology. Overall, there was no performance measurement framework to guide DHDA in its measurement, monitoring and reporting on the Australian Government's contribution to achieving suicide prevention objectives. (See paragraphs 3.3 to 3.13)

16. DHDA has established arrangements for monitoring and reporting on suicide prevention measures at the agreement and enterprise levels. Arrangements at the program level are largely incomplete and arrangements at the provider level focus on compliance. In practice, DHDA's monitoring and reporting at the agreement and enterprise level does not provide insight into the achievement of outcomes. DHDA did not monitor or report on program-level performance for the six suicide prevention measures examined. Provider-level performance information was collected but not verified. DHDA evaluated or was evaluating all six measures. Completed evaluations showed some evidence that short-term outcomes were being achieved but identified a lack of fit-for-purpose performance data. DHDA did not publish evaluation findings. (See paragraphs 3.14 to 3.36)

Recommendations

Recommendation no. 1
Paragraph 2.13

The Department of Health, Disability and Ageing finalise an agreement with the National Suicide Prevention Office to ensure there are clear roles and responsibilities, including in relation to developing and providing advice to government on suicide prevention policy.

Department of Health, Disability and Ageing response: *Agreed*

Recommendation no. 2
Paragraph 2.25

The Department of Health, Disability and Ageing:

(a) develop a plan to support the department's contribution to implementation of the National Suicide Prevention Strategy that includes documenting responsibilities and timeframes for the 106 actions outlined in the Strategy;

(b) work with Gayaa Dhuwi to develop an implementation plan for the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy; and

(c) provide advice to support government decision-making where decisions of government are required to finalise or publish either plan.

Department of Health, Disability and Ageing response: *Agreed in principle*

Recommendation no. 3
Paragraph 2.42

The Department of Health, Disability and Ageing establish controls to ensure that future advice to government on the establishment or extension of suicide prevention measures is clearly informed by evidence such as stakeholder views and monitoring and evaluation data, findings and recommendations.

Department of Health, Disability and Ageing response: *Agreed*

Recommendation no. 4
Paragraph 2.72

The Department of Health, Disability and Ageing ensure:

(a) governance and funding arrangements for the Social and Emotional Wellbeing Policy Partnership are consistent with the commitment in the National Closing the Gap Agreement to 'empower' Aboriginal and Torres Strait Islander parties to share decision-making authority with governments;

(b) the role of the Social and Emotional Wellbeing Policy Partnership as a partner in policy development is clearly defined, including in relation to aspects of social and emotional wellbeing beyond the health system; and

(c) arrangements are established to regularly monitor the Social and Emotional Wellbeing Policy Partnership to support shared accountability for the achievement of intended outcomes.

Department of Health, Disability and Ageing response: *Agreed in principle*

Recommendation no. 5
Paragraph 3.12

The Department of Health, Disability and Ageing ensure that funding agreements for suicide prevention measures include provider performance indicators to assist in monitoring provider performance and evaluating whether grant program outcomes have been achieved.

Department of Health, Disability and Ageing response: *Agreed*

Recommendation no. 6
Paragraph 3.29

The Department of Health, Disability and Ageing develop and publish performance monitoring and reporting framework(s) for suicide prevention measures, including arrangements for regular outcome reporting on specific suicide prevention measures to relevant oversight committees and improved public transparency, which could be informed by the National Suicide Prevention Outcomes Framework (once developed).

Department of Health, Disability and Ageing response: *Agreed in principle*

Summary of entity response

17. The proposed audit report was provided to DHDA. An extract of the proposed audit report was provided to the National Indigenous Australians Agency (NIAA), Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi), and the National Aboriginal Community Controlled Health Organisation (NACCHO). DHDA's summary response is reproduced below. Full responses from DHDA and NACCHO are in Appendix 1. NIAA did not provide comments and Gayaa Dhuwi did not provide a letter of response. Improvements observed by the ANAO during the course of the audit are listed at Appendix 2.

Department of Health, Disability and Ageing

> The Department of Health, Disability and Ageing (the department) welcomes the findings in the report. The department agrees with three recommendations and agrees in principle with three recommendations. The department is committed to effective implementation of Australian National Audit Office recommendations and is already taking steps to address some of the issues identified in this audit.
>
> The audit identified opportunities to strengthen governance, planning and accountability when developing and monitoring suicide prevention measures. To address these findings the department will clarify suicide prevention responsibilities with the National Suicide Prevention Office, provide advice to government on implementation of national suicide prevention strategies, and develop and embed stronger suicide prevention performance monitoring and reporting frameworks.
>
> The audit also identified opportunities to improve empowerment and decision-making in relation to Aboriginal and Torres Strait Islander stakeholders. The department is committed to working in partnership with First Nations Australians and will prioritise actions to achieve this goal within the scope of the department's policy remit. The department will also continue to support the delivery of social and emotional wellbeing and suicide prevention initiatives led and designed by Aboriginal and Torres Strait Islander people.

Key messages from this audit for all Australian Government entities

18. Below is a summary of key messages, including instances of good practice, which have been identified in this audit and may be relevant for the operations of other Australian Government entities.

Governance and risk management

- The National Agreement on Closing the Gap includes a commitment for governments to work in full and genuine partnership with Aboriginal and Torres Strait Islander people. Appropriate governance arrangements for partnerships can help ensure that the aspirations and objectives of all partners are met. Membership and reporting arrangements should ensure that the influence of government and First Nations partners is appropriately balanced; roles and responsibilities are clear; operating protocols are agreed and understood; and there are agreed shared accountabilities.

- One of the 'strong partnership' elements in the National Agreement on Closing the Gap is that adequate funding is needed to support Aboriginal and Torres Strait Islander parties to be genuine partners with governments in formal partnerships. When designing and administering funding arrangements for partnerships, including through grants, entities should ensure that the arrangements are aligned with partnership objectives. Considerations may include whether funding is sufficiently stable and predictable to support parties' meaningful participation and that the design and administration of funding agreements does not reinforce or exacerbate a power imbalance.

Policy/program design

- Policy advice should instil trust in decision-makers. Entities should ensure that advice provides decision-makers with options, which should be explained and justified with relevant evidence, such as stakeholder views and data from monitoring and evaluation activities. Advice should demonstrate to decision-makers that risks, implementation details and monitoring and evaluation arrangements have been appropriately considered. Incomplete advice prevents decision-makers from making informed decisions.

Performance and impact measurement

- Achieving the intent of the National Agreement on Closing the Gap requires government entities to build and sustain effective partnerships with Aboriginal and Torres Strait Islander people. Australian Government entities should work with First Nations partners to establish appropriate measures of success to provide a robust basis for assessing the health of partnerships and their contribution to improved outcomes. Reporting on partnership activities and outcomes provides accountability and transparency over entities' efforts to work in full and genuine partnership with Aboriginal and Torres Strait Islander people.
- Where it is difficult to attribute long-term outcomes to programs and services, entities should monitor other meaningful indicators of performance, such as reach, quality, efficiency, and the achievement of short-term outcomes. Internal and external performance measures should provide insight into program effectiveness to support accountability and continuous improvement. Monitoring and reporting activities should be regular and ongoing to ensure that meaningful data is available to inform decision-making at all stages in the program lifecycle.
- When government commits to the achievement of objectives and outcomes, entities are expected to provide the Parliament and the public with meaningful information about progress. The absence of published performance information weakens accountability and transparency over the achievement of government objectives and the use of public money.

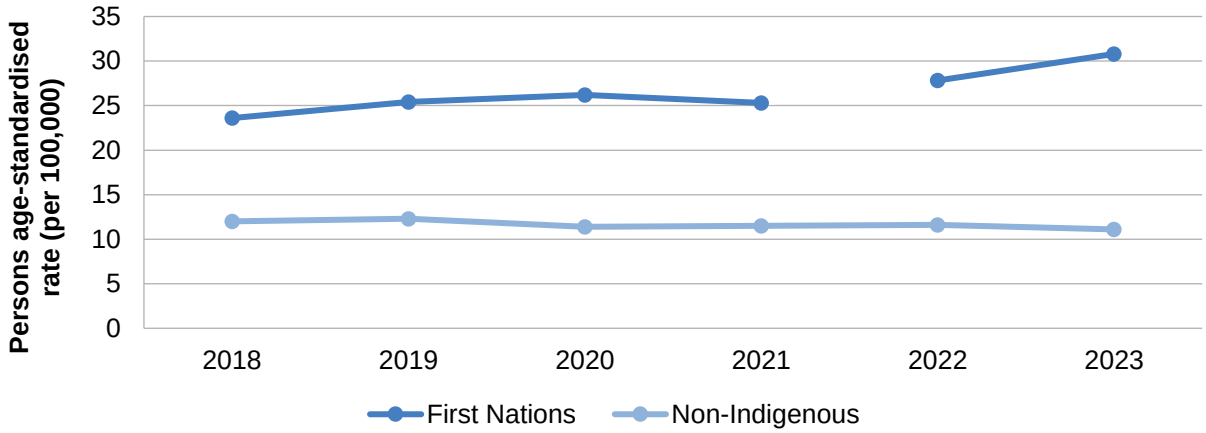
Audit findings

1. Background

Introduction

1.1 In 2024, there were 3,307 suicide deaths recorded in Australia (778 female and 2,529 male).[3] Suicide is the leading cause of death in Australians aged 15 to 44 years.[4] The suicide rate for Aboriginal and Torres Strait Islander people increased over the decade to 2021 and is more than twice that of the general population (Figure 1.1).[5] In 2023–24, there were approximately 24,074 hospitalisations for intentional self-harm.[6] An Australian Bureau of Statistics (ABS) study found that one in six Australians aged 16 to 85 years have experienced suicidal thoughts or behaviours in their life.[7]

Figure 1.1: Suicide deaths by year of registration of death, Indigenous status, Australia[a], 2018–2023



Note a: Data by Indigenous status is reported by usual residence for New South Wales (NSW), Northern Territory, Queensland, South Australia (SA), Victoria and Western Australia only. Preliminary data for 2021–2023. The Australian Institute of Health and Welfare (AIHW) advises caution when making comparisons of data from 2022 onwards with data from 2021 and earlier due to an improvement in methodology for deriving Indigenous status for deaths registered in NSW. This change resulted in an increase in the number of deaths identified as Aboriginal or Torres Strait Islander that was substantial enough to cause a break in the time series of suicide deaths among First Nations people.

Source: AIHW, *Suicide and intentional self-harm hospitalisations among First Nations people*.

3 Australian Bureau of Statistics, *Causes of Death, Australia,* ABS, Canberra, 14 November 2025, available from https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2024 [accessed 17 November 2025].
The ABS states the number of deaths classified as suicide is preliminary with an expectation that there will be an increase in some jurisdictions as more coronial information becomes available to the ABS.

4 ibid.

5 Australian Institute of Health and Welfare, *Suicide and intentional self-harm hospitalisations among First Nations people*, AIHW, Canberra, 8 August 2025, available from https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/first-nations-people [accessed 25 September 2025].

6 Australian Institute of Health and Welfare, *Intentional self-harm hospitalisations by states and territories*, AIHW, Canberra, 11 August 2025, available from https://www.aihw.gov.au/suicide-self-harm-monitoring/service-use/hospitalisations/hospitalisations-by-states-and-territories [accessed 11 November 2025].

7 Australian Bureau of Statistics, *National Study of Mental Health and Wellbeing 2020–2022*, ABS, Canberra, 5 October 2023, available from https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release#lived-experience-of-suicide [accessed 12 November 2025].

1.2 Suicide and self-harm accounted for 2.8 per cent of the total burden of disease in Australia in 2024 and was the sixth leading cause in 2024, compared to ninth in 2003.[8] In 2020, the Productivity Commission estimated the cost of diminished health and reduced life expectancy attributable to suicide was $29 billion annually.[9]

1.3 The National Suicide Prevention Strategy (see paragraph 2.4) states that drivers of suicidal distress are complex and interrelated. Drivers include social determinants (such as income, education, employment and housing); individual and contextual factors (such as stressful life events, trauma, abuse and discrimination); clinical factors (such as mental illness, drug and alcohol use, chronic physical illness); personality factors; genetic factors; and demographic factors (such as age, gender, sexual orientation, ethnicity, cultural heritage).[10]

Governance of suicide prevention policy

1.4 The Australian and state and territory governments have committed to address suicide through two national agreements.

- National Agreement on Closing the Gap (Closing the Gap Agreement) (July 2020) — The agreement includes socio-economic outcome 14: 'Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing'; and target 14: a 'significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero'.[11] Progress against the target is not on track and is worsening.[12] Under the Closing the Gap Agreement, governments committed to work in full and genuine partnership with Aboriginal and Torres Strait Islander people in policy development and to establish policy partnerships to support a 'joined up' approach with Aboriginal and Torres Strait Islander people in five priority areas, including 'social and emotional wellbeing (mental health)'.[13]

8 Burden of disease is measured using the summary metric of disability-adjusted life years (DALY, also known as the total burden). One DALY is one year of healthy life lost to disease and injury.
Australian Institute of Health and Welfare, *Australian Burden of Disease Study 2024*, AIHW, Canberra, available from https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024/contents/interactive-data-on-disease-burden/burden-of-disease-in-australia. [accessed 25 September 2025].

9 Productivity Commission, *Mental Health*, Inquiry Report, Productivity Commission, Canberra, June 2020, available from https://assets.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume2.pdf [accessed 11 November 2025].
This is additional to direct economic costs such as expenditure on healthcare and other services and lower economic participation.

10 National Suicide Prevention Office, *The National Suicide Prevention Strategy 2025–2035*, 2025, NSPO, January 2025, available from https://www.mentalhealthcommission.gov.au/national-suicide-prevention-strategy [accessed 24 September 2025].

11 Australian Government, *National Agreement on Closing the Gap*, Commonwealth of Australia, Canberra, July 2020, available from https://www.closingthegap.gov.au/national-agreement [accessed 24 September 2025].
There are 23 targets that measure progress against 17 socio-economic outcomes.

12 Productivity Commission, *Closing the Gap Information Repository – Socio-economic outcome area 14*, Productivity Commission, Canberra, available from https://www.pc.gov.au/closing-the-gap-data/dashboard/se/outcome-area14 [accessed 24 September 2025].

13 In October 2023, through the National Skills Agreement, the Australian Government committed to establishing a Vocational Education and Training Policy Partnership. In June 2025, a sixth policy partnership (the Data Policy Partnership) was established.

- National Mental Health and Suicide Prevention Agreement (National Agreement) (March 2022) — The agreement includes the objective to implement whole-of-government approaches to suicide prevention, including beyond the mental health system, to progress the goal of zero lives lost to suicide and to deliver a suicide prevention system that is comprehensive, coordinated, consumer focused and compassionate to benefit all Australians. Suicide prevention and response is one of nine priorities. Under the National Agreement, the Australian Government has a national leadership role in suicide prevention and is responsible for delivering whole-of-population suicide prevention activities in a nationally consistent way. Bilateral schedules between the Australian Government and each state and territory government set out specific commitments and funding contributions.[14]

1.5 The Department of Health, Disability and Ageing (DHDA) is responsible for administering the National Agreement, providing policy advice on suicide prevention, and administering specific suicide prevention measures. Within DHDA, suicide prevention is managed by the Mental Health and Suicide Prevention Division in the Primary and Community Care Group. Program 1.2 Mental Health and Suicide Prevention has the objective to 'Support the mental health and wellbeing of all Australians by facilitating access to high quality, affordable, culturally appropriate and timely mental health and suicide prevention services.'[15] As at December 2025, for 2025–26, the Mental Health and Suicide Prevention Division had an operating budget of $25.2 million, was responsible for an administered budget of $1.59 billion, and was allocated 156 full-time equivalent staff.

1.6 Other Australian Government entities have responsibilities in relation to suicide prevention, including the following.

- National Mental Health Commission and National Suicide Prevention Office — The National Mental Health Commission was established as an Executive agency in 2012. The National Suicide Prevention Office was established as a non-statutory office within the National Mental Health Commission in February 2022. The commission was responsible for monitoring, reporting, and providing policy advice on the mental health system; and producing annual national progress reports under the National Agreement. Following a review, the National Mental Health Commission's and National Suicide Prevention Office's functions, resources and appropriations transferred to DHDA on 30 September 2024, with both continuing to report directly to the Minister for Health and Ageing. In September 2024, DHDA released a consultation paper on future arrangements, which as at September 2025 had not been finalised.[16]
- Australian Institute of Health and Welfare (AIHW) — The AIHW, under a contract with DHDA, is responsible for administering the National Suicide and Self-harm Monitoring

14 Australian Government, *National Mental Health and Suicide Prevention Agreement*, Commonwealth of Australia, Canberra, March 2022, available from https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement [accessed 24 September 2025].

15 Department of Health, Disability and Ageing, *Corporate Plan 2025–26*, DHDA, Canberra, 27 August 2025, pp. 32–34, available from https://www.health.gov.au/resources/publications/corporate-plan-2025-26 [accessed 24 September 2025].

16 Department of Health, Disability and Ageing, *Discussion Paper — Strengthening the National Mental Health Commission and National Suicide Prevention Office*, DHDA, Canberra, available from https://consultations.health.gov.au/primary-care-mental-health-division/nmhc-nspo-reforms/ [accessed 24 September 2025].

System, which consists of a public website and a secure data portal to assist governments in policy and program development and evaluation.[17]

- Productivity Commission — The Productivity Commission is responsible for publishing the Closing the Gap Information Repository, which includes data on progress against outcome 14 and target 14.[18]
- Department of Defence (Defence), Department of the Prime Minister and Cabinet (PM&C) and Department of Veterans' Affairs — Defence and the Department of Veterans' Affairs are responsible for administering suicide prevention measures to support the Defence and veteran community. A PM&C taskforce was established in December 2024 to support implementation of the Australian Government response to the Royal Commission into Defence and Veteran Suicide.

1.7 Two other bodies were established under the National Agreement and Closing the Gap Agreement.

- Mental Health and Suicide Prevention Senior Officials Group — The Mental Health and Suicide Prevention Senior Officials Group was established in June 2022 to oversee and help implement the National Agreement.[19] It comprises senior officials from Australian health departments; lived experience members, including two Aboriginal and Torres Strait Islander representatives and one individual with a lived experience of suicide; and two Social and Emotional Wellbeing Policy Partnership representatives. The Deputy Secretary of the Primary and Community Care Group in DHDA chairs the group. The Mental Health and Suicide Prevention Senior Officials Group is delegated functions by, and reports to, the chief executive officers of health departments.
- Social and Emotional Wellbeing Policy Partnership (Policy Partnership) — The Policy Partnership was established under the Closing the Gap Agreement and met for the first time in March 2023.[20] The Deputy Secretary of the Primary and Community Care Group co-chairs with a representative of Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi).[21] The Policy Partnership comprises five Aboriginal and Torres Strait Islander members representing the Coalition of Peaks[22] (including a co-chair); five independent Aboriginal and Torres Strait Islander members; and nine representatives from Australian and state

17 Australian Institute of Health and Welfare, *Suicide & self-harm monitoring*, AIHW, Canberra, available from https://www.aihw.gov.au/suicide-self-harm-monitoring [accessed 24 September 2025].

18 Productivity Commission, *Closing the Gap Information Repository*, Productivity Commission, Canberra, available from https://www.pc.gov.au/closing-the-gap-data [accessed 24 September 2025].

19 Department of Health, Disability and Ageing, *Mental Health and Suicide Prevention Senior Officials Group (MHSPSO)*, DHDA, Canberra, 20 May 2025, available from https://www.health.gov.au/committees-and-groups/mental-health-and-suicide-prevention-senior-officials-group-mhspso [accessed 24 September 2025].

20 Department of Health, Disability and Ageing, *Social and Emotional Wellbeing Policy Partnership*, DHDA, Canberra, 7 July 2025, available from https://www.health.gov.au/committees-and-groups/social-and-emotional-wellbeing-policy-partnership [accessed 24 September 2025].

21 Gayaa Dhuwi (Proud Spirit) Australia was established in March 2020 as the national peak body for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide prevention. Available from https://www.gayaadhuwi.org.au.

22 The Coalition of Peaks represents over 80 Aboriginal and Torres Strait Islander community-controlled peak and member organisations. In March 2019, the Council of Australian Governments (now National Cabinet) and the Coalition of Peaks agreed the Partnership Agreement on Closing the Gap 2019–2029, which established a formal partnership relating to the Closing the Gap framework and targets. Available from https://www.coalitionofpeaks.org.au/.

and territory governments (including the DHDA co-chair). Non-voting members comprise an Aboriginal and Torres Strait Islander deputy co-chair and a representative from the National Indigenous Australians Agency. The primary function is to make recommendations about social and emotional wellbeing, mental health and suicide prevention to the Joint Council of Australian Governments and Aboriginal and Torres Strait Islander People on Closing the Gap (Joint Council).[23]

Australian Government funding for suicide prevention

1.8 Under the National Agreement, governments are required to maintain or increase their existing levels of investment in mental health and suicide prevention over the life of the agreement, against 2018–19 funding levels. The AIHW estimated that Australian Government expenditure on mental-health related services was $4.6 billion ($175 per capita) in 2022–23, compared with $4.1 billion ($163 per capita) in 2018–19.[24]

1.9 Of the total Australian Government contribution to initiatives under the National Agreement ($843.3 million from April 2022 to June 2026), $215.5 million (26 per cent) was for suicide prevention activities. From 2022–23 to 2025–26, DHDA administered 41 suicide prevention measures (including three under the National Agreement) with total Australian Government funding of over $990 million. These included programs and initiatives for service delivery, awareness raising, data and research, governance and workforce support.

Suicide prevention measures examined in this audit

1.10 From the total population of 41 measures administered by DHDA, the ANAO examined six (representing total grant funding for 2022–23 to 2025–26 of $559.8 million) (Table 1.1 and Table 1.2).[25]

23 Joint Council is responsible for ongoing administration and oversight of the Closing the Gap Agreement. It is co-chaired by the Minister for Indigenous Australians and the Lead Convenor of the Coalition of Peaks. Membership of Joint Council comprises one minister from each jurisdiction, one representative of the Australian Local Government Association and 12 representatives nominated by the Coalition of Peaks. Joint Council has equal representation from the Coalition of Peaks and governments. Available from https://www.closingthegap.gov.au/joint-council-closing-gap.

24 This estimate includes Medicare-subsidised mental health-specific services and mental health-related medications provided through the Pharmaceutical Benefits Scheme; national programs and initiatives, including those managed by DHDA; and mental health specific payments to states and territories. The AIHW states that there are other known Australian Government areas of spending attributable to supporting mental health issues not included in this estimate.

Australian Institute of Health and Welfare, *Expenditure on mental health services*, AIHW, Canberra, available from https://www.aihw.gov.au/mental-health/topic-areas/facilities-resources/expenditure [accessed 2 December 2025].)

25 Sample selection focused on measures funded between 2022–23 and 2025–26 with total funding greater than $10 million that involved service delivery or awareness raising directed at the whole of the Australian population or Aboriginal and Torres Strait Islander people, having consideration for previous audit coverage. One of the selected measures was specifically directed at Aboriginal and Torres Strait Islander people (Culture Care Connect) and one was focused on regional activity (Targeted Regional Initiatives for Suicide Prevention).

Table 1.1: Selected suicide prevention measures administered by the Department of Health, Disability and Ageing

Measure	Funding (2022–23 to 2025–26)[a] ($m)	Grantees	Funded under the National Agreement
Universal Aftercare	$185.4	Primary Health Networks[b]	Yes
Culture Care Connect (CCC)	$73.2	National Aboriginal Community Controlled Health Organisation (NACCHO)[c]	No
Distress Brief Support Trial (DBST)	$10.0	Primary Health Networks	Yes
National Suicide Prevention Leadership and Support Program (NSPLSP)	$180.1	31 individual service providers from 2022–23 to 2024–25; 28 providers in 2025–26	No
Postvention	$47.9	YouTurn Ltd (YouTurn)	Yes
Targeted Regional Initiatives for Suicide Prevention (TRISP)	$63.2[d]	Primary Health Networks	No

Note a: Funding for Universal Aftercare and Postvention is exclusive of indexation and Community Service Organisation supplementation payments (where applicable). Funding for CCC, DBST, NSPLSP and TRISP is inclusive of indexation and Community Service Organisation supplementation payments (where applicable).

Note b: Primary Health Networks (PHNs) are non-government organisations funded through Australian Government grants to coordinate and commission primary health care services. There are 31 PHNs across all states and territories. DHDA is responsible for administering PHN grant agreements, including monitoring compliance and the performance of PHNs, and supporting PHNs to improve.

Note c: NACCHO is the national peak body representing Aboriginal Community Controlled Health Organisations.

Note d: Funding for TRISP was provided from 2022–23 to 2024–25. Due to delays in delivering funding in 2024–25, PHNs were approved to use unspent 2024–25 funds in 2025–26.

Source: ANAO analysis of DHDA documentation.

Table 1.2: Description of selected suicide prevention measures

Measure	Description
Universal Aftercare 'Aftercare' refers to support services to individuals following a suicide attempt or crisis	Universal Aftercare aims to deliver services to all Australians discharged from hospital after a suicide attempt or suicidal crisis. The program includes a pilot to extend referral pathways to aftercare services to people who have attempted suicide or experienced suicidal crisis without presenting at a hospital. PHNs commission service providers to deliver aftercare services in all states and territories, except in Victoria where area-based mental health services commission non-government organisations to deliver aftercare services or deliver aftercare services directly.
Culture Care Connect (CCC)	CCC is a national, community-led suicide prevention and aftercare program for Aboriginal and Torres Strait Islander people. It aims to reduce suicide rates and self-harm; provide culturally safe, trauma-aware, and healing-informed support; and empower communities to design and lead their own suicide prevention strategies. NACCHO developed the CCC model, which includes community-controlled suicide prevention networks; aftercare; and suicide prevention training.

Measure	Description
Distress Brief Support Trial (DBST)	DBST is a community-based initiative being piloted in NSW, Queensland, SA and Victoria. Objectives are to provide early, compassionate, and non-clinical support to people experiencing distress who do not require emergency care.
National Suicide Prevention Leadership and Support Program (NSPLSP)	NSPLSP aims to deliver suicide prevention programs; facilitate leadership and strategic partnerships; build the evidence base; reduce stigma and raise awareness; support people with lived experience; and improve care and support for high-risk communities. NSPLSP funded 40 projects from 2022–23 to 2024–25 and 36 projects in 2025–26 across seven activity streams across the Australian population and in at-risk populations.
Postvention 'Postvention' refers to activities or interventions occurring after a suicide death to support those bereaved or affected	The Australian Government funds postvention via the Standby Support After Suicide (StandBy) program, which is a national program operated by YouTurn. StandBy is accessible seven days a week and provides face-to-face or telephone support, resources, and connections to local services and groups to anyone bereaved or impacted by suicide. StandBy services are provided in all states and territories. Enhancements or adaptions to the program are developed and agreed between the Australian Government, the co-funding state or territory government, and Youturn.
Targeted Regional Initiatives for Suicide Prevention (TRISP)	TRISP aims to reduce suicide rates through region-specific, community-led, and evidence-based interventions. TRISP provides funding to establish a suicide-prevention coordinator role in each of the 31 PHNs and for PHNs to commission suicide prevention activities to address gaps in local suicide prevention systems.

Source: ANAO analysis of DHDA documentation.

Related reviews and inquiries

1.11 Suicide prevention policies and programs at a national level have been informed by the findings and recommendations made in two reports delivered between 2020 and 2025.

- In June 2020, the Productivity Commission completed a 'whole-of-system and whole-of-life inquiry' into mental health.[26] The inquiry report made 21 recommendations (including one specifically about suicide prevention, three related to suicide prevention, and one that mentioned suicide prevention), which included the development of an intergovernmental mental health and suicide prevention agreement.
- In July 2019, the Prime Minister appointed a National Suicide Prevention Adviser (NSPA)[27], which was supported by a taskforce in DHDA. In December 2020, the NSPA published

26 Productivity Commission, *Mental Health*, Inquiry Report, June 2020, Productivity Commission, Canberra, 30 June 2020, available from https://www.pc.gov.au/inquiries-and-research/mental-health/report/ [accessed 25 September 2025].

27 Prime Minister, 'Making suicide prevention a national priority', media release, 8 July 2019, available from https://pmtranscripts.pmc.gov.au/release/transcript-42324 [accessed 25 September 2025].

four reports with final advice, which made eight recommendations and included 27 priority actions.[28]

1.12 The Australian Government responded to the recommendations made in both reports in the National Mental Health and Suicide Prevention Plan, which was released in May 2021 in conjunction with the 2021–22 Federal Budget.[29] Of the 29 recommendations, the Australian Government agreed in full to three, agreed in part to 16, and agreed in principle to 10. The Australian Government's response included the commitment to establish the National Suicide Prevention Office. The plan allocated $2.0 billion for mental health and suicide prevention initiatives. The National Agreement 'recognises' the recommendations from both reports and included a commitment to address areas identified for immediate reform in both reports and other relevant inquiries.

1.13 As required under the National Agreement, in January 2025 the Productivity Commission commenced a final review of the objectives, outcomes and outputs of the National Agreement. A June 2025 interim report stated that the National Agreement was not fit for purpose and did not advance system reform, and that, while most outputs specified in the agreement had been delivered, outcomes had not improved.[30] A final report was provided to the parties to the agreement in October 2025 and published in November 2025. The final report stated that in the three years since the National Agreement was signed, little had improved for the people who access mental health and suicide prevention services, and their supporters, family, carers and kin. The final report made 24 recommendations, including that the National Agreement be extended until June 2027 to give sufficient time to develop the foundations of a new agreement, which should include separate schedules on suicide prevention and Aboriginal and Torres Strait Islander social and emotional wellbeing.[31]

28 Australian Government, *National Suicide Prevention Adviser Final Advice*, Commonwealth of Australia, Canberra, Executive Summary, December 2020, available from https://www.mentalhealthcommission.gov.au/nspo/projects/national-suicide-prevention-adviser-final-advice [accessed 25 September 2025].

29 Australian Government, *National Mental Health and Suicide Prevention Plan*, Commonwealth of Australia, Canberra, May 2021, available from https://www.health.gov.au/resources/publications/the-australian-governments-national-mental-health-and-suicide-prevention-plan [accessed 11 September 2025].

30 Productivity Commission, *Mental Health and Suicide Prevention Agreement Review, Interim Report*, Productivity Commission, Canberra, June 2025, available from https://www.pc.gov.au/inquiries/current/mental-health-review/interim [accessed 24 September 2025].

31 Productivity Commission, *Mental Health and Suicide Prevention Agreement Review, Inquiry Report*, Productivity Commission, Canberra, 16 October 2025, available from https://www.pc.gov.au/inquiries-and-research/mental-health-review/report/ [accessed 12 November 2025].

In November 2025, the Minister for Health and Ageing stated that he would bring the report to the next Health Ministers' Meeting in December 2025 and the next joint Health and Mental Health Ministers' Meeting to begin discussions on future arrangements.

Minister for Health and Ageing, 'Review of National Mental Health and Suicide Prevention Agreement released', media release, 12 November 2025, available from https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/review-of-national-mental-health-and-suicide-prevention-agreement-released [accessed 28 November 2025].

Rationale for undertaking the audit

1.14 In 2024, there were more than 3,300 deaths by suicide in Australia. Suicide is the leading cause of death for Australians aged 15 to 44 years. The suicide rate for Aboriginal and Torres Strait Islander people is more than double the rate for non-Indigenous Australians and is increasing.

1.15 Reducing suicide deaths is a public health priority for all Australian governments. Under the National Agreement, the Australian Government has a national leadership role in suicide prevention. The Closing the Gap Agreement includes a target of a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero. From 2022–23 to 2025–26, Australian Government expenditure on suicide prevention measures was approximately $1 billion.

1.16 This audit provides assurance to the Australian Parliament that Australian Government suicide prevention measures have been informed by robust policy advice and are effectively monitored and evaluated.

Audit approach

Audit objective, criteria and scope

1.17 The audit objective was to assess whether DHDA effectively developed and monitored suicide prevention measures.

1.18 To form a conclusion against the objective, the following high-level criteria were adopted.

- Has DHDA provided robust policy advice on suicide prevention measures?
- Has DHDA effectively monitored and evaluated suicide prevention measures?

1.19 The audit scope did not include DHDA's administration of the National Agreement or suicide prevention measures administered by Australian Government entities other than DHDA.

Audit methodology

1.20 The audit involved:

- analysis of DHDA records;
- meetings with DHDA officials;
- meetings with the National Mental Health Commission, National Suicide Prevention Office, Productivity Commission, 13 government and Aboriginal and Torres Strait Islander members of the Social and Emotional Wellbeing Policy Partnership, and other stakeholders;
- observing meetings of Mental Health and Suicide Prevention Senior Officials Group in November 2025 and the Social and Emotional Wellbeing Policy Partnership in December 2025; and
- reviewing 11 written contributions received from peak bodies, service providers, PHNs and individuals.

1.21 Australian Government entities largely give the ANAO electronic access to records by consent, in a form useful for audit purposes. For the purposes of this audit, DHDA advised the ANAO that it would not voluntarily provide certain information requested by the ANAO due to concerns about its obligations under the *Privacy Act 1988* and the *Public Interest Disclosure Act 2013* as well as the secrecy provisions in Health and Aged Care portfolio legislation. DHDA advised that this type of information largely was not segregated in the department's records management systems and it could not be certain, in providing documents through electronic means, that documents containing this type of information were excluded. On 6 May 2025, the Auditor-General issued the Secretary of DHDA with a notice directing the Secretary to provide information and produce documents pursuant to section 32 of the *Auditor-General Act 1997.*

1.22 The audit was conducted in accordance with ANAO Auditing Standards at a cost to the ANAO of approximately $563,000.

1.23 The team members for this audit were Dr Ashley Stephens, Jillian Ghosh, Katiloka Ata, Magdalena Carrasco, Lorcan Stevens, Callum Mann and Christine Chalmers.

2. Policy advice

Areas examined

This chapter examines whether the Department of Health, Disability and Ageing (DHDA) has provided robust policy advice on suicide prevention measures.

Conclusion

Policy advice on two national suicide prevention strategies and six suicide prevention measures was not fully robust. Advice lacked consideration of program logics, implementation, stakeholder input, evaluation findings, and performance measurement and monitoring. Policy advice included consideration of how the proposed measures would be evaluated. Australian Government commitments to develop policy in partnership with Aboriginal and Torres Strait Islander people were partly met. A lack of clear roles and responsibilities impacted on policy development effectiveness, including the way in which the policy was developed in partnership with First Nations peoples.

Areas for improvement

The ANAO made four recommendations for DHDA to clarify roles and responsibilities between itself and the National Suicide Prevention Office; develop implementation plans for national suicide prevention strategies; ensure policy advice to government is evidence-based; and strengthen partnership processes with Aboriginal and Torres Strait Islander people. The ANAO identified opportunities for DHDA to establish clear processes when developing policies with third parties; improve and publish program logics; and include more consideration of implementation in policy advice.

2.1 The function of policy advice is to provide decision-makers with the information they need to make the best possible decisions. Among other better practice elements, the Australian Public Service Commission's (APSC's) *Delivering Great Policy* guidance states that entities should clearly define the objectives of a proposed policy; be informed by evidence, including stakeholder feedback and lessons from experience; and provide options, including identifying the key risks and benefits.[32] The guidance states that influential policy advice involves engaging with those with influence early in the policy process. Other Australian Government guidance states that governments and partners should agree on ways of working to progress shared goals.[33]

2.2 The National Mental Health and Suicide Prevention Agreement (National Agreement) includes a commitment for governments to work in partnership with Aboriginal and Torres Strait Islander peoples in alignment with commitments under the National Agreement on Closing the Gap

32 Australian Public Service Academy, *Delivering Great Policy*, APSA, Canberra, 20 December 2024, available from https://www.apsacademy.gov.au/aps-craft/strategy-policy-evaluation/delivering-great-policy [accessed 11 September 2025].

33 Australian Government, *APS framework for engagement and participation*, Commonwealth of Australia, Canberra, August 2021, available from https://www.industry.gov.au/publications/aps-framework-engagement-and-participation [accessed 10 October 2025].

Australian Government, *The Charter of Partnerships and Engagement*, Commonwealth of Australia, Canberra, November 2023, available from https://www.apsreform.gov.au/news/charter-partnerships-and-engagement [accessed 10 October 2025].

(Closing the Gap Agreement).[34] One of the outcomes of the Closing the Gap Agreement is that Aboriginal and Torres Strait Islander people are empowered to share decision-making authority with governments through formal partnership arrangements, which will exhibit 'strong partnership elements' outlined in clauses 32 and 33.[35]

2.3 In 2025, DHDA developed guidance on working in partnership with Aboriginal and Torres Strait Islander people and developing policy advice. In April 2025, DHDA published the *Aboriginal and Torres Strait Islander Partnership and Engagement Framework*. The framework states 'partnership goes beyond policy commitment, it is about recognising and embedding self-determination, decision making and leadership throughout all stages of the policy lifecycle.'[36] In June 2025, DHDA published a 'Policy Playbook' to support DHDA staff working on policy development.[37]

Has policy advice supported development of key national strategies?

In 2019 and 2021, the Australian Government committed to developing two national strategies for suicide prevention: the National Suicide Prevention Strategy and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. The National Suicide Prevention Office and Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi), respectively, were responsible for developing the strategies. DHDA did not establish clear roles for all parties in the development and approval of the strategies, which impacted DHDA's ability to effectively advise government and contributed to delays in the strategies being finalised. DHDA's advice to government on the development of the strategies was not always complete. DHDA's guidance and instructions to the National Suicide Prevention Office were not fully aligned with its advice to government, and its guidance and instructions to Gayaa Dhuwi were unclear or inconsistent with a commitment to work in partnership. The strategies were initially intended to be finalised in 2021 and 2023 but were released in 2024 and 2025 respectively. As at September 2025, there was no implementation plan and DHDA had not provided advice to government on implementation of either strategy.

2.4 Between 2019 and 2021, the Australian Government committed to developing two national strategies for suicide prevention.

- National Suicide Prevention Strategy — In May 2021, the Australian Government committed to establish the National Suicide Prevention Office with a key function to develop the National Suicide Prevention Strategy (see paragraph 1.6). In March 2022, the

34 Australian Government, *National Mental Health and Suicide Prevention Agreement*, Commonwealth of Australia, Canberra, March 2022, clause 110, available from https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement [accessed 11 September 2025].

35 Australian Government, *National Agreement on Closing the Gap*, Commonwealth of Australia, Canberra, July 2020, available from https://www.closingthegap.gov.au/national-agreement [accessed 12 September 2025].

36 Department of Health, Disability and Ageing, *Aboriginal and Torres Strait Islander Partnership and Engagement Framework*, DHDA, Canberra, April 2025, p. 2, available from https://www.health.gov.au/resources/publications/aboriginal-and-torres-strait-islander-partnership-and-engagement-framework [accessed 22 September 2025].

37 The Policy Playbook was released after advice to government on the six suicide prevention measures examined in this audit and was not used as a basis for the assessment of the advice.

Minister for Health and Ageing (minister) wrote to the Prime Minister stating that the National Suicide Prevention Strategy would be a 'whole of government' strategy. In addition to its responsibility for developing the National Suicide Prevention Strategy, the National Suicide Prevention Office provided advice directly to the minister.

- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (Indigenous Suicide Prevention Strategy) — In September 2019, the Australian Government committed to fund Gayaa Dhuwi to deliver a national plan for culturally appropriate care. In May 2021, the Australian Government committed to renew the May 2013 Indigenous Suicide Prevention Strategy in response to recommendations of the Productivity Commission and National Suicide Prevention Adviser (see paragraph 1.12). The 2021–22 Federal Budget allocated $79 million for initiatives under the renewed Indigenous Suicide Prevention Strategy. Under a grant agreement with DHDA, Gayaa Dhuwi was responsible for developing the strategy (see paragraph 2.17).

2.5 While the National Suicide Prevention Office and Gayaa Dhuwi were responsible for developing the respective strategies, DHDA had primary responsibility for providing advice to government on suicide prevention policy. DHDA was also responsible for supporting the Australian Government's commitment to develop the Indigenous Suicide Prevention Strategy in partnership with Aboriginal and Torres Strait Islander people (see paragraph 2.15). DHDA provided advice to the Australian Government on the development and approval of the National Suicide Prevention Strategy and Indigenous Suicide Prevention Strategy between 2019 and 2025. Key milestones in the development of the National Suicide Prevention Strategy and Indigenous Suicide Prevention Strategy are shown in Appendix 3.

National Suicide Prevention Strategy

Policy advice and development

2.6 The National Mental Health Commission and National Suicide Prevention Office are separate non-statutory offices within DHDA (see paragraph 1.6). Both report directly to the minister and Assistant Minister for Mental Health and Suicide Prevention. Advice to government prior to the establishment of the National Suicide Prevention Office outlined its proposed role and functions. A September 2024 consultation paper on arrangements for the National Mental Health Commission and National Suicide Prevention Office (see paragraph 1.6) stated that the National Suicide Prevention Office providing policy advice separate to DHDA 'risks causing confusion and misalignment in national suicide prevention policy'.[38] DHDA and the National Suicide Prevention Office do not have a finalised agreement setting out respective roles and responsibilities for developing suicide prevention policy. In September 2025, DHDA drafted an 'initial version of the split of responsibilities'.

2.7 In October 2022, the National Suicide Prevention Office released a scoping paper to seek stakeholders' views on a proposed process for developing the National Suicide Prevention Strategy. The paper stated that the strategy would identify priority actions to enable an effective cross-portfolio response to suicide prevention and included an 'aspirational' timeline, with

38 Department of Health, Disability and Ageing, *Discussion Paper — Strengthening the National Mental Health Commission and National Suicide Prevention Office*, DHDA, Canberra, available from https://consultations.health.gov.au/primary-care-mental-health-division/nmhc-nspo-reforms/ [accessed 24 September 2025].

consultation to be undertaken in June 2023 and the strategy to be finalised in September 2023. In September 2023, the National Suicide Prevention Office stated it was developing the strategy and did not provide an updated timeframe.[39]

2.8 Between March and December 2023, DHDA provided feedback to the National Suicide Prevention Office on the draft strategy, including processes for seeking government approval to release the draft strategy for public consultation. In December 2023, DHDA told the National Suicide Prevention Office that it supported consultation with jurisdictions and then the public. On 4 April 2024, the National Suicide Prevention Office requested that the minister endorse the draft strategy and write to the Prime Minister about public consultation, stating the draft strategy had been endorsed by all relevant Australian Government entities and state and territory governments, who supported its release. In response to a request from the minister for advice, on 17 April 2024 DHDA advised the minister that the draft strategy was not suitable for public consultation, citing concerns about practicality of implementation, readability and reputational risk to government if expectations were raised about government investment. DHDA presented three options: reframe the draft strategy as 'draft advice' from the National Suicide Prevention Office with some amendments (preferred); transition responsibility for the strategy to a non-government entity as a 'sector-led' strategy[40]; or do not progress the strategy. In relation to the first option, DHDA stated that, once the strategy was finalised, the minister could transition 'ongoing policy development and response' to DHDA. The minister agreed to the first of the three options in May 2024. In July 2024, the National Suicide Prevention Office provided a revised draft strategy to the minister and in September 2024, following Prime Ministerial approval, released 'draft advice' for public consultation from 10 September to 27 October 2025.[41]. In December 2024 and January 2025, release of the National Suicide Prevention Strategy was endorsed by all Health Chief Executives Forum[42] members and seven Australian Government ministers with portfolio responsibilities. The strategy was released as a Commonwealth strategy in February 2025.[43]

Implementation

2.9 The purpose of the National Suicide Prevention Strategy is to 'guide long-term, coordinated suicide prevention activity in Australia' through prevention and support. The National Suicide Prevention Strategy states that the National Suicide Prevention Office will monitor implementation and impact and develop an outcomes framework, which the office is aiming to finalise by

39 National Suicide Prevention Office, 'A National Suicide Prevention Strategy to create hope through action', media release, 10 September 2023, available from https://www.mentalhealthcommission.gov.au/nspo/news-media/news/national-suicide-prevention-strategy-create-hope-through-action [accessed 28 November 2025].

40 DHDA stated an example of a sector-led strategy was the Indigenous Suicide Prevention Strategy.

41 National Suicide Prevention Office, 'Media Release: The draft Advice on the National Suicide Prevention Strategy is now open for public consultation', media release, 10 September 2024, available from https://www.mentalhealthcommission.gov.au/nspo/news-media/news/media-release-draft-advice-national-suicide-prevention-strategy-now-open-public-consultation [accessed 4 September 2025].

42 Health Chief Executives Forum comprises the chief executive officers of the Australian government health departments.

Department of Health, Disability and Ageing, *Health Chief Executives Forum (HCEF)*, DHDA, Canberra, available from https://www.health.gov.au/committees-and-groups/health-chief-executives-forum-hcef [accessed 24 September 2025].)

43 National Suicide Prevention Office, *The National Suicide Prevention Strategy 2025–2035*, NSPO, January 2025, available from https://www.mentalhealthcommission.gov.au/national-suicide-prevention-strategy [accessed 24 September 2025].

mid-2026.[44] The National Suicide Prevention Strategy includes 106 recommended actions and states that the first of two five-year implementation phases commenced in 2025.

2.10 A December 2024 Health Chief Executives Forum paper (see paragraph 2.8) stated that, following the release of the National Suicide Prevention Strategy, the Australian Government would engage with states and territories about implementation, including through the Mental Health and Suicide Prevention Senior Officials Group (Senior Officials Group). As at September 2025, DHDA had not sought to discuss implementation through the Senior Officials Group.

2.11 Under the National Agreement, all governments committed to pursuing 'whole-of-government approaches to mental health and suicide prevention', including in specific priority areas (such as homelessness, alcohol and other drugs, and family, domestic and sexual violence), which would be implemented through a working group for the life of the agreement. Health and mental health ministers would have collective responsibility.[45] A working group was established by the Department of the Prime Minister and Cabinet (PM&C) in August 2022 to 'drive collective action … beyond the health system', comprising representatives from the Australian and state and territory governments, including a PM&C official as co-chair and DHDA officials as observers, and three lived experience representatives. As at September 2025, the working group last met in March 2024. A theme in written contributions to this audit (see paragraph 1.20) was inadequate progress in suicide prevention policy beyond the health system to address drivers of suicidality.

2.12 In April 2024, DHDA and PM&C discussed implementation responsibilities, including that the National Suicide Prevention Office's intention to develop an implementation plan would overlap with DHDA's responsibilities and cause delay in releasing the strategy. As at September 2025, there was no implementation plan and DHDA had not provided advice to government on implementation. DHDA advised the ANAO in November 2025 that government had not requested that DHDA develop an implementation plan.

44 National Suicide Prevention Office, *Development of the National Suicide Prevention Outcomes Framework,* NSPO, September 2024, available from https://www.mentalhealthcommission.gov.au/sites/default/files/2024-09/development-of-the-national-suicide-prevention-outcomes-framework.pdf [accessed 10 November 2025].

45 Australian Government, *National Mental Health and Suicide Prevention Agreement*, Commonwealth of Australia, Canberra, March 2022, Schedule A, clauses 1, 10 and 11, available from https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement [accessed 11 September 2025].

Recommendation no. 1

2.13 The Department of Health, Disability and Ageing finalise an agreement with the National Suicide Prevention Office to ensure there are clear roles and responsibilities, including in relation to developing and providing advice to government on suicide prevention policy.

Department of Health, Disability and Ageing response: *Agreed*

2.14 *The Department of Health, Disability and Ageing (the department) notes that interim arrangements for the National Suicide Prevention Office (NSPO), locating the NSPO within the department, are currently in place. In the immediate term, the department and the NSPO will agree on and document roles and responsibilities in relation to suicide prevention policy advice to government within the existing operating arrangements. Once future arrangements for the NSPO have been determined by government and put into effect, the department will establish mechanism(s) to provide continued clarity on roles and responsibilities in relation to suicide prevention policy advice to government.*

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

Policy advice and development

2.15 In August 2021, in the 2022 implementation plan under the National Agreement on Closing the Gap Closing (Closing the Gap Agreement), the Australian Government committed to developing the Indigenous Suicide Prevention Strategy and its implementation plan in partnership with Aboriginal and Torres Strait Islander people, noting that:

> partnerships and engagement with Aboriginal and Torres Strait Islander leaders, Elders and communities is a common success factor in community-based interventions or responses to Aboriginal and Torres Strait Islander suicide.[46]

2.16 The commitment was restated in the 2024 Closing the Gap implementation plan.[47]

2.17 The Australian Government began funding Gayaa Dhuwi in March 2020, with funding partly provided through a grant agreement with DHDA that ended in 2022.[48] Gayaa Dhuwi was required to 'lead the co-design and implementation of a strengths-based indigenous Suicide Prevention Strategy and Implementation Plan'. Gayaa Dhuwi committed to deliver the strategy by late 2020. A new grant agreement with DHDA was executed in June 2022, with an initial end date of November 2024.[49] An activity work plan submitted by Gayaa Dhuwi in January 2023 specified a completion date of June 2023 for the implementation plan. By June 2023, the Indigenous Suicide Prevention Strategy had not been finalised and an implementation plan was not delivered.

46 Australian Government, *Closing the Gap Implementation Plan 2022*, Commonwealth of Australia, Canberra, 5 August 2021, available from https://www.niaa.gov.au/resource-centre/closing-gap-implementation-plan-2022 [accessed 28 July 2025].

47 Australian Government, *Commonwealth Closing the Gap 2023 Annual Report and 2024 Implementation Plan*, Commonwealth of Australia, Canberra, 13 February 2024, available from https://www.niaa.gov.au/resource-centre/commonwealth-closing-gap-2023-annual-report-and-2024-implementation-plan.

48 GrantConnect number GA72764, total value $4,950,000 (GST included).

49 The grant was subsequently varied three times. As at September 2025, the end date is June 2026. GrantConnect number GA255351-V3, total value $8,812,343 (GST included).

2.18 In October 2020, Gayaa Dhuwi established an expert committee to oversee the development of the Indigenous Suicide Prevention Strategy, and led public consultation processes in late 2020 and early 2021. DHDA did not play a substantive role and did not establish an agreed approach or process for government approval of the Indigenous Suicide Prevention Strategy. In June 2021, a DHDA official testified at a Senate Estimates hearing that the Indigenous Suicide Prevention Strategy was 'very much in the final stages of consultation' and was expected to be released in the middle of 2021.[50] Gayaa Dhuwi received an Australian Government grant to support stakeholders to attend a launch event, which Gayaa Dhuwi anticipated would occur in August 2021.[51]

2.19 Between 2021 and 2024, Gayaa Dhuwi sought advice from DHDA about the process for finalising the Indigenous Suicide Prevention Strategy. In response, DHDA either did not provide advice, provided inconsistent advice or provided advice that was not aligned with the commitment to work in partnership.

- 2021 — In August 2021, Gayaa Dhuwi developed a final draft Indigenous Suicide Prevention Strategy, intending to release it in September 2021. DHDA told Gayaa Dhuwi that, as this was insufficient time to seek ministerial agreement, it would work with Gayaa Dhuwi to publicly release the strategy in October 2021. In late October 2021, DHDA advised Gayaa Dhuwi that the minister had not agreed to the draft strategy. Gayaa Dhuwi requested clarification about finalisation processes and a new timeframe, which DHDA did not provide.
- 2022 — In February 2022, DHDA provided feedback to Gayaa Dhuwi on the draft strategy including a request for it to change 'some of the language in a way that presents the strategy as a collaborative effort by government and [Gayaa Dhuwi] … '. In May 2022, Gayaa Dhuwi asked for clarification about finalisation, which DHDA did not provide.
- 2023 — In May 2023, a steering committee chaired by Gayaa Dhuwi and including DHDA and the National Aboriginal Community Controlled Health Organisation (NACCHO) was established and a DHDA timeline included seeking ministerial endorsement of the strategy in 'late September/early October' 2023. In September 2023, DHDA told Gayaa Dhuwi that because the strategy was 'sector-led' it did not need government approval. In October 2023, the Gayaa Dhuwi chair wrote to the minister that DHDA had provided it with 'conflicting advice resulting in a halt of proceedings'. A DHDA ministerial brief for a November 2023 meeting stated that DHDA had advised Gayaa Dhuwi that there was no formal process for government approval and did not refer to the government's commitment to develop a strategy in partnership.
- 2024 — In April 2024, Gayaa Dhuwi agreed with the minister that the strategy would be described as 'co-designed' with government rather than 'sector-led'. In June 2024, DHDA told Gayaa Dhuwi that it viewed the strategy as 'sector-led' and that Gayaa Dhuwi could (with DHDA's assistance) seek endorsement by the minister and various government bodies to get 'buy-in'.[52] In November 2024, DHDA advised the minister that delays to the

50 Senate Community Affairs Legislation Committee, Committee Hansard, 1 June 2021.

51 Grant Connect number GA184747, total value $55,000 (GST included).

52 These were: the Mental Health and Suicide Prevention Senior Officials Group, the Health Chief Executives Forum, and the Health Ministers' Meeting. The Health Ministers' Meeting comprises Australian and state/territory government ministers responsible for health portfolios.

development of the strategy were due to the need to 'socialise' the documents with jurisdictions and stakeholders and achieve consensus; and delivery partners having limited understanding of government processes.

- The Indigenous Suicide Prevention Strategy was released in December 2024.[53] DHDA's website stated that the strategy was developed in partnership with Gayaa Dhuwi.

2.20 On DHDA's advice, the minister wrote to the Prime Minister recommending health ministers' endorsement be sought prior to a public launch. At the time the strategy was published, ministers from three jurisdictions had not endorsed it.[54] DHDA did not advise the minister that the strategy was published without full endorsement.

Implementation

2.21 The Indigenous Suicide Prevention Strategy states that an implementation plan should outline actions to achieve the strategy's priorities and initiatives and that an advisory group would facilitate and oversee implementation, monitoring and evaluation.

2.22 The March 2020 grant agreement with Gayaa Dhuwi included co-design and delivery of an Indigenous Suicide Prevention Strategy implementation plan. In November 2023, DHDA advised the minister that it would work with Gayaa Dhuwi to identify priority areas for implementation once the Indigenous Suicide Prevention Strategy was finalised. In November 2024, DHDA advised the minister that it would be involved in the co-design of an implementation plan with Gayaa Dhuwi. In December 2024, the Australian Government announced[55] $1.9 million in funding to develop implementation plans for the Indigenous Suicide Prevention Strategy and in February 2025 that an implementation plan would be finalised by June 2025.

2.23 As at September 2025, there was no implementation plan and an advisory group had not been established. A status update provided by DHDA to government in July 2025 noted an implementation plan was expected to be delivered in mid-2026. In the absence of a plan, no specific actions have been taken to implement the Indigenous Suicide Prevention Strategy.

53 Minister for Health and Ageing, 'A better way: suicide prevention in First Nations communities', media release, 13 December 2024, available from www.health.gov.au/ministers/the-hon-mark-butler-mp/media/a-better-way-suicide-prevention-in-first-nations-communities [accessed 23 September 2025].
Department of Health, Disability and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, DHDA, 2025, available from www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-suicide-prevention-strategy [accessed 8 September 2025].

54 The initial deadline for ministerial approval was 20 December 2024. On 5 December 2024, at DHDA's request, the Health Chief Executives Forum agreed to change to deadline to 12 December 2024. On 12 December 2024, ministers were advised that nil responses would be 'taken as noted'. The strategy was published on 13 December 2024. Ministers from the Northern Territory and Queensland endorsed the strategy on 16 December and 18 December 2024 respectively. The minister from Victoria did not endorse the strategy.

55 Minister for Health and Ageing, 'A better way: suicide prevention in First Nations communities', media release, 13 December 2024, available from www.health.gov.au/ministers/the-hon-mark-butler-mp/media/a-better-way-suicide-prevention-in-first-nations-communities [accessed 23 September 2025].

Opportunity for improvement

2.24 When developing suicide prevention policies, strategies or plans in partnership with third parties, or when supporting development by third parties, DHDA could: agree at the outset and follow an appropriate engagement approach (including specifying roles and responsibilities, timeframes and processes for government approval); and regularly brief government on progress against agreed timeframes.

Recommendation no. 2

2.25 The Department of Health, Disability and Ageing:

(a) develop a plan to support the department's contribution to implementation of the National Suicide Prevention Strategy that includes documenting responsibilities and timeframes for the 106 actions outlined in the Strategy;

(b) work with Gayaa Dhuwi to develop an implementation plan for the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy; and

(c) provide advice to support government decision-making where decisions of government are required to finalise or publish either plan.

Department of Health, Disability and Ageing response: *Agreed in principle*

2.26 *The National Suicide Prevention Strategy comprises 106 actions that vary significantly in scope and complexity, and many sit outside the direct policy responsibilities of the department. In addition, agreement and publication of both plans would be subject to government decision as noted in 2(c). This would include ensuring agreement to the approach to consultation and agreement with the entities outside of the Health portfolio.*

2.27 *To support the intent of this recommendation, the Department of Health, Disability and Ageing (the department) will work with the National Suicide Prevention Office to develop an initial implementation approach, including timeframes, for the actions in the National Suicide Prevention Strategy that are the primary responsibility of the department. The department will provide advice to government on this approach. The department will also provide advice to government on options for broader implementation of the National Suicide Prevention Strategy, including a cross-portfolio and cross-jurisdictional process to agree responsibilities and timeframes for implementation of the remaining actions.*

2.28 *For the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, the department will continue to support the work of Gayaa Dhuwi (Proud Spirit) Australia on the co-design of an implementation plan. This work is already well under way, with an anticipated delivery date of 30 June 2026. The department will provide advice to government to support the finalisation of this plan.*

Has policy advice been fit for purpose?

Policy advice on the establishment or expansion of six suicide prevention measures between April 2021 and March 2022 was aligned with government objectives. Advice did not present stakeholder feedback and largely did not present relevant evaluation evidence, options or specific benefits. Regulatory impact statements were completed for each measure and regulatory costs were estimated for five of six measures. Legal and reputational risks were identified, however proposed mitigations were incomplete. Implementation risks were identified for two of six measures. Between April and October 2024, DHDA advised government on possible extension of four of the suicide prevention measures. Despite having access to evaluation evidence for three of the four measures, the advice to extend provided limited evidence from evaluations.

2.29 The ANAO examined policy advice for six suicide prevention measures administered by DHDA (see Table 1.1): Universal Aftercare (Aftercare); Culture Care Connect (CCC); Distress Brief Support Trial (DBST); National Suicide Prevention Leadership and Support Program (NSPLSP); Postvention; and Targeted Regional Initiatives for Suicide Prevention (TRISP).

Advice on new and expanded measures (April 2021 and March 2022)

2.30 DHDA provided advice to government on five of the six suicide prevention measures in a package of policy proposals in April 2021 that were responding to recommendations in the Productivity Commission's *Mental Health Inquiry* report (PC report) and National Suicide Prevention Adviser's *Final Advice* (NSPA Final Advice) (see paragraph 1.11). The new policy proposals were for the establishment of three new measures (Aftercare, CCC and DBST) and expansion[56] of two existing measures (NSPLSP and Postvention). Advice on the sixth measure (TRISP), which was a new measure, was provided in March 2022 in a second package of proposed measures to respond to the PC report and the NSPA Final Advice.

Link to policy objectives

2.31 Advice to government on the six measures described what the measures were aiming to achieve and identified how they aligned with government objectives and commitments. It described the six measures as responding to or being consistent with the findings and recommendations in the PC report and NSPA Final Advice. Advice for five of the six measures identified direct or indirect relevance of the measure to specific recommendations.

Use of evidence

2.32 Under the National Agreement, the Australian Government committed to 'making new investment decisions that are appropriately informed by evaluation, while supporting new and innovative initiatives to be trialled and tested'.[57]

56 Expansion in this context refers to funding for the continuation of an existing measure with additional activities or services.

57 Australian Government, *National Mental Health and Suicide Prevention Agreement*, Commonwealth of Australia, Canberra, March 2022, clause 98, available from https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement [accessed 11 September 2025].

2.33 The extent to which evidence was presented in policy advice varied. Advice for all measures identified affected stakeholders. Advice for four measures (Aftercare, CCC, Postvention and TRISP) presented expected views of some stakeholders. None of the advice presented actual stakeholder views.[58] A theme in written contributions to this audit (see paragraph 1.20) was insufficient stakeholder consultation and engagement. Relevant evaluations existed for all six measures. Advice for one measure (CCC) did not refer to the evaluation. Advice for the other five measures referred to relevant evaluation findings, which were generally supportive of the proposed measures. The description of evaluation findings was complete for one measure (Aftercare) and incomplete for four measures (DBST, NSPLSP, Postvention and TRISP). Evaluation findings and recommendations that could have informed the proposals were largely not presented or addressed in the advice. For example, advice on the NSPLSP did not refer to evaluation findings that the program did not have a clear definition of suicide prevention leadership and that a lack of visibility of activities across the program may lead to duplication.

Risks and benefits of different options

2.34 Based on a preliminary assessment completed by DHDA, the Office of Best Practice Regulation (OBPR) stated to DHDA that each of the six measures were likely to have minor regulatory impacts[59] and that it should prepare a 'minor' regulatory impact statement (RIS)[60] for each. DHDA prepared and included a minor RIS in policy advice for the six measures. The quality of minor RISs was not required to be assessed by the OBPR.

2.35 For two measures (CCC and TRISP), policy options were included in the minor RIS attached to the advice. The two minor RISs briefly stated why the options were not preferred and did not analyse or present the options in a format that would enable comparison. For the other four measures (Aftercare, DBST, NSPLSP and Postvention) advice did not provide options through the minor RIS or elsewhere.

2.36 The OBPR told DHDA that a minor RIS should include an overview of likely impacts, an outline of regulatory costs or savings, and identified offsets for any increase in regulatory costs, or an explanation of why they have not been identified. The minor RISs varied in completeness of cost/benefit analysis. Advice on the six measures discussed general benefits of the measures. Aside from the minor RIS for Aftercare, none of the advice included an assessment of specific benefits to enable government to consider the net benefit of the proposed measures. Regulatory costs were estimated for five of the six measures. For three of the four measures assessed to have a net increase in regulatory costs (CCC, NSPLSP, Postvention), the minor RIS stated that the increased costs would be met within allocated provider funding. For the other measure (TRISP), the minor RIS stated that no offsets had been identified and did not provide a reason.

58 The PC report, NSPA Final Advice and evaluation reports involved stakeholder consultation.

59 The OBPR was a branch in the Department of the Prime Minister and Cabinet responsible for administration of the Australian Government impact analysis framework. The OBPR was renamed the Office of Impact Analysis in November 2022.

60 A RIS is a factual and analytical assessment of a policy options, including an assessment of the likely net benefit of each option, intended to inform government decision making. A minor RIS is a simplified document that sets out the policy problem and the likely impacts of the preferred solution. Under the March 2020 impact analysis framework, a RIS (standard or minor) was required to be prepared and included with all new policy proposals considered by Cabinet. Changes to the framework in March 2023 removed the requirement for a RIS (renamed Impact Analysis) to be included with new policy proposals assessed to have a minor impact.

2.37 Advice on the six measures included identification of legal and reputational risks (Table 2.1). Advice for two of the six measures identified implementation risks. In total across the six measures, mitigations were proposed for two of 11 identified legal risks; nine of 12 identified reputational risks; and six of seven identified implementation risks.

Table 2.1: Identification of risks and mitigations in policy advice

Measure	Legal[a]		Reputational		Implementation[b]	
	Number of risks identified	Number of risks for which mitigations were proposed	Number of risks identified	Number of risks for which mitigations were proposed	Number of risks identified	Number of risks for which mitigations were proposed
Aftercare	2	0	3	3	4	4
CCC	2	0	3	3	0	N/A
DBST	2	0	3	2	0	N/A
NSPLSP	2	1	1	1	0	N/A
Postvention	2	0	1	0	3	2
TRISP	1	1	1	0	0	N/A

Note a: The template for policy proposals included a mandatory field for assessment of legal risk.

Note b: Risks related to funding for or delivery of the measure.

Source: ANAO analysis of DHDA documentation.

Advice to extend suicide prevention measures (April 2024 to October 2024)

2.38 Between March 2023 and March 2024, at the request of government, DHDA provided advice on mental health and suicide prevention expenditure under DHDA's Program 1.2 (see paragraph 1.5). The advice described deficiencies with existing funding arrangements, including that many measures were administered on a short-term or ad hoc basis and/or received funding without sufficient market testing or evaluation, and that funding arrangements lacked an overarching structure to align funding with outcomes and priorities.

2.39 Between April 2024 and October 2024, DHDA provided advice to government on proposed extensions for four of the six measures (CCC, NSPLSP, Postvention and TRISP).[61] Each extension was proposed to be achieved via variations to existing grant agreements.

2.40 Advice for all four measures provided reasons for the proposed extensions and stated that the proposed extensions aligned with government priorities. Reasons focused on maintaining service provision.[62]

61 Extension in this context refers to funding for the continuation of an existing measure without broadening the scope of the measure via additional activities or services.

62 A theme in written contributions to this audit was the need for more sustainable long-term funding arrangements.

2.41 The *Commonwealth Grants Rules and Principles* state that entities should evaluate grant opportunities before extending existing grant agreements.[63] For one measure (Postvention), advice to government in April 2021 stated that DHDA would evaluate the program before seeking funding for 2025–26.[64] At the time extension advice was provided, the four measures had been in operation for between 20 and 30 months and an evaluation was in progress or completed (see Table 3.6) for each. Evaluation findings were available for three (CCC, NSPLSP and TRISP), which were generally supportive of the proposed extensions. Advice on extending these three measures either did not refer to the evaluation findings or did not include a complete description of findings or use the most recent information available. For two measures (NSPLSP and TRISP), evaluations identified opportunities to strengthen implementation, which were not presented in the advice.[65] For example, the evaluation of TRISP made recommendations related to updating the funding model and reducing duplication with state and territory measures, and this was not discussed. Use of other evidence in extension advice, such as stakeholder views or performance monitoring data, was limited.

Recommendation no. 3

2.42 The Department of Health, Disability and Ageing establish controls to ensure that future advice to government on the establishment or extension of suicide prevention measures is clearly informed by evidence such as stakeholder views and monitoring and evaluation data, findings and recommendations.

Department of Health, Disability and Ageing response: *Agreed*

2.43 *The Department of Health, Disability and Ageing will establish controls within the Mental Health and Suicide Prevention Division to give effect to this recommendation. This will include a divisional protocol applicable across all mental health and suicide prevention branches with guidance on preparing evidence-based advice to government, based on the Delivering Great Policy model of the APS Academy.*

Has policy advice included plans for implementation and evaluation?

DHDA developed program logics for the six suicide prevention measures examined. None were completed in time to inform policy advice to government and the quality of the models was inconsistent. Advice on the six measures contained limited information on how the measures would be implemented. Advice proposed that all six measures would be evaluated and sought evaluation funding. Advice did not include information on how performance would be monitored or how DHDA would measure success. Evaluation plans were subsequently developed for all six measures.

63 Department of Finance, *Commonwealth Grants Rules and Principles*, Finance, Canberra, October 2024, paragraphs 10.8–10.9, available from https://www.legislation.gov.au/F2024L00854/latest/versions [accessed 10 September 2025].

64 The commitment to evaluate the measure was made in the context of a recommendation to government to engage a service provider via a non-competitive process.

65 The advice for NSPLSP stated that DHDA would provide advice to government on a proposed redesign of the measure, informed by the evaluation, to commence in 2027.

Program logic models

2.44 Program logic models are structured visual representations of how a program is intended to work. They are a useful tool in the early stages of policy or program design.[66] At the time the measures were proposed (between April 2021 and March 2022), DHDA's internal guidance stated that program logics should be developed when developing new policy proposals. DHDA's June 2025 Policy Playbook (see paragraph 2.3), released subsequent to the advice on the six measures, established a requirement within DHDA to develop a program logic for certain proposals, including proposals for high-risk or high-value grant programs. Five of the six measures would have met the criteria for requiring a program logic.

2.45 DHDA developed program logic models for all six measures between 12 and 24 months after government decisions to establish or expand the measures. The models, while useful for evaluation, were not available to inform the development of advice to government.

2.46 All program logic models contained most key expected elements: a program objective, inputs, outputs, activities and outcomes. The program logic models for CCC, NSPLSP and TRISP did not include a rationale for the measures. Quality, in terms of how the elements were described and whether they were logically linked, was mixed. The program logic models for CCC, NSPLSP and TRISP were not consistently logical and were described with insufficient detail, impeding understanding of how the measures would be delivered and how outcomes would be achieved. For example, in the NSPLSP program logic model, 'increased instances of service design being informed by lived experience' was a short-term outcome and 'increased understanding of the importance of the integration of lived experience to program design' was a medium-term outcome. An activity in the program logic model was 'support implementation of research translation'.

2.47 A program logic model can be a useful source of information for stakeholders and the public. While DHDA shared draft program logic models for three measures with state and territory governments, as at September 2025, none of the program logic models developed by DHDA for the six suicide prevention measures had been published.

Opportunity for improvement

2.48 DHDA could:

- develop program logic models to inform program design as well as evaluation;
- improve program logics for suicide prevention measures where these do not articulate clear and causally linked inputs, activities, outputs and outcomes; and
- publish program logics for suicide prevention measures to provide information to service providers responsible for delivering the measures and other stakeholders.

66 Program logics identify the causal links between inputs, activities, outputs and intended short, medium and long-term outcomes. The *Commonwealth Evaluation Policy* and *Toolkit* defines outcomes as changes that occur over different periods of time because of program activities: short-term outcomes occur as a direct result of program activities and may involve the acquisition of knowledge and skills; medium-term outcomes describe behavioural changes; and long-term outcomes describe system changes.
The Department of the Treasury, *Commonwealth Evaluation Policy*, Treasury, Canberra, December 2021, available from https://evaluation.treasury.gov.au/about/commonwealth-evaluation-policy [accessed 19 September 2025].

Implementation and evaluation planning

2.49 The *Delivering Great Policy* guidance states that policy advice should demonstrate that a proposed policy or program is practical to implement and that evaluation should be 'baked in' from the outset and linked to policy outcomes.[67] The December 2021 *Commonwealth Evaluation Toolkit* stated that for a proposal to be 'fit to evaluate' it should include: clearly articulated and measurable objectives and outcomes; and robust performance monitoring to support future evaluations.[68] DHDA's *Evaluation Strategy 2016–2019* (which was in effect until July 2023) stated it is essential that evaluation is considered early in the policy and program cycle. DHDA's *Evaluation Strategy 2023–2026* included a priority area to improve DHDA's evaluation maturity, including by planning early for evaluation to avoid evaluation that is disconnected from planning and decision-making. Both strategies included an action for business areas to consider evaluation requirements in new policy proposals. DHDA's June 2025 Policy Playbook (see paragraph 2.3) states that a policy proposal needs to explain implementation and evaluation to the right level of detail so that it builds trust.

2.50 Advice to government between April 2021 and March 2022 proposing to establish or expand the six measures focused on describing services to be delivered by third parties and did not contain information on governance arrangements (including key roles and responsibilities) that would support implementation, DHDA's implementation activities, or timeframes for implementing other than in relation to the allocation of funding over financial years. However, for the four measures that were new (Aftercare, CCC, and DBST and TRISP), the advice identified similar measures in operation in Australia or overseas. DHDA advised the ANAO in November 2025 that because three of the measures relating to the National Agreement (Aftercare, DBST and Postvention) were subject to negotiations with states and territories at the time, implementation detail 'would not have been available'.

2.51 The Australian Government can use different types of financial arrangements to achieve policy objectives, including grants and procurements.[69] None of the advice identified the specific financial arrangement that would be used to fund service providers.

2.52 As stated in Table 2.1, advice to government on four of the six measures did not discuss implementation risks. After decisions by government to establish or expand the six measures, there were delays to implementation or changes in funding arrangements for four of the measures, including the three measures where no implementation risks were identified in advice (CCC, DBST and TRISP). Advice for the fourth measure (Postvention) identified a risk that was subsequently realised, but the advice did not propose a mitigation.

67 Australian Public Service Academy, *Delivering Great Policy — Practical to implement*, APSA, Canberra, 14 July 2025, available from https://www.apsacademy.gov.au/aps-craft/strategy-policy-evaluation/delivering-great-policy/practical-implement [accessed 11 September 2025].

68 The Department of the Treasury, *Commonwealth Evaluation Toolkit*, Treasury, Canberra, available from https://evaluation.treasury.gov.au/toolkit/commonwealth-evaluation-toolkit [accessed 19 September 2025].

69 Department of Finance, *Grants, Procurements and other financial arrangements (RMG 411)*, Finance, Canberra, 18 October 2024, available from https://www.finance.gov.au/publications/resource-management-guides/grants-procurements-and-other-financial-arrangements-rmg-411 [accessed 19 September 2025].

Opportunity for improvement

2.53 DHDA could provide more complete information on implementation in advice to government on suicide prevention measures to assist in identifying and mitigating risks to the achievement of government objectives and building trust.

2.54 Advice for each of the six measures identified that an evaluation would be conducted, with funding included as part of the proposed measure. Advice for two of the measures (NSPLSP and TRISP) included funding for data collection. The proposals did not identify how performance would be monitored or provide timeframes for the development of a monitoring and evaluation framework or plan that would set out these details. None of the advice identified how success would be measured or benchmarked. DHDA developed or commissioned evaluation plans for all six measures between seven and 38 months after the measures commenced (see paragraphs 3.32 to 3.34).

Has policy been developed in partnership with Aboriginal and Torres Strait Islander people?

The Social and Emotional Policy Partnership (Policy Partnership) was established in part to reduce Aboriginal and Torres Strait Islander suicide rates. DHDA is the lead Australian Government entity for developing and supporting the Policy Partnership. DHDA put in place governance and funding arrangements for the Policy Partnership that were not consistent with the principles of strong partnership and shared decision-making. As at September 2025, DHDA had not effectively ensured that the Policy Partnership was a genuine partner in suicide prevention policy development. A suicide prevention measure, Culture Care Connect, is an advisory arrangement funded under a grant agreement with the National Aboriginal Community Controlled Health Organisation (NACCHO). By helping to build the Aboriginal community-controlled sector, it contributes to the achievement of Closing the Gap Priority Reform 2, however it does not meet the criteria of a policy partnership.

Social and Emotional Wellbeing Policy Partnership

2.55 The Social and Emotional Wellbeing Policy Partnership (Policy Partnership) is one of five formal policy partnerships required under the Closing the Gap Agreement (see paragraphs 1.4 and 1.7) by 2022. The minister is responsible for progress against outcome 14 and target 14 and DHDA is the lead Australian Government agency for the outcome and target, which includes responsibility for developing and supporting the Policy Partnership. In March 2022, the Australian Government announced funding of $8.6 million from 2022–23 to 2024–25 to establish the Policy Partnership[70], which included funding for Gayaa Dhuwi to provide joint administrative support with DHDA.[71]

70 Australian Government, *Budget Paper No. 2: Budget 2022–23*, Commonwealth of Australia, Canberra, 29 March 2022, p. 110, available from https://archive.budget.gov.au/2022-23/bp2/download/bp2_2022-23.pdf [accessed 25 September 2025].

71 Department of Health, Disability and Ageing, *Social and Emotional Wellbeing Policy Partnership*, DHDA, Canberra, 7 July 2025, available from https://www.health.gov.au/committees-and-groups/social-and-emotional-wellbeing-policy-partnership [accessed 17 October 2025].

Alignment with strong partnership elements of the National Agreement on Closing the Gap

2.56 Under the Closing the Gap Agreement, governments have committed to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments such as through formal partnership arrangements that include the 'strong partnership' elements outlined in clauses 32 and 33.

- Clause 32 sets out elements across three categories: a formal agreement is in place, partnerships are accountable and representative, and decision-making is shared.
- Clause 33 sets out 'resourcing' elements and states: 'The Parties recognise that adequate funding is needed to support Aboriginal and Torres Strait Islander parties to be partners with governments in formal partnerships.'[72]

2.57 The National Indigenous Australians Agency (NIAA) undertakes annual stocktakes of the number and nature of formal partnership arrangements. Between 2022 and 2024, the stocktakes included an assessment of the Policy Partnership against the strong partnership elements. In 2022 and 2023, the stocktakes stated that all strong partnership elements were met. In 2024, the stocktake stated that elements relating to: formal agreement were met; accountability and representation and shared decision-making were partially met; and resourcing were 'not applicable' noting 'ongoing discussions'.

2.58 The Social and Emotional Wellbeing Policy Partnership Agreement was endorsed at the Policy Partnership's first meeting in March 2023. The Policy Partnership Agreement articulates a framework for the partnership, including objectives, roles and responsibilities, and principles and procedures for shared decision-making.[73] Gayaa Dhuwi representatives are co-chair and deputy co-chair of the partnership.[74]

2.59 The Policy Partnership Agreement requires the Policy Partnership to meet at least four times per calendar year. The Policy Partnership met seven times between March 2023 and December 2025, with the last two meetings held in February 2025 and December 2025. The ANAO assessed the Policy Partnership Agreement and its implementation in practice during meetings against the strong partnership elements, where applicable and possible. As at September 2025, the Policy Partnership Agreement fully or largely aligned with eight out of the 11 elements assessed. In practice, the implementation of the Policy Partnership Agreement fully or largely aligned with five out of the 10 elements assessed (Appendix 4).

2.60 Although Gayaa Dhuwi is a member of the Policy Partnership, DHDA's arrangements and behaviours in working with Gayaa Dhuwi reinforced a 'purchaser-provider' arrangement rather than a partnership, due to the way in which the secretariat function was shared, capacity was supported, funding was committed and reviews were administered.

72 Australian Government, *National Agreement on Closing the Gap*, Commonwealth of Australia, Canberra, July 2020, available from https://www.closingthegap.gov.au/national-agreement [accessed 12 September 2025].

73 Department of Health, Disability and Ageing *Agreement to Implement the Social and Emotional Wellbeing Policy Partnership*, DHDA, Canberra, 5 June 2023, available from www.health.gov.au/resources/publications/agreement-to-implement-the-social-and-emotional-wellbeing-policy-partnership [accessed 18 September 2025].

74 The co-chair is a voting member. The deputy co-chair provides administrative and operational support to the co-chair and is not a voting member (except as a proxy in exceptional circumstances).

- Secretariat function largely not shared — The Policy Partnership Agreement states that secretariat responsibilities are to be shared between Aboriginal and Torres Strait Islander and government 'leads' to support shared decision-making. In November 2022, DHDA procured Gayaa Dhuwi to provide secretariat, administration and policy support services for the Policy Partnership until November 2025.[75] The contract and an August 2023 secretariat work plan agreed between DHDA and Gayaa Dhuwi made Gayaa Dhuwi fully responsible for developing agendas, meeting papers, minutes and actions, an annual workplan and a three-year strategic plan. In August 2023, DHDA offered, and Gayaa Dhuwi agreed, to alternate responsibility for preparing minutes.
- No capacity building — As at September 2025, DHDA had not undertaken any activities to strengthen the capacity of Gayaa Dhuwi to support its role in the Policy Partnership.
- Insecure funding arrangements — In December 2024, the Australian Government announced additional funding of $2.6 million in 2025–26 to support the operation of the Policy Partnership until June 2026.[76] In September 2025, DHDA invited Gayaa Dhuwi to respond to a request for tender for secretariat, administration and policy support for the Policy Partnership in collaboration with DHDA, and to deliver enabling services to establish and manage a 'Small Initiatives' fund (see paragraph 2.68), until June 2026. A contract was finalised and commenced in January 2026.[77] The APSC's June 2025 *First Nations Partnerships Playbook* states that entities can 'take a proportional and risk based approach to create greater certainty of funding and reduce administrative burden'.[78]
- DHDA assessment of Gayaa Dhuwi — In March 2024, DHDA commenced a process to assess Gayaa Dhuwi. DHDA proposed to Gayaa Dhuwi that the scope of the assessment would be to consider 'organisational capacity and capability, including governance and financial management, in the context of … grant and contract arrangements' with Gayaa Dhuwi. The scope of the assessment included Gayaa Dhuwi's role as a national peak body but not its role as the provider of support services for the Policy Partnership.[79] DHDA funded the assessment from a 2021–22 Federal Budget measure for evaluation of programs under the National Agreement. In July 2024, DHDA told Gayaa Dhuwi that: DHDA 'is committed to ensuring expenditure is evidence based, contestable and improving outcomes' and the assessment would 'contribute to future policy development and advice to the Australian Government to inform decisions about future sustainable

75 AusTender Contract Notice number CN3930123, commencement date 11 November 2022, contract value $4,950,000 (GST included). The initial end date for the contract was 30 June 2025. Between June and October 2025, the contract was varied three times to extend the original end date with no change to contract value. As at November 2025, the end date was 14 November 2025.

76 Minister for Health and Ageing, 'A better way: suicide prevention in First Nations communities' media release, 13 December 2024, available from www.health.gov.au/ministers/the-hon-mark-butler-mp/media/a-better-way-suicide-prevention-in-first-nations-communities [accessed 23 September 2025].

77 AusTender Contract Notice number CN4214848, commencement date 14 January 2026, contract value $2,750,000 (GST included).

78 Australian Public Service Commission, *First Nations Partnerships Playbook*, APSC, Canberra, 12 June 2025, available from https://www.apsc.gov.au/news-and-events/aps-news/working-genuine-partnership-first-nations-people [accessed 26 September 2025].

79 Gayaa Dhuwi has separate funding agreements with the Australian Government for its distinct roles as the national peak body for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide prevention and as the provider of secretariat, administration and policy support services for the Policy Partnership.

funding options for Gayaa Dhuwi'; and would not assess the outcomes of the Policy Partnership 'pending further discussion'. In November 2024, DHDA commissioned Keogh Bay People Pty Ltd to conduct the assessment, with a final report to be delivered by 31 March 2025.[80] The February 2025 final report stated that 'Stakeholders unanimously reported that the partnership between Gayaa Dhuwi and DHDA has been under strain and often has had an adversarial tone' but also noted an improvement in the relationship during 2025.

Governance arrangements

2.61 In announcing funding for the Policy Partnership, the Australian Government committed that the Policy Partnership would 'advise on policy and implementation of actions to address social and emotional wellbeing, mental health and suicide prevention closing the gap targets'.[81]

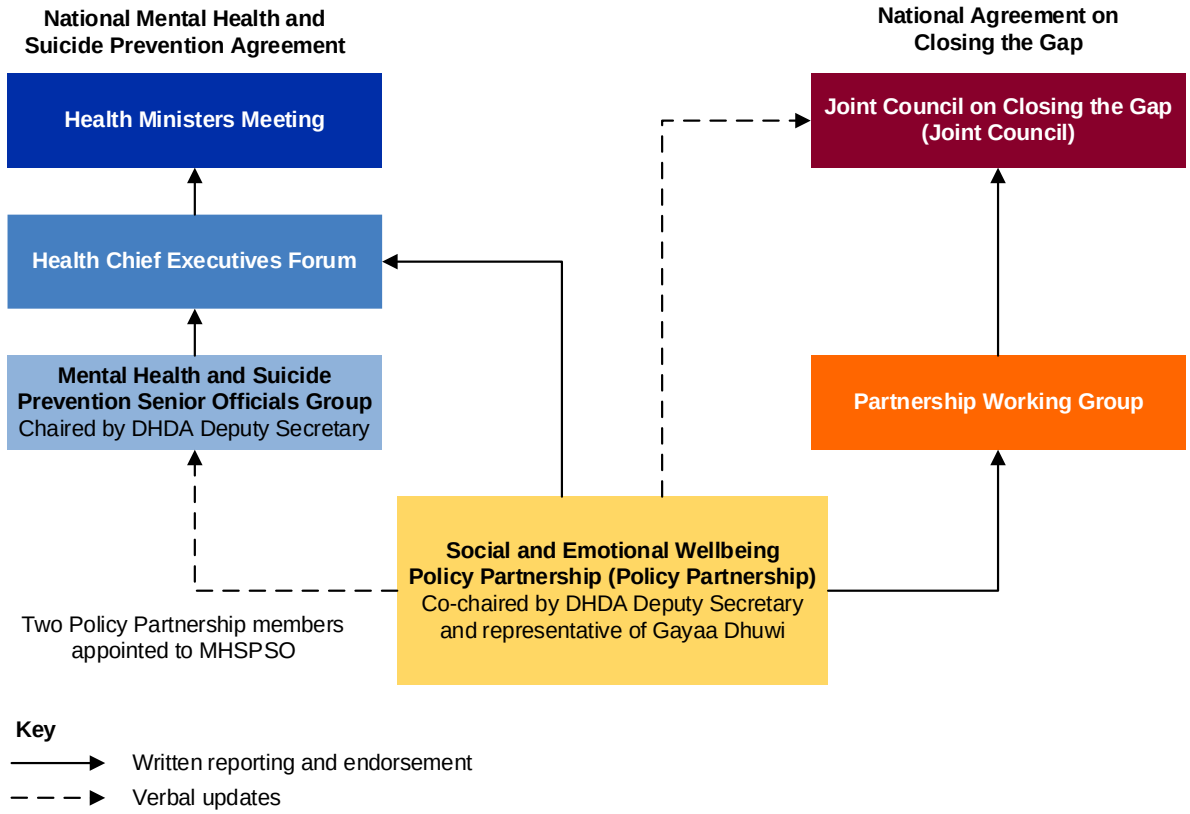
2.62 The primary function of the Policy Partnership is to make recommendations to Joint Council (see paragraph 1.7). DHDA's November 2022 contract with Gayaa Dhuwi committed Gayaa Dhuwi, in its secretariat role, to 'develop recommendations for action for consideration through both the [Closing the Gap Agreement] and [National Agreement] governance structures'. On 14 December 2022, the Mental Health and Suicide Prevention Senior Officials Group (Senior Officials Group) agreed to integrate the Policy Partnership into the governance arrangements for the National Agreement. At this stage, no decisions had been made by the Policy Partnership about its governance arrangements as the Policy Partnership had not met. On 14 December 2022, the Policy Partnership co-chairs wrote to the Closing the Gap Partnership Working Group[82] that the Policy Partnership would provide advice in relation to both national agreements. Governance arrangements as at September 2025 are illustrated in Figure 2.1.

80 AusTender Contract Notice number CN4108473, contract value $391,516 (GST included). The due date for the final report was extended five times. DHDA received a final report in February 2026.

81 Australian Government, *Budget Paper No. 2, Budget 2022–23*, Commonwealth of Australia, Canberra, 29 March 2022, p. 110, available from https://archive.budget.gov.au/2022-23/bp2/download/bp2_2022-23.pdf [accessed 25 September 2025].

82 The Partnership Working Group is responsible for supporting Joint Council by developing policy positions and providing advice to inform discussions between Joint Council members. It comprises senior government officials and representatives from the Coalition of Peaks.

Figure 2.1: Reporting and endorsement processes, as at September 2025



Source: ANAO analysis of DHDA documentation.

Governance arrangements under the National Mental Health and Suicide Prevention Agreement

2.63 The Policy Partnership's governance arrangements did not fully support shared decision-making in policy development. The ability of the Policy Partnership to develop policy in partnership is not easily facilitated through a structure involving it reporting to the Senior Officials Group.

- The Senior Officials Group has a focus on implementation of the National Agreement.
- At the Policy Partnership's first meeting in March 2023, it agreed that two Aboriginal and Torres Strait Islander Policy Partnership members and two other Aboriginal and Torres Strait Islander representatives with lived experience be on the Senior Officials Group. As at September 2025, of the 24 Senior Officials Group members, 16 were government representatives. Seven of the 16 government members on the Senior Officials Group were also on the Policy Partnership. Of the nine government members on the Policy Partnership, seven were on the Senior Officials Group. The number of and overlap between government members on the two bodies may create an imbalance in the partnership approach.
- At Policy Partnership meetings between March 2023 and February 2025, members raised concerns that the Policy Partnership reporting to the Senior Officials Group placed the Policy Partnership in a subordinate position, contrary to principles of partnership and shared decision-making, and reduced the influence of Aboriginal and Torres Strait Islander members.

2.64 In August 2024, the Policy Partnership co-chairs wrote to the Health Chief Executives Forum to inform them that the Policy Partnership would report to the Health Chief Executives Forum and not the Senior Officials Group because the previous arrangement was diluting shared decision-making. In February 2025, DHDA presented a paper to the Policy Partnership suggesting that ministerial engagement should occur through the Senior Officials Group. The Policy Partnership agreed to DHDA sharing Senior Officials Group meeting minutes with the Policy Partnership and ensuring there is a standing agenda item for the Policy Partnership at Senior Officials Group meetings.

2.65 The October 2025 Productivity Commission report on the National Agreement (see paragraph 1.13) stated that it was unclear how the Senior Officials Group and the Policy Partnership were intended to interact and how decisions were expected to be made, and that there was 'little accountability' for how governance mechanisms under the National Agreement ensure they adequately embed Aboriginal and Torres Strait Islander voices.[83] A theme in written contributions and stakeholder meetings for this audit (see paragraph 1.20) was that shared decision-making and governance structures when co-designing policy and strategic priorities were inadequate.

Governance arrangements under the National Agreement on Closing the Gap

2.66 The Policy Partnership Agreement states that, in addition to providing verbal updates, the Policy Partnership will report annually in writing to Joint Council, including on recommendations it has made, actions taken, progress against Policy Partnership objectives and relevant priority reforms and socioeconomic targets in the Closing the Gap Agreement. The Policy Partnership made two verbal updates to Joint Council, in June 2023 and November 2024[84], and had not provided any written reports or made any recommendations as at September 2025. Joint Council's responsibilities include oversight and monitoring of performance against priority reforms, socio-economic targets and agreed partnership actions. The limitations of reporting to Joint Council impedes its ability to oversee progress.

2.67 The Policy Partnership Agreement states that social and emotional wellbeing 'includes a collective sense of self that is defined by connections to mind, body, family, community, culture, Country and spirituality' and that the Policy Partnership is approaching social and emotional wellbeing from a 'comprehensive and holistic perspective, looking at all factors including prevention, protective factors, mental health, mental health complexities, and suicide prevention/postvention'. A theme in consultations with Policy Partnership members for this audit was a lack of clarity about ways in which the Policy Partnership could work with governments to address aspects of social and emotional wellbeing beyond the health system, in part due to governance arrangements having a health focus.

Involvement in policy development

2.68 The Policy Partnership has not been actively involved in suicide prevention strategy or policy development. This was a consistent theme in consultations with Policy Partnership members for this audit. Since its establishment in 2022, the Policy Partnership's role has been largely to note or

83 Productivity Commission, *Mental Health and Suicide Prevention Agreement Review, Inquiry Report*, Productivity Commission, Canberra, 16 October 2025, p. 226, available from https://www.pc.gov.au/inquiries-and-research/mental-health-review/report/ [accessed 12 November 2025].

84 In June 2023, the update was provided by the co-chairs. In November 2024, the update was provided by the Aboriginal and Torres Strait Islander co-chair.

endorse strategic documents and frameworks (such as the Indigenous Suicide Prevention Strategy) developed by Gayaa Dhuwi as deliverables under grant agreements with DHDA. In relation to the six suicide prevention measures examined in this audit, the Policy Partnership received regular updates on the implementation of one (CCC).[85] It did not discuss or consider the other five measures. In August 2023, the Policy Partnership agreed that the Aboriginal and Torres Strait Islander co-chair and other members be invited to relevant discussions with ministers. This did not occur. Australian Government funding for the Policy Partnership for 2022–23 to 2024–25 included $1.02 million for research and enabling activities (such as developing and analysing data, undertaking community consultations and implementing small initiatives) to be determined by the Policy Partnership. As at September 2025, an approach to using the funds had not been agreed.

2.69 DHDA has described that it has a close working relationship with the Policy Partnership, that the Policy Partnership actively contributed to the development of the Indigenous Suicide Prevention Strategy, and that, through the strategy, the Policy Partnership was guiding DHDA's current activities in relation to suicide prevention.[86] However, in a July 2025 position paper, Gayaa Dhuwi stated 'At present, the [Policy Partnership] functions more as a symbolic advisory body than a governing mechanism, lacking the autonomy, authority, and decision-making power required to influence system reform'.[87]

2.70 At the December 2025 meeting, the Policy Partnership discussed the operation and effectiveness of the Policy Partnership to date.[88] A meeting paper stated that the Policy Partnership had faced challenges in fulfilling its intended functions as it had been used primarily as an information-sharing forum, which had limited its ability to influence national policy and make joint recommendations. Aboriginal and Torres Strait Islander members described that they had met in August 2025 to reflect on the Policy Partnership and had identified barriers to progress, including cancellation of meetings, unclear processes, limited government preparedness and meeting papers not enabling meaningful discussion and decision-making. The Policy Partnership discussed an approach to revising the Policy Partnership Agreement and developing a new strategic plan and workplan.

2.71 The Policy Partnership Agreement requires that the partnership is reviewed before March 2026. Australian Government funding for the Policy Partnership for 2022–23 to 2024–25 included $409,000 to evaluate the effectiveness of the Policy Partnership. In November 2024, the NIAA developed the *Policy Partnership Evaluation Guideline Statement of Requirement*, a non-mandatory framework to guide policy partnerships when procuring an evaluator. In February 2025, the Policy Partnership discussed the review of the Policy Partnership. As at December 2025, the Policy Partnership review had not commenced.

85 One of the members of the Social and Emotional Wellbeing Policy Partnership was a representative of the National Aboriginal Community Controlled Health Organisation, which administers CCC.

86 Senate Community Affairs Legislation Committee, Committee Hansard, 9 October 2025.

87 Gayaa Dhuwi, *System-Wide Approach to Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, Mental Health, and Suicide Prevention*, July 2025, p. 6, available from www.gayaadhuwi.org.au/?s=system-wide [accessed 23 September 2025].

88 Other topics discussed at the meeting were the current National Agreement and a potential new agreement, and ways in which the Policy Partnership could contribute to addressing Target 11 of the Closing the Gap Agreement (which relates to reducing the rate of Aboriginal and Torres Strait Islander young people in detention).

Recommendation no. 4

2.72 The Department of Health, Disability and Ageing ensure:

(a) governance and funding arrangements for the Social and Emotional Wellbeing Policy Partnership are consistent with the commitment in the National Closing the Gap Agreement to 'empower' Aboriginal and Torres Strait Islander parties to share decision-making authority with governments;

(b) the role of the Social and Emotional Wellbeing Policy Partnership as a partner in policy development is clearly defined, including in relation to aspects of social and emotional wellbeing beyond the health system; and

(c) arrangements are established to regularly monitor the Social and Emotional Wellbeing Policy Partnership to support shared accountability for the achievement of intended outcomes.

Department of Health, Disability and Ageing response: *Agreed in principle*

2.73 *The Department of Health, Disability and Ageing (the department) notes that this recommendation will depend on agreement with, and support from, relevant external stakeholders as noted below.*

2.74 *The department will give effect to the intent of recommendation 4(a) through the Social and Emotional Wellbeing (SEWB) Policy Partnership's Agreement to Implement and its Strategic Plan. The department notes that this will require the agreement and support of the SEWB Policy Partnership membership.*

2.75 *In relation to recommendation 4(b), the department also notes that broader responsibility for social and emotional wellbeing policy lies with the National Indigenous Australians Agency (NIAA) and other relevant entities. The department will work with NIAA and other entities to explore options for implementation of recommendation 4(b).*

2.76 *The department also notes that all Policy Partnerships are established under the authority of the Joint Council on Closing the Gap, and any changes to existing arrangements, including formal role clarification, would require the approval of the Joint Council.*

2.77 *The department agrees in principle with recommendation 4(c). The department notes that this action will require co-design, and any arrangements for the Policy Partnership to monitor its own progress against priority areas would need agreement from both the Policy Partnership and the Joint Council. The department also notes that any additional monitoring processes for the SEWB Policy Partnership must align with the spirit of partnership and avoid contradicting the intent of recommendation 4(a). The department will work with the SEWB Policy Partnership membership to explore options to implement the intent of recommendation 4(c).*

2.78 The June 2025 *Independent Aboriginal and Torres Strait Islander-Led Review of Closing the Gap* (Independent Review) stated that 'governments must rethink what genuine partnership entails' and that 'forgoing power in favour of partnership is urgently needed'.

> When done well, co-design shifts engagement from consultation to collaboration. It invites Aboriginal and Torres Strait Islander people into the process from the outset, empowering them to shape the direction, substance, and implementation of decisions that affect them.[89]

2.79 The Independent Review, the NSW Auditor-General, and the ANAO have identified instances of genuine partnership in policy development.

- In May 2025, the NSW Auditor-General found that while governance arrangements for the implementation of the Closing the Gap Agreement in NSW were not operating effectively, arrangements had provided new opportunities for Aboriginal and Torres Strait Islander partnership members to speak directly with ministers, including through regular ministerial meetings to report progress, raise issues and discuss programs and initiatives.[90]
- In June 2025, the New South Wales Coalition of Aboriginal Peak Organisations undertook a Cross-Portfolio Closing the Gap budget submission process with NSW Treasury. This included joint preparation of a budget submission, which demonstrated 'shared priority setting and collaboration in action'.[91]
- In January 2026, the ANAO found that, in schooling and early childhood development, Australian Government entities are increasingly working with First Nations people in designing policy. The Early Childhood Care and Development Policy Partnership (ECCDPP), of which the Department of Education is co-chair, is a formal policy partnership required under the Closing the Gap Agreement. The ANAO found that the agreement to establish the ECCDPP and the way it is implemented align well with the strong partnership elements of the Closing the Gap Agreement and that the ECCDPP is a good example of a successful policy partnership.[92]

Culture Care Connect

2.80 DHDA's April 2025 *Aboriginal and Torres Strait Islander Partnership and Engagement Framework* states that 'All partnerships should develop, agree on, and document a clear set of expectations that are mutually beneficial and accepted.' Examples listed include formal partnership agreements, memoranda of understanding and terms of reference.[93]

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89 Coalition of Peaks, *Independent Aboriginal and Torres Strait Islander-Led Review of Closing the Gap*, June 2025, available from https://www.coalitionofpeaks.org.au/independent-review-of-closing-the-gap [accessed 16 October 2025].

90 NSW Auditor-General's Report to Parliament, *Governance of the National Agreement on Closing the Gap in NSW*, Audit Office of New South Wales, Sydney, 29 May 2025, available from https://www.audit.nsw.gov.au/our-work/reports/governance-of-the-national-agreement-on-closing-the-gap-in-nsw [accessed 16 October 2025].

91 Coalition of Peaks, *Independent Aboriginal and Torres Strait Islander-Led Review of Closing the Gap*, June 2025, available from https://www.coalitionofpeaks.org.au/independent-review-of-closing-the-gap [accessed 16 October 2025].

92 Auditor-General Report No. 19 2025–26, *Closing the Gap in Schooling and Early Childhood Development — Partnership and Reporting*, ANAO, Canberra, 21 January 2026, available from https://www.anao.gov.au/work/performance-audit/closing-the-gap-schooling-and-early-childhood-development-partnership-and-reporting, p. 25 [accessed 11 February 2026].

93 Department of Health, Disability and Ageing, *Aboriginal and Torres Strait Islander Partnership and Engagement Framework*, DHDA, Canberra, April 2025, p. 15, available from https://www.health.gov.au/resources/publications/aboriginal-and-torres-strait-islander-partnership-and-engagement-framework [accessed 22 September 2025].

2.81 In May 2022, the Australian Government entered into a grant agreement with NACCHO for CCC (see Table 1.1). The grant agreement stated that NACCHO would work in partnership with DHDA and consult with key stakeholders including Gayaa Dhuwi, peak bodies and experts. As at September 2025, DHDA had not developed a partnership agreement or similar document that articulated how DHDA and NACCHO would work in partnership on the delivery of CCC.

2.82 In May 2022, NACCHO established an Aboriginal and Torres Strait Islander advisory group to provide advice to NACCHO on the implementation of CCC and support monitoring and evaluation. The advisory group membership comprised NACCHO representatives, DHDA representatives and stakeholders with expertise across the mental health system.

2.83 In the 2022 and 2023 NIAA partnership stocktakes (see paragraph 2.57), CCC was identified as a 'place-based partnership'[94] between DHDA and NACCHO relevant to outcome 14 of the Closing the Gap Agreement.[95] The stocktakes assessed the partnership as being aligned with all applicable strong partnership elements (see paragraph 2.2). In 2024, DHDA, in consultation with NACCHO, submitted to NIAA that CCC was a partnership, however the 2024 stocktake identified CCC as an advisory body. The APSC's June 2025 *First Nations Partnerships Playbook* states that commercial relationships, such as those established through grant agreements with Aboriginal and Torres Strait Islander organisations, do not typically include shared decision-making and are not partnerships and that advisory bodies are a form of engagement rather than partnership, as they do not involve shared decision-making.[96]

2.84 Under the Closing the Gap Agreement, Priority Reform 2 relates to building the community-controlled sector, with the intended outcome that there is a strong and sustainable sector delivering high-quality services to meet the needs of Aboriginal and Torres Strait Islander people.[97] While CCC does not involve a partnership agreement between DHDA and NACCHO, the grant agreement provided NACCHO with control over the implementation of the program. In doing so, the grant agreement contributed to Priority Reform 2. NACCHO advised the ANAO in February 2026 (see Appendix 1) that 'While the arrangement may not meet the definition under the [Closing the Gap Agreement] of a formal partnership arrangement between DHDA and NACCHO, we believe that [DHDA] has worked in partnership with NACCHO during the development and implementation of the program.'

94 Place-based partnerships are partnerships based on a specific region, between government and Aboriginal and Torres Strait Islander representatives, and others by agreement, from those specific areas.

95 In the 2022 partnership stocktake, CCC was referred to as the 'Integrated Approach to Suicide Prevention Aboriginal and Torres Strait Islander Advisory Group'.

96 Australian Public Service Commission, *First Nations Partnerships Playbook*, APSC, Canberra, 12 June 2025, available from https://www.apsc.gov.au/news-and-events/aps-news/working-genuine-partnership-first-nations-people [accessed 26 September 2025].

97 Closing the Gap, *Priority Reform Two*, available from www.closingthegap.gov.au/national-agreement/priority-reforms [accessed 22 September 2025].

3. Monitoring and evaluation

Areas examined

This chapter examines the effectiveness of the Department of Health, Disability and Ageing's (DHDA) monitoring and evaluation of suicide prevention measures.

Conclusion

DHDA's monitoring and evaluation of suicide prevention measures was partly effective. Nearly four years after the National Mental Health and Suicide Prevention Agreement, and over five years since the National Agreement on Closing the Gap, government objectives to reduce suicide have not been achieved. An appropriate performance measurement framework for suicide prevention agreements, measures and grants was not established. Monitoring and reporting was incomplete, compliance focused, based on unverified performance information and provided little insight into the achievement of intended outcomes. Although evaluations are planned and underway, a lack of fit-for-purpose performance data limits DHDA's ability to conduct robust evaluations of suicide prevention measures. As a result, there is limited information available to DHDA and the public about the extent to which Australian Government investment in mental health and suicide prevention is contributing to reducing suicide.

Areas for improvement

The ANAO made two recommendations for DHDA to ensure grant agreements for suicide prevention measures include performance indicators; and develop and publish performance monitoring and reporting frameworks for suicide prevention measures. The ANAO identified opportunities for DHDA to identify evaluation and data requirements for suicide prevention measures prior to their implementation; and publish evaluation findings.

3.1 Through the National Mental Health and Suicide Prevention Agreement (National Agreement), the Australian Government committed to monitor and evaluate the suicide prevention system and measures funded under the agreement, and to increase transparency and accountability of suicide prevention outcomes.[98] The *Commonwealth Evaluation Policy* emphasises the importance of evaluation to inform program delivery and support continuous improvement and accountability against program objectives.[99] DHDA establishes grant agreements with Primary Health Networks (PHNs) and providers to deliver suicide prevention measures. The Department of Finance's Resource Management Guide (RMG) 410 *Commonwealth Grants* states that entities should adopt an early focus on evaluation through developing a strategy and performance

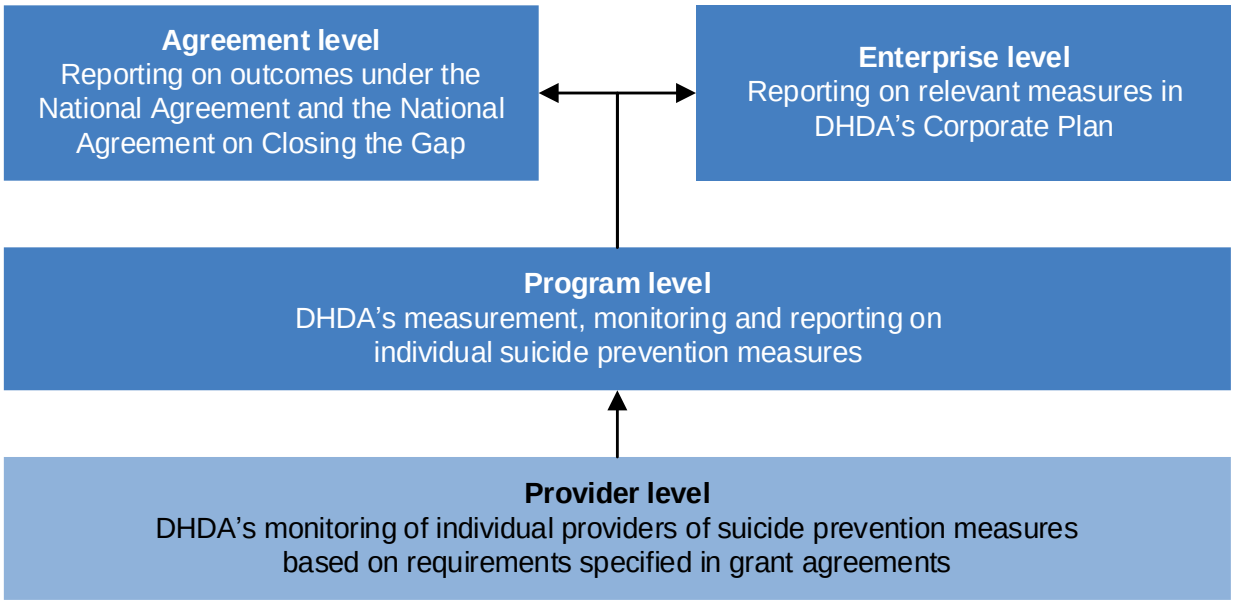
98 Australian Government, *National Mental Health and Suicide Prevention Agreement*, Commonwealth of Australia, Canberra, March 2022, available from https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement [accessed 11 September 2025].

99 The Department of the Treasury, *Commonwealth Evaluation Policy,* Treasury, Canberra, December 2021, available from https://evaluation.treasury.gov.au/about/commonwealth-evaluation-policy [accessed 4 September 2025].

indicators during the design phase of grant programs, in order to evaluate individual grants and overall programs.[100]

3.2 The ANAO examined performance measurement, monitoring and evaluation across four levels (Figure 3.1). At the program level, the measures examined were a selection of six suicide prevention measures administered by DHDA (Universal Aftercare (Aftercare); Culture Care Connect (CCC); Distress Brief Support Trial (DBST); National Suicide Prevention Leadership and Support Program (NSPLSP); Postvention; and Targeted Regional Initiatives for Suicide Prevention (TRISP)). Three of the measures (Aftercare, DBST and Postvention) were developed under the National Agreement.

Figure 3.1: Performance measurement, monitoring, evaluation and reporting



Source: ANAO analysis of DHDA performance monitoring.

Has an appropriate performance measurement framework been established?

Performance indicators for suicide prevention activities at the national agreement and enterprise level have improved and are continuing to develop. For the six suicide prevention measures examined, performance indicators were established for four measures. In addition, performance indicators for grantees were established in grant agreements with third-party providers for four measures. Established indicators largely focus on the delivery of activities and outputs and provide limited information about the impact and effectiveness of that work. Performance indicators in grant agreements are not verifiable due to a lack of a clear measurement and reporting methodology. Overall, there was no performance measurement framework to guide DHDA in its measurement, monitoring and reporting on the Australian Government's contribution to achieving suicide prevention objectives.

100 Department of Finance, *Resource Management Guide 410: Commonwealth Grants*, Finance, Canberra, 27 September 2024, available from: https://www.finance.gov.au/government/managing-commonwealth-resources/commonwealth-grants-rmg-410 [accessed 11 September 2025].

National agreement level performance indicators

3.3 DHDA co-chairs the Mental Health and Suicide Prevention Senior Officials Group Data Governance Forum, which has oversight of the implementation of data and performance measurement commitments in the National Agreement, including development of the priority data and indicators.[101] For the National Agreement, there are two types of agreement level performance indicators.

- Operational indicators — The bilateral schedules to the National Agreement state that the Australian Government and state and territory governments will develop a nationally consistent approach to data collection and sharing, including developing key performance indicators. DHDA established arrangements to collect service volume data (number of centres, clients, and service contacts) for Aftercare and Postvention from 2022–23. There are eleven operational indicators for the three suicide prevention measures developed under the National Agreement (Aftercare, DBST and Postvention), which were first included in the jurisdictional performance reports (see paragraph 3.15) in 2023–24. These indicators were largely activity and output focused and for two measures (Aftercare and Postvention) indicators related to undertaking an evaluation of the measures that is due to be completed in December 2026 (see Table 3.6).
- Outcome indicators — The National Agreement commits to measuring and reporting on outcomes as well as outputs, and specifies 23 'priority data and indicators' to measure progress of the five priority outcomes.[102] Three indicators are specifically related to the outcome of reducing suicide and self-harm. As at October 2025, of the 23 priority data and indicators, most were 'not commenced' (7); 'in progress' (7); or involved preliminary indicators requiring 'further work' (5). Four were 'complete'. Of the three suicide prevention indicators, one was 'in progress', one required 'further work' and one was 'complete'. The one 'complete' suicide prevention indicator was first included in a draft 2023–24 national progress report (see paragraph 3.17).

3.4 A consistent theme in written contributions to this audit (see paragraph 1.20) related to a lack of outcomes and impact monitoring. The National Suicide Prevention Office is developing an outcomes framework anticipated to be finalised in mid-2026 (see paragraph 2.9). In a September 2024 update on the development of the outcomes framework, the National Suicide Prevention Office stated that measuring progress in suicide prevention has focused on monitoring suicide rates and the implementation of activities, which, while important, did not provide insight into whether progress is being made to address factors that lead to suicidal distress and suicide.[103]

101 The Mental Health and Suicide Prevention Data Governance Forum was established in September 2022 and has responsibilities including agreeing frameworks and systems for data sharing and linking activities; improving national consistency data collections and agreeing minimum data specifications for initiatives under the National Agreement; agreeing appropriate measurement and monitoring methodologies, including performance indicators; and providing technical advice on data and outcomes activities relevant to initiatives under the National Agreement.

102 Of the 13 'high level outputs' specified in the National Agreement, one relates specifically to suicide prevention (the establishment of the National Suicide Prevention Office) and was completed prior to the commencement of the agreement.

103 National Suicide Prevention Office, *Development of the National Suicide Prevention Outcomes Framework,* NSPO, September 2024, available from https://www.mentalhealthcommission.gov.au/sites/default/files/2024-09/development-of-the-national-suicide-prevention-outcomes-framework.pdf [accessed 10 November 2025].

The National Suicide Prevention Office advised the ANAO in September 2025 that the framework would be oriented at the suicide prevention system, rather than individual suicide prevention measures, and that it would support governments to align performance indicators and monitoring activities for individual suicide prevention measures to outputs and impacts that, if achieved, may contribute to broader outcomes. The National Suicide Prevention Office noted in September 2024 that:

> There are many sources of evidence in the suicide prevention landscape, such as research about best practice, evaluations of programs, and monitoring of suicide trends. Each of these types of evidence are useful by themselves and vital to understanding the bigger picture of suicide prevention in Australia. The Outcomes Framework is intended to complement rather than duplicate these existing forms of evidence and insights.[104]

3.5 The National Agreement on Closing the Gap (Closing the Gap Agreement) establishes seven key indicators (divided into drivers and contextual information) to measure progress against target 14 (see paragraph 1.4). The Closing the Gap Data Development Plan (DDP) was established in 2022 to improve the quality, availability, and relevance of data used to monitor and support the implementation of the Closing the Gap Agreement. DHDA is responsible for progressing 10 data development actions to support the monitoring of target 14.[105] In June 2025, DHDA advised the National Indigenous Australians Agency (NIAA) that, of the 10 actions, four were 'stalled and not started'; four were 'delayed but continuing'; and two were complete.

Enterprise level performance indicators

3.6 The *Commonwealth Performance Framework* sets out requirements for Australian Government entities for measuring, assessing and publicly reporting on activities.[106]

3.7 Performance indicators for suicide prevention activities funded under Program 1.2 were included in DHDA's corporate plans (see paragraph 1.5) in 2021–22 and 2025–26 (see Table 3.1). DHDA stated in its 2022–23 Annual Report that the inclusion of performance indicators is dependent on whether an activity is assessed as 'material' based on the activity's funding level, public and stakeholder interest and impact on the portfolio. From 2022–23 to 2024–25, suicide prevention activities did not meet DHDA's materiality threshold. The 2025–26 performance indicator (number of service contacts for Universal Aftercare services) was selected because Aftercare was considered a major suicide prevention initiative and the only one for which data was available. The measure has no target. Internal documentation states that DHDA was continuing to consider the most appropriate performance indicator for its suicide prevention activities.

104 ibid.

105 Australian Government, *Data Development Plan 2022–2030*, Commonwealth of Australia, Canberra, p. 32, available from https://www.closingthegap.gov.au/resources [accessed 15 September 2025].

106 Department of Finance, *Commonwealth Performance Framework*, Finance, Canberra, 23 September 2024, available from https://www.finance.gov.au/government/managing-commonwealth-resources/planning-and-reporting/commonwealth-performance-framework [accessed 27 August 2025].

Table 3.1: Performance indicators for suicide prevention activities in DHDA corporate plans, 2021–22 to 2025–26

Year	Program 1.2 objective	Performance indicator[a]	Target
2021–22	Improve the mental health and wellbeing of all Australians, including a focus on suicide prevention.	Improve mental health outcomes for all Australians and combat suicide.	National Mental Health and Suicide Prevention Agreement agreed by November 2021 Establish a National Suicide Prevention Office
2022–23		–	–
2023–24		–	–
2024–25		–	–
2025–26	Support the mental health and wellbeing of all Australians by facilitating access to high quality, affordable, culturally appropriate and timely mental health and suicide prevention services.	Number of service contacts for Universal Aftercare services.	Program is demand driven[b]

Note a: Performance indicators not specifically related to suicide prevention not shown.

Note b: The target for the performance indicator differed between the 2025–26 Portfolio Budget Statements and Corporate Plan. The Portfolio Budget Statements target was for an 'annual increase' in the number of service contacts, whereas the Corporate Plan did not include a measurable target, stating: 'Given the inherent variability in demand, establishing a fixed performance target for service usage is not considered a practicable or meaningful measure of system performance'.

Source: ANAO analysis of DHDA's Corporate Plans 2021–22 to 2025–26.

3.8 ANAO audits of DHDA's 2022–23 and 2023–24 annual performance statements[107] found that the line of sight between DHDA's planning (Portfolio Budget Statements and corporate plans) and reporting documents (annual reports) was unclear, and the linkages between objectives, key activities and performance indicators were not complete.[108] DHDA accepted the 2022–23 finding and made improvements to the narrative and analysis included in its 2024–25 annual performance statements.[109] The 2024–25 annual performance statements included an indicator related to suicide prevention that was not identified in DHDA's corporate plan (the National Suicide Prevention Office's development of a national outcomes framework for suicide prevention (see paragraph 2.9)). The indicator was included in the National Mental Health Commission's Corporate

107 Auditor-General Report No. 16 2022–23, *Audits of the Annual Performance Statements of Australian Government Entities*, ANAO, Canberra, 12 February 2024, p. 88, available from www.anao.gov.au/work/performance-statements-audit/audits-of-the-annual-performance-statements-of-australian-government-entities-2022-23 [accessed 21 October 2025].
Auditor-General Report No. 25 2023–24, *Audits of the Annual Performance Statements of Australian Government Entities*, ANAO, Canberra, 19 February 2025, pp. 82–85, available from www.anao.gov.au/work/performance-statements-audit/performance-statements-auditing-the-commonwealth-outcomes-from-the-2023-24-audit-program [accessed 21 October 2025].

108 One of the objectives of the *Performance, Governance and Public Accountability Act 2013* is to require Australian Government entities to provide meaningful information on their performance to the Parliament and the public (section 5(c)(ii)). In that context, performance information is unlikely to be meaningful if it is not complete.

109 Department of Health, Disability and Ageing, *Annual Report 2024–25*, pp. 32–44, DHDA, Canberra, 4 November 2025, available from https://www.health.gov.au/resources/publications/department-of-health-disability-and-ageing-2024-25-annual-report [accessed 6 November 2025].

Plan 2024–25 and was one of two indicators transferred to DHDA following the transfer of the National Mental Health Commission to DHDA (see paragraph 1.6). As part of the 2024–25 performance statement audit, the ANAO advised DHDA in October 2025 that there remained further scope for DHDA to improve its performance statements to ensure they present a comprehensive picture of performance. The ANAO recommended DHDA continue to review and improve the selection of key activities and performance measures where appropriate, including in response to changes in priorities and functions.

Program level performance indicators

3.9 DHDA developed program level performance indicators for four of the six suicide prevention measures examined (Aftercare, DBST, NSPLSP and Postvention). Except for one measure (DBST), indicators focused on activities and outputs (Table 3.2).

Table 3.2: Assessment of program level performance indicators for suicide prevention measures, as at September 2025

Measure	Assessment summary	Assessment of performance indicators
Aftercare	▲	Of the eleven operational indicators under the National Agreement (see paragraph 3.3), two relate to Aftercare. The indicators are activity and output focused.
CCC	■	There are no program level performance indicators for CCC.
DBST[a]	◆	Of the eleven operational indicators under the National Agreement (see paragraph 3.3), eight relate to DBST. Additional performance indicators were under development, which focused on: service usage; impact; engagement experience; and workforce. The indicators are a mix of activity, output, and effectiveness indicators.
NSPLSP	▲	Performance indicators were established for the seven activity streams. A 2021 evaluation found program reporting was activity and output-focused and suggested DHDA introduce an outcomes-based performance framework to better communicate progress. When DHDA updated performance indicators to reflect new activity streams from July 2022, they remained activity and output focused. DHDA did not establish a performance framework. DHDA advised the ANAO in July 2025 that performance indicators are for monitoring grant activities rather than providing a view of program performance.
Postvention	▲	Of the eleven operational indicators under the National Agreement (see paragraph 3.3), one relates to Postvention.
TRISP	■	In the 2022–23 Budget, $0.9 million was allocated for TRISP data development and collection. In December 2022, PHN program guidance stated that DHDA would explore options for improving performance monitoring.[b] DHDA advised the ANAO in July 2025 that there were no mandated performance indicators for TRISP and that it had 'little visibility' over performance of TRISP activities. A new overarching PHN program performance and quality framework was published in December 2025.[c] The framework includes 27 indicators, including seven 'commissioning indicators', which are intended to provide a 'consistent set of indicator specifications that can be adapted to a range of current and future programs'.

Key: ◆ Established and include outcome-focused indicators (measuring efficiency and/or effectiveness)
▲ Established and activity and/or output focused, or under development
■ Not established

Note a: Trial sites for the DBST are not yet operational and the DBST model is still under development.

Note b: Department of Health, Disability and Ageing, Targeted Regional Initiatives for Suicide Prevention, available from https://www.health.gov.au/our-work/targeted-regional-initiatives-for-suicide-prevention [accessed 1 September 2025].

Note c: The ANAO has not assessed the PHN program performance and quality framework. (Department of Health, Disability and Ageing, *Primary Health Network Program – Performance Measurement and Reporting Framework 2025*, available from https://www.health.gov.au/resources/publications/primary-health-network-program-performance-measurement-and-reporting-framework-2025 [accessed 13 February 2026].)

Source: ANAO analysis of DHDA documentation.

Provider level performance indicators

3.10 The *Commonwealth Grants Rules and Principles 2024* (CGRPs) state that officials should establish appropriate performance indicators with which to evaluate the achievement of grant objectives, which should be included in grant agreements.[110] DHDA's *Performance Measurement and Reporting Framework* states that where multiple stakeholders contribute to a program, consideration needs to be given to how third parties will be held to account through an agreement for performance measurement, data collection and reporting.

3.11 Grant agreements for two of the six measures (DBST and TRISP) had no relevant performance indicators.[111] For Aftercare, CCC, NSPLSP and Postvention, performance indicators in grant agreements represented a mix of qualitative and quantitative indicators, however they lacked verifiability and reliability (Table 3.3) as all were reported on using third-party provider narrative-style self-assessments (see paragraph 3.27) and DHDA had not specified data sources or standard methodologies for any. Approximately half were input/operational activity indicators and half were output indicators; there were no efficiency or outcome (effectiveness) indicators. Two of 35 indicators had a target that could help determine whether goals had been achieved. DHDA advised the ANAO in November 2025 that 'it is important to note in a First Nations context, flexibility is important in how and what First Nations people and service providers provide in their reports to measure impact'.

110 Department of Finance, *Commonwealth Grants Rules and Principles 2024*, Finance, Canberra, October 2024, paragraphs 10.7–10.8, available from https://www.legislation.gov.au/F2024L00854/latest/text [accessed 10 September 2025].

111 TRISP funding was provided to PHNs to commission region-specific community-based suicide prevention activities under the PHN Program: Primary Mental Health Care (PMHC) Schedule. The Schedule had a set of performance indicators, but none were specific to TRISP.

Table 3.3: Assessment of provider level performance indicators for six suicide prevention measures, as at September 2025

Principles	Measures						Total	
	Aftercare	CCC	DBST	NSPLSP	Postvention	TRISP	**Total**	**% of total**
Total number of performance indicators	**1**	**16**	**0**	**12**	**6**	**0**	**35**	**100**
Relate directly to key activities or outputs[a]	0	8	N/A	12	4	N/A	**24**	**69**
Reliable and verifiable, and free from bias	0	0	N/A	0	0	N/A	**0**	**0**
Have targets	0	2	N/A	0	0	N/A	**2**	**6**
Comprise qualitative and quantitative indicators								
Qualitative	1	12	N/A	2	2	N/A	**17**	**49**
Quantitative	0	4	N/A	9	0	N/A	**13**	**37**
Both	0	0	N/A	1	4	N/A	**5**	**14**
Include output, efficiency and effectiveness indicators								
Input or operational activity indicator	1	11	N/A	2	2	N/A	**16**	**46**
Output indicator	0	5	N/A	10	4	N/A	**19**	**54**
Efficiency indicator	0	0	N/A	0	0	N/A	**0**	**0**
Effectiveness indicator	0	0	N/A	0	0	N/A	**0**	**0**

Note a: Performance indicators assessed as 'relate directly' are indicators that relate to a key activity or output in the relevant (suicide prevention measure) program logic. Indicators that measure compliance with grant agreements or project milestones were not considered as relating directly to a purpose or key activity.

Source: ANAO analysis of DHDA documentation.

Recommendation no. 5

3.12 The Department of Health, Disability and Ageing ensure that funding agreements for suicide prevention measures include provider performance indicators to assist in monitoring provider performance and evaluating whether grant program outcomes have been achieved.

Department of Health, Disability and Ageing response: *Agreed*

3.13 *The Department of Health, Disability and Ageing (the department) will strengthen internal controls within the Mental Health and Suicide Prevention Division to embed performance indicators in funding agreements for suicide prevention measures.*

Have suicide prevention activities, outputs and outcomes been appropriately measured, monitored, evaluated and reported?

DHDA has established arrangements for monitoring and reporting on suicide prevention measures at the agreement and enterprise levels. Arrangements at the program level are largely incomplete and arrangements at the provider level focus on compliance. In practice, DHDA's monitoring and reporting at the agreement and enterprise level does not provide insight into the achievement of outcomes. DHDA did not monitor or report on program-level performance for the six suicide prevention measures examined. Provider-level performance information was collected but not verified. DHDA evaluated or was evaluating all six measures. Completed evaluations showed some evidence that short-term outcomes were being achieved but identified a lack of fit-for-purpose performance data. DHDA did not publish evaluation findings.

Monitoring and reporting of suicide prevention measures

Agreement level monitoring and reporting

National Mental Health and Suicide Prevention Agreement

3.14 The parties to the National Agreement are required to prepare annual jurisdictional performance reports by 31 August each year that provide information about progress against key deliverables (including three suicide prevention measures: Aftercare, DBST, and Postvention) and implementation plans.

3.15 As at January 2026, jurisdictional performance reports had been finalised for all jurisdictions for 2022–23 and 2023–24. The jurisdictional performance reports in 2022–23 did not include reporting against the 11 'operational performance' indicators[112] (see paragraph 3.3) but did in 2023–24. In total across the states and territories, the 11 performance indicators resulted in 39 reported results. Of these, 35 were reported as 'not applicable'; three were reported as 'not met'; and one was reported as 'met' (Table 3.4).[113] Most performance indicators were reported as

112 The 2022–23 jurisdictional performance reports stated 'minimum data specifications have yet to be officially agreed by all states and territories' and 'work is currently underway to develop Key Performance Indicators (KPIs) under the National Agreement. KPIs for all operational services will likely be reported on in the next reporting period'.

113 In the 2023–24 reporting period no DBST trial sites were operational.

'not applicable' because the indicators related to evaluations that were not completed or, in the case of DBST, because services were not operational.

Table 3.4: 'Operational' indicator results in jurisdictional performance reports, 2023–24

Operational indicator status	Number of reported results from 11 operational indicators								
	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	**Total**
Not applicable	2	8	3	8	6	1	6	1	**35**
Met	0	0	0	0	0	1	0	0	**1**
Not met	0	1	0	1	0	0	0	1	**3**
Total	**2**	**9**	**3**	**9**	**6**	**2**	**6**	**2**	**39**

Source: ANAO analysis of DHDA documentation.

3.16 In addition to reporting against operational performance indicators, jurisdictional progress reports included a self-assessment of progress implementing initiatives specified in bilateral schedules. Jurisdictional progress reports for 2023–24 assessed that, in most jurisdictions, the three suicide prevention measures were 'partially progressed' or 'well progressed'.[114]

3.17 Jurisdictional reports are required to be consolidated into a national progress report that is provided to Australian and state/territory health and mental health ministers by 30 November each year and published within three months of completion. The National Mental Health Commission is responsible for developing the national progress report. Reporting of operational and outcome performance indicator data has been incomplete in national progress reports.

- 2022–23 national progress report — The 2022–23 national progress report included progress on National Agreement outputs, implementation of initiatives specified in bilateral schedules and whole-of-government deliverables (see paragraph 2.11) but omitted results of operational and outcome performance indicators because the development of the outcome indicators was not finalised (see paragraph 3.3) and the operational indicators were not collected from jurisdictions (see paragraph 3.15). In a paper prepared to support health ministers' consideration of the national report, DHDA stated that the 'full' progress report was intended for government only due to it being lengthy and the detail allowing for comparisons across jurisdictions. DHDA sought agreement to publish a summary report. The summary report omitted key performance details (including updates on initiatives, case studies, survey responses and the status of jurisdictional implementation plans) and focused on highlighting achievements. The health ministers endorsed the reports in August 2024 and the summary report was published on the National Mental Health Commission's website in December 2024.[115]

114 There were four possible ratings: 'yet to commence' (planning or implementation has not yet commenced); 'partially progressed' (planning and implementation underway, some aspects yet to be determined); 'well progressed' (planning complete, establishment of service has commenced); and 'complete' (service established, with ongoing monitoring and reporting required).

115 National Mental Health Commission, *National Mental Health and Suicide Prevention Agreement 2022–2023 – Annual National Progress Report Summary*, NMHC, December 2024, available from https://www.mentalhealthcommission.gov.au/publications/national-mental-health-and-suicide-prevention-agreement-2022-2023-annual-national-progress-report-summary [accessed 18 September 2025].

- 2023–24 national progress report — The draft 2023–24 report did not include results of the operational indicators, and included 12 of the 23 outcome indicators (including one of the three suicide prevention outcome indicators). The draft report stated that the National Mental Health Commission had not included jurisdictions' operational performance indicator data as many indicators were reported as 'not applicable', and that indicators were output based or were not 'traditional' performance indicators (see paragraph 3.15). As stated in paragraph 3.3, three 'outcome' indicators are specifically related to the outcome of reducing suicide and self-harm. For the one suicide prevention outcome indicator included, which measures post-discharge community mental health care, the draft report stated that in 2022–23, 76.2 per cent of separations from public sector acute hospital services had a follow-up community care service contact, in which the consumer participated, in the seven days after the hospital stay.[116] As at September 2025, the report was not published.

3.18 There was no evidence that the national progress reports were used to inform program improvements. The Productivity Commission's October 2025 report into the National Agreement (see paragraph 1.13) stated that, while eight of the agreement's 13 outputs had been delivered, there was insufficient information to assess progress of all initiatives included in the bilateral schedules. The report stated there were significant data gaps, including a lack of current data on outcomes achieved, and that the delay in reporting and lack of public reporting had made it difficult to assess progress against the National Agreement's commitments, including whether there had been a realisation of a whole-of-government approach to suicide prevention activities.[117] A theme in written contributions to this audit (see paragraph 1.20) related to limited transparency over the expenditure of funds allocated under the National Agreement.

3.19 The Productivity Commission's October 2025 report stated that, since the National Agreement was signed, there had been no change in the suicide rate and anecdotal evidence of an increase in rates of distress; and Aboriginal and Torres Strait Islander social and emotional wellbeing did not appear to have improved, with Aboriginal and Torres Strait Islander suicide rates worsening, noting there was limited up-to-date data available.[118]

National Agreement on Closing the Gap

3.20 Parties under the Closing the Gap Agreement are required to monitor and report on the actions being taken to achieve the priority reforms, outcomes and targets in Closing the Gap annual reports.[119] The NIAA is responsible for preparing the Australian Government implementation plans and annual reports. DHDA provides information to the NIAA on activities, timeframes and outputs relevant to output 14 and target 14 (see paragraph 1.4).

116 The proportion of separations that had a follow-up contact within seven days increased from 60.6 per cent in 2012–13 to 76.2 per cent in 2022–23. (Australian Institute of Health and Welfare, 'Performance indicators', available from https://www.aihw.gov.au/mental-health/monitoring/performance-indicators [accessed 1 December 2025].

117 Productivity Commission, *Mental Health and Suicide Prevention Agreement Review, Inquiry Report*, Productivity Commission, 16 October 2025, available from https://www.pc.gov.au/inquiries-and-research/mental-health-review/report/ [accessed 12 November 2025].

118 ibid.

119 Australian Government, *Closing the Gap*: *Implementation Plans,* Commonwealth of Australia, Canberra, available from: https://www.closingthegap.gov.au/implementation-plans [accessed 22 September 2025].

3.21 Since 2022, the Australian Government has published implementation plans that set out the alignment of policies and programs to the Closing the Gap Agreement and planned actions to achieve the priority reforms and socio-economic outcomes.[120] The Australian Government has published annual reports to demonstrate delivery of the implementation plans.[121] Three of the six suicide prevention measures examined were included in at least one implementation plan or report (CCC, NSPLSP and TRISP). Content focused on funding allocated to establish the measures and program implementation updates, and did not report on activities or outcomes. Overall, the Australian Government implementation plans and annual reports from 2022–23 to 2024–25 did not provide meaningful information about progress against actions and commitments for the three measures, in part due to inconsistencies in the format of the plans and reports and a lack of clarity and consistency in the description of actions, commitments and progress achieved. For example, one measure (TRISP) was reported in the 2023 implementation plan as a 'new' action with an expected completion date of June 2024; as an 'underway' action in the 2023 annual report with an expected completion date of June 2025; and as a 'new' commitment in the 2024 implementation plan. It was not reported in the combined 2024 annual report or 2025 implementation plan.

3.22 A March 2025 update to the Closing the Gap Information Repository (see paragraph 1.6) reported that progress against target 14 was not on track and was worsening. A July 2025 update on a supporting indicator[122] to target 14 reported that between 2018–19 and 2022–23, the rate of intentional self-harm hospitalisation among Aboriginal and Torres Strait Islander people decreased by 9.1 per cent for males and 15.8 per cent for females.[123]

Enterprise level reporting

3.23 Section 16EA of the Public Governance, Performance and Accountability Rule 2014 (PGPA Rule) sets out requirements for annual performance statements for an Australian Government entity.[124] In its 2021–22 Annual Report, DHDA reported on the in-principle endorsement of the National Agreement and the establishment of the National Suicide Prevention Office. As there were no enterprise-level performance indicators for suicide prevention in 2022–23 or 2023–24 (see Table 3.1), annual reports in those years contained no performance information about DHDA's work in this area. In its 2024–25 Annual Report, although no performance indicators were included in the 2024–25 Corporate Plan, DHDA reported on the performance indicators that were included in the National Mental Health Commission's Corporate Plan 2024–25, one of which related to suicide

120 National Indigenous Australians Agency, *Closing the Gap*, NIAA, Canberra, available from https://www.niaa.gov.au/our-work/closing-gap [accessed 22 September 2025].

121 Australian Government, *Commonwealth Closing the Gap 2024 Annual Report and 2025 Implementation Plan*, Commonwealth of Australia, Canberra, 10 February 2025, available from https://www.niaa.gov.au/resource-centre/commonwealth-closing-gap-2024-annual-report-and-2025-implementation-plan [accessed 22 September 2025].

122 In addition to socio-economic outcomes and targets, the Closing the Gap Agreement includes supporting indicators, which are intended to provide greater understanding of and insight into how governments are tracking against the outcomes and targets.

123 Productivity Commission, *Closing the Gap Information Repository — Socio-economic outcome area 14*, Productivity Commission, Canberra, available from https://www.pc.gov.au/closing-the-gap-data/dashboard/se/outcome-area14 [accessed 2 December 2025].

124 Department of Finance, *Resource Management Guide No.131*: *Developing good performance information*, Finance, Canberra, 8 August 2025, available from https://www.finance.gov.au/government/managing-commonwealth-resources/developing-performance-measures-rmg--131 [accessed 27 August 2025].

prevention (see paragraph 3.8).[125] The annual report stated that the performance indicator 'Design phase of the National Suicide Prevention Outcomes Framework to be completed 30 June 2025' was 'achieved' on the basis that a paper describing the planned approach to the outcomes framework (see paragraph 2.9) was published in September 2024. The annual report stated that consultation to develop components of the outcomes framework was ongoing as at 30 June 2025.[126] There was no performance indicator related to the outcomes framework in DHDA's 2025–26 Corporate Plan (see Table 3.1).

Program level monitoring and reporting

3.24 DHDA has two committees with responsibilities that include monitoring the achievement of objectives and outcomes of suicide prevention measures (Table 3.5).

Table 3.5: Committees with responsibility for monitoring suicide prevention measures

Role	Membership	Required meeting frequency
Delivery Committee		
• To provide oversight, advice, and assurance on the effective implementation of tier 1 projects[a] and government initiatives.[b] • To report to DHDA's Executive Committee on DHDA's portfolio of government initiatives and tier 1 projects.	• Chaired by Deputy Secretary, Interim Australian Centre for Disease Control • Membership comprises two deputy secretaries and selected senior executive service (SES) Band 2 and 1 officials	Every 6–8 weeks
Mental Health and Suicide Prevention Division (MHSPD) Program Governance Board		
• To provide strategic oversight and performance monitoring of government initiatives and projects managed by MHSPD. Review and approval of project documentation is limited to tier 1 projects.	• Chaired by First Assistant Secretary, MHSPD • Membership comprises of all MHSPD SES officials	Monthly

Note a: DHDA's Project Management Framework (July 2025) categorises projects into three tiers, based on attributes including budget, complexity, risk and impact, which determine the governance, documentation and assurance requirements for the project: tier 1 — high complexity; tier 2 — medium complexity; and tier 3 — low complexity. The Delivery Committee reviews or provides assurance over tier 2 and 3 projects if these are escalated to it.

Note b: Government initiatives include election commitments, budget measures and ministerial announcements.

Source: ANAO analysis of DHDA documentation.

3.25 Between July 2022 and June 2025, reporting to both committees consisted of updates on milestone progress. Neither committee monitored the performance of suicide prevention measures. DHDA advised the ANAO in July 2025 that it did not undertake assurance activities or

125 Department of Health, Disability and Ageing, *Budget 2024–25: Health Portfolio Additional Estimates Statements 2024–25*, DHDA, Canberra, 5 February 2025, p. 47, available from www.health.gov.au/resources/publications/budget-2024-25-health-portfolio-additional-estimates-statements [accessed 24 September 2025].

126 Department of Health, Disability and Ageing, *Annual Report 2024–25*, DHDA, Canberra, 4 November 2025, pp. 43–44, available from https://www.health.gov.au/resources/publications/department-of-health-disability-and-ageing-2024-25-annual-report [accessed 6 November 2025].

aggregate provider-level performance information to arrive at an assessment of performance at the overall program level, other than periodic program evaluations (see paragraph 3.32).

3.26 In June 2023, DHDA's Program Assurance Committee[127] received an update from the MHSPD, which stated that 'the majority of mental health and suicide prevention investment is well-targeted, aligned with Government priorities and is achieving outcomes'. The update did not provide information on the performance of individual measures or further evidence or information to support the overall conclusion. In March 2024, the Program Assurance Committee received a report from the MHSPD on implementation of the National Agreement and assurance arrangements. The update did not provide information on the achievement of National Agreement outcomes and noted that doing so was challenging due to the lack of an agreed program logic and under-developed data frameworks. The Program Assurance Committee requested that a program logic be developed to provide a strategic basis for reporting. A program logic was developed and endorsed by the committee in July 2024.

Provider level monitoring and reporting

3.27 Arrangements for monitoring provider performance are specified in grant agreements for all six measures. Providers are required to submit annual activity work plans (AWP) and submit narrative-style performance reports every six or 12 months.[128] Performance reports are required to include updates on implementation of activities in the approved AWP and self-assessment against performance indicators, where these are specified in grant agreements. For the four measures where performance indicators are specified in grant agreements (see paragraph 3.11), DHDA collected provider performance reports, which included reporting against performance indicators. DHDA does not verify reported performance information.

3.28 As stated at paragraph 3.4, the National Suicide Prevention Outcomes Framework under development is intended to complement and not replace existing forms and evidence and insights, and could provide a useful reference to inform DHDA's program-specific outcomes monitoring.

127 The Program Assurance Committee ceased in March 2024 and was replaced by the Delivery Committee.

128 A review by KPMG (June 2020) found that six monthly reporting, as was required at the time, was burdensome for PHNs and offered little value to DHDA. KPMG recommended DHDA simplify reporting and remove the requirement. As at September 2025, as trial sites for the DBST are not yet operational and the DBST model is still under development, reporting for DBST has not commenced.

Recommendation no. 6

3.29 The Department of Health, Disability and Ageing develop and publish performance monitoring and reporting framework(s) for suicide prevention measures, including arrangements for regular outcome reporting on specific suicide prevention measures to relevant oversight committees and improved public transparency, which could be informed by the National Suicide Prevention Outcomes Framework (once developed).

Department of Health, Disability and Ageing response: *Agreed in principle*

3.30 *The Department of Health, Disability and Ageing (department) agrees with the intent of the recommendation, but notes that further work and consideration is needed to identify the appropriate level and number of framework(s) for suicide prevention measures, and that the National Suicide Prevention Outcomes Framework is not yet finalised.*

3.31 *The department will seek a decision of government on the publication of these frameworks.*

Evaluation of suicide prevention measures

3.32 Between May 2023 and September 2024, DHDA commissioned four evaluations, which covered all six measures. DHDA developed evaluation plans/frameworks for two of the six measures (NSPLSP and TRISP) prior to commissioning the evaluations. Evaluation plans/frameworks were contract deliverables for the other four measures (Table 3.6).

Table 3.6: Evaluations of suicide prevention measures, as at September 2025

Measure	Date measure commenced	Date commissioned	Date plan delivered (due)	Date final report delivered (due)	Evaluator	Value of contract
CCC	April 2022	April 2024[a]	July 2024	June 2025	Inside Policy Pty Ltd	$2,108,920
NSPLSP	July 2022[b]	May 2023[c]	N/A[d]	September 2025	Australian Health Care Associates Pty Ltd	$1,493,255
TRISP	July 2022	October 2023[e]	N/A[f]	February 2024	KPMG Australia	$462,161
National Agreement measures	July 2022 (Postvention) May 2023 (Aftercare and DBST)	September 2024[g]	(October 2025)	(December 2026)	ARTD Pty Ltd	$2,879,238
Total						**$6,943,574**

Note a: AusTender Contract Notice number CN4045407-A1.

Note b: This date refers to the commencement of NSPLSP grant agreements for the period from July 2022 to June 2025.

Note c: AusTender Contract Notice number CN3965752-A1.
Note d: An evaluation plan was developed by DHDA in February 2023.
Note e: AusTender Contract Notice number CN3993216-A1.
Note f: An evaluation plan was developed by DHDA in March 2023.
Note g: AusTender Contract Notice number CN4095375.
Source: ANAO analysis of DHDA documentation.

3.33 As at September 2025, evaluations were finalised for three measures (CCC, NSPLSP and TRISP). Evaluations of Aftercare, DBST and Postvention were in progress (Table 3.6).

- CCC — The evaluation found that there was early evidence of positive outcomes and that, overall: supports available through CCC were accessible; activity streams were enabling Aboriginal community-led suicide prevention and aftercare; and the design and delivery of CCC was appropriate. The evaluation noted the importance of the funding and authorising environment created by DHDA and the National Aboriginal Community Controlled Health Organisation (NACCHO) in the measure's success.
- NSPLSP — The evaluation found that: the NSPLSP was making a meaningful contribution to sector leadership, whole-of-population and targeted supports, and community engagement in suicide prevention; activity streams had generally achieved expected short-term outcomes, although there were challenges in effectively measuring the impact of discrete activities; and there were opportunities to improve program design, funding, monitoring and coordination to align with recent policy and sector developments and better meet the needs of the sector and the Australian population. The evaluation found that progress, and the NSPLSP itself, was 'invisible' to stakeholders due to a lack of transparency and communication.
- TRISP — The evaluation found that: it was too soon to have realised medium to long-term outcomes. Implementation progress and integration of lived experience varied across PHNs; challenges and barriers included recruiting and retaining regional coordinators and duplication with other measures; short-term funding significantly impacted activity commissioning; and data was not reported nationally in a meaningful way.

3.34 The time between the commencement of the measures and the development or delivery of evaluation plans was between seven and 38 months. Establishing evaluation plans during the implementation phase of a program hampers the ability to generate robust evaluation data (including from grant agreement data collection and reporting requirements for third party providers). The evaluations identified a lack of fit-for-purpose performance data, limiting the ability to evaluate if the suicide prevention measures were meeting objectives and outcomes (Appendix 5).

3.35 The *Commonwealth Evaluation Policy* advises that evaluations should be transparent by default unless there are appropriate reasons not to be; and evaluation findings should be provided to appropriate stakeholders.[129] The National Agreement includes commitments to improve

129 The Department of the Treasury, *Commonwealth Evaluation Policy,* Treasury, Canberra, December 2021, available from https://evaluation.treasury.gov.au/about/commonwealth-evaluation-policy [accessed 18 September 2025].

transparency and reporting to support continuous improvement.[130] As at September 2025, DHDA had not published the evaluation reports for CCC and TRISP or shared the findings with stakeholders. DHDA did not publish the 2021 evaluation of the NSPLSP. In November 2021, DHDA released a redacted version of the report in response to a freedom of information request and published a 'research summary brief'.[131]

Opportunity for improvement

3.36 DHDA could identify evaluation questions and related performance indicators and data sources during the development of suicide prevention measures and prior to implementation to ensure robust data and evidence is collected to support effective evaluation, and publish evaluation reports in a timely manner.

Dr Caralee McLiesh PSM
Auditor-General

Canberra ACT
20 February 2026

130 Australian Government, *National Mental Health and Suicide Prevention Agreement*, Commonwealth of Australia, Canberra, March 2022, part 7, available from https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement [accessed 11 September 2025].

131 Department of Health, Disability and Ageing, *Evaluation and Review of the NSPLSP — Final Report*, DHDA, Canberra, April 2021, available from https://www.health.gov.au/resources/foi-disclosure-log/foi-request-2758-release-documents-inquiry-into-mental-health-and-suicide-prevention [accessed 15 September 2025].
Department of Health, Disability and Ageing, *Evaluation and review of the NSPLSP — Research summary brief*, DHDA, Canberra, April 2021, available from https://www.health.gov.au/resources/publications/evaluation-and-review-of-the-national-suicide-prevention-leadership-and-support-program-nsplsp-research-summary-brief [accessed 25 September 2025].

Appendices

Appendix 1 Entity responses

Department of Health, Disability and Ageing

Australian Government
Department of Health, Disability and Ageing

Acting Secretary

Dr Caralee McLiesh PSM
Auditor-General for Australia
Australian National Audit Office
GPO Box 707
CANBERRA ACT 2601

Dear Dr McLiesh

Department of Health, Disability and Ageing's response to the Proposed Audit Report – *Suicide prevention policy development and monitoring*.

Thank you for providing the Australian National Audit Office's (ANAO) proposed report pursuant to section 19 of the *Auditor-General Act 1997* on the audit of the *Suicide prevention policy development and monitoring*. I appreciate the opportunity to respond to the report.

The Department of Health, Disability and Ageing (the department) acknowledges the findings in the report and agrees – either in full or in principle – with all recommendations. Elements of recommendations 2 and 4 sit outside the department's direct responsibilities for health system policy, and implementation will depend on agreement with, and support from, the Australian Government and relevant external stakeholders. The wording provided for the Summary Response and itemised responses to the recommendations can be found at Attachment A and Attachment B.

If you have any questions regarding the department's response please contact Aimee Reeves, acting Assistant Secretary, Assurance Branch on 0420 537 634.

Yours sincerely

Dr Liz Develin

2 February 2026

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National Aboriginal Community Controlled Health Organisation

12 February 2026

NACCHO acknowledges the reference to our Culture Care Connect program throughout the report extract.

Culture Care Connect

We note the reference to Culture Care Connect as an advisory arrangement funded under a grant agreement with NACCHO and that whilst it contributes to Priority reform 2 it is not a policy partnership. NACCHO agrees that CCC is not a policy partnership, it is a suicide prevention program funded by government.

While the arrangement may not meet the definition under the National Agreement of a formal partnership arrangement between DHDA and NACCHO, we believe that the Department has worked in partnership with NACCHO during the development and implementation of the program.

The department is a member of the CCC advisory committee. The advisory committee has significantly influenced program development and implementation, making key decisions in relation to the program framework. Additionally, the department supported NACCHO in the development of a site selection methodology and provided flexibility through the grant agreement to enable place-based delivery of a national program. This flexibility has meant that services have had the ability contextualise the national framework to respond to the needs of their community.

The department's understanding of the CCC program and its close working relationship with NACCHO further resulted in additional funding through the NSPLSP to support the adaptation and/or development of a community suicide awareness program. It is expected that this program will be embedded in the Culture Care Connect program, building community awareness and reducing stigma around suicide within our communities.

It is NACCHO's view that the nature of the relationship with DHDA in relation to CCC constitutes a strong partnership arrangement.

SEWB Policy Partnership

It is important to note that the NIAA *compiles* information to identify the number and nature of partnership arrangements. The assessment of partnerships and completion of the relevant template is generally undertaken by the members of the partnership, it is not undertaken by NIAA. Therefore, the assessment of functioning of the SEWBPP under the stocktake has been determined by its members. As above, members may consider the

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arrangement to be a partnership, whether or not it meets the technical requirements for partnership.

It is important to make a clear distinction between the different relationships between GDPSA and DHDA. GDPSA is funded to provide secretariat support to the SEWBPP, as noted earlier in the report. GDPSA is also separately funded by DHDA as a peak organisation. This relationship sits outside of the SEWBPP and should not be conflated with the work of the SEWBPP.

While we acknowledge that potential disharmony in this relationship relating to the review may impact the operations of the SEWBPP, this disharmony should not be directly attributed to the relationship between the two at the SEWBPP.

As Co-chairs of the SEWBPP, GDPSA and DHDA agreed a workplan for the provision of secretariat support. It is our understanding that GDPSA was responsible for secretariat functions and supporting the Aboriginal and Torres Strait Islander representatives. Both co-Chairs have responsibility for the effective functioning of the SEWBPP.

While the original workplan has not progressed as intended, both GDPSA and DHDA as co-Chairs, have had the opportunity to work closely on developing the agenda, setting the tone for each meeting and driving the development and implementation of the workplan and 3 year strategic plan with all partnership members. SEWBPP members received communication during 2025 that DHDA and GDPSA were working together on a review. This is an opportunity for both parties to build a stronger working relationship.

Kind regards,

Dr Dawn Casey PSM FAHA

Acting CEO

National Aboriginal Community Controlled Health Organisation

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Appendix 2 Improvements observed by the ANAO

1. The existence of independent external audit, and the accompanying potential for scrutiny improves performance. Improvements in administrative and management practices usually occur: in anticipation of ANAO audit activity; during an audit engagement; as interim findings are made; and/or after the audit has been completed and formal findings are communicated.

2. The Joint Committee of Public Accounts and Audit (JCPAA) has encouraged the ANAO to consider ways in which the ANAO could capture and describe some of these impacts. The ANAO's corporate plan states that the ANAO's annual performance statements will provide a narrative that will consider, amongst other matters, analysis of key improvements made by entities during a performance audit process based on information included in tabled performance audit reports.

3. Performance audits involve close engagement between the ANAO and the audited entity as well as other stakeholders involved in the program or activity being audited. Throughout the audit engagement, the ANAO outlines to the entity the preliminary audit findings, conclusions and potential audit recommendations. This ensures that final recommendations are appropriately targeted and encourages entities to take early remedial action on any identified matters during the course of an audit. Remedial actions entities may take during the audit include:

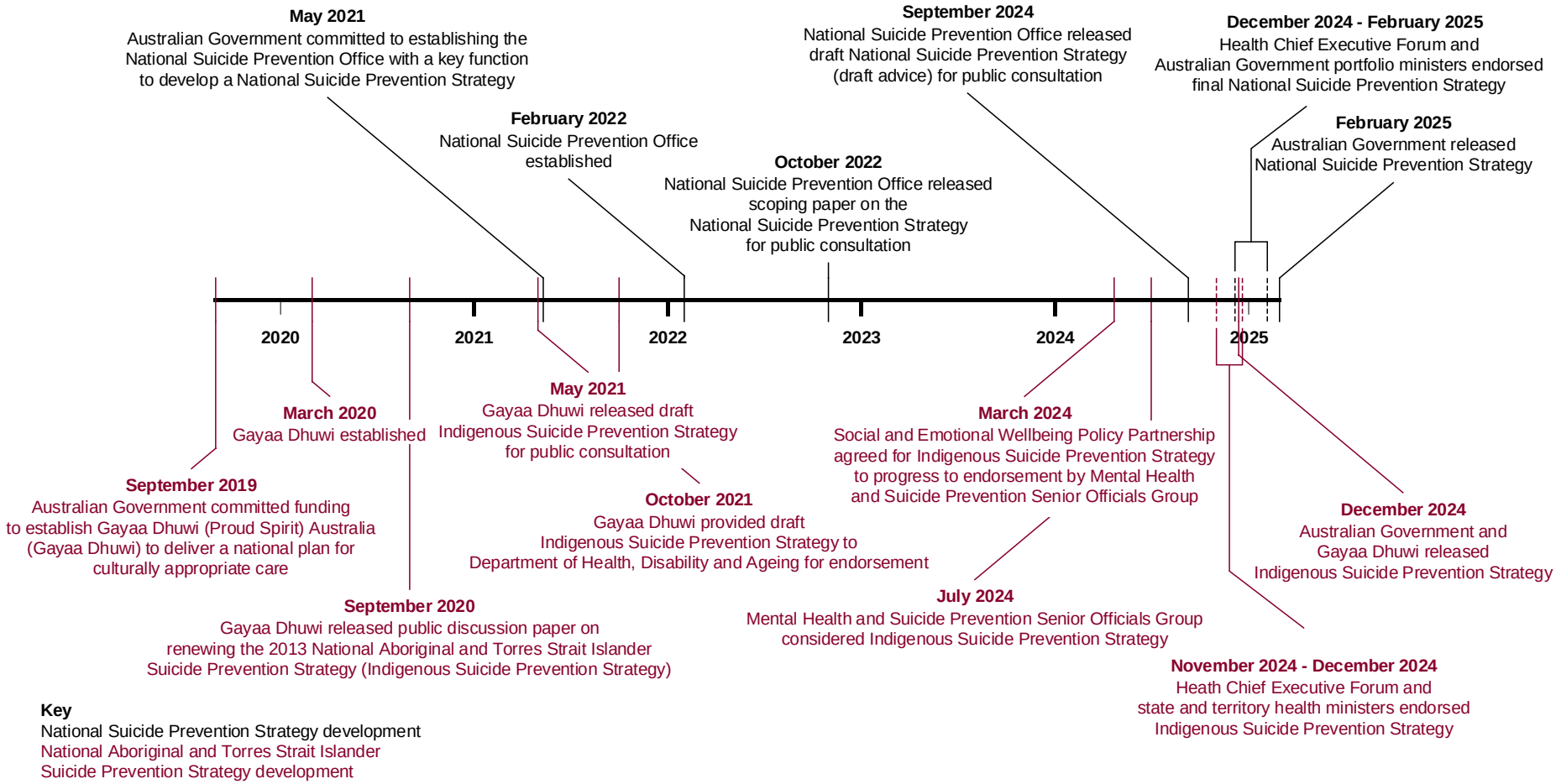
- strengthening governance arrangements;
- introducing or revising policies, strategies, guidelines or administrative processes; and
- initiating reviews or investigations.

4. In this context, the below actions were observed by the ANAO during the course of the audit. It is not clear whether these actions and/or the timing of these actions were planned in response to proposed or actual audit activity. The ANAO has not sought to obtain assurance over the source of these actions or whether they have been appropriately implemented.

- In February 2025, the Department of Health, Disability and Ageing (DHDA) assessed activities relating to suicide prevention as 'material' for the purposes of reporting against Program 1.2 Mental Health and Suicide Prevention in its annual performance statement. In established an enterprise-level performance indicator for suicide prevention activities and committed to 'continu[ing] to consider the most appropriate performance reporting for the department's suicide prevention program' (see paragraph 3.7).
- In April 2025, DHDA released its *Aboriginal and Torres Strait Islander Partnership and Engagement Framework,* which provides guidance to DHDA staff on planning, engaging, and partnering with the Aboriginal and Torres Strait Islander stakeholders to achieve genuine partnership (see paragraph 2.3).
- In June 2025, in response to the Australian Public Service Commission's Capability Review (2023), DHDA published its *Policy Playbook*. This document provides guidance to DHDA staff on developing high quality policy advice (see paragraph 2.3).
- In September 2025, DHDA drafted an 'initial version of the split of responsibilities' between DHDA and the National Suicide Prevention Office (see paragraph 2.6).

- In September 2025, DHDA invited Gayaa Dhuwi to respond to a request for tender for secretariat, administration and policy support for the Social and Emotional Wellbeing Policy Partnership in collaboration with DHDA, and to deliver enabling services to establish and manage a 'Small Initiatives' fund, until June 2026. A contract was finalised and commenced in January 2026 (see paragraph 2.60).
- In December 2025, the Social and Emotional Wellbeing Policy Partnership discussed an approach to revising its Agreement to Implement and developing a new strategic plan and workplan (see paragraph 2.70).
- In December 2025, DHDA published the Primary Health Network Program – Performance Measurement and Reporting Framework 2025 (see Table 3.2).

Appendix 3 Timeline for development of national strategies



Source: ANAO analysis of DHDA documentation.

Appendix 4 Assessment of Social and Emotional Wellbeing Policy Partnership

1. The Social and Emotional Wellbeing Policy Partnership (Policy Partnership) Agreement and its implementation in practice were assessed against the strong partnership elements in clauses 32 and 33 of the National Agreement on Closing the Gap (see paragraph 2.2) (Table A.1).

Table A.1: Social and Emotional Wellbeing Policy Partnership alignment with strong partnership elements

Clause	Description	Alignment of Policy Partnership Agreement	Alignment in practice
Accountable and representative			
32.a(i)	Aboriginal and Torres Strait Islander members are appointed by and accountable to Aboriginal and Torres Strait Islander peoples	▲ a	◆
32.a(ii)	Between up to three levels of government, where government representatives have negotiating and decision-making authority	◆	▲ b
32.a(iii)	Includes other parties as agreed by Aboriginal and Torres Strait Islander representatives and governments	▲ c	◆
Formal agreement			
32.b	Formal agreement is in place	◆	N/A
32.b(i)	… that includes roles, purpose, scope of shared decision-making, reporting, timeframes, monitoring, and dispute mechanisms	◆	N/A
32.b(ii)	Aboriginal and Torres Strait Islander parties can agree to the agenda	◆	◆
32.b(iii)	… is public and easily accessible	■ d	▲ e
Shared decision-making			
32.c(i)	Decision-making is shared and made by consensus with equal weight given to Aboriginal and Torres Strait Islander parties	◆	■ f
32.c(ii)	Matters can be understood by all parties	◆	■ g
32.c(iii)	Aboriginal and Torres Strait Islander representatives can speak without fear of reprisal	N/A	◆

Clause	Description	Alignment of Policy Partnership Agreement	Alignment in practice
32.c(iv)	A wide variety of Aboriginal and Torres Strait Islander groups can be heard	◆	Not assessed
32.c(v)	Self-determination is supported, lived experience is respected	Not assessed	◆
Funding			
33	Adequate funding is needed to support First Nations parties to be partners	◆	▲ h

Key: ◆ Largely or fully aligns with the strong partnership element ▲ Partly aligns with the strong partnership element ■ Does not align with the strong partnership element

Note a: There are no procedures in the Policy Partnership Agreement for the appointment of members other than in the event of a member missing three meetings.

Note b: In meetings with Policy Partnership members a consistent theme was that government members were often represented by proxies and were not able to commit to decisions in meetings. At each of the six meetings held as at September 2025, at least two of the nine government members were represented by proxies or were absent.

Note c: There is no guidance in the Policy Partnership Agreement in relation to agreement processes for other attendees, such as proxies, observers and secretariat or support staff.

Note d: There is no requirement in the Policy Partnership Agreement for the agreement to be made public.

Note e: The May 2023 Policy Partnership Agreement was published on the Department of Health, Disability and Ageing's (DHDA) website in June 2023. The Policy Partnership Agreement was amended in February 2025 to reflect new members and membership changes. As at September 2025, DHDA and no other party had published the February 2025 Policy Partnership Agreement.

Note f: The Policy Partnership does not have operating protocols which described how consensus would be achieved in practice. At meetings, concerns were raised by members about arrangements for shared decision-making (see paragraph 2.63). Policy Partnership members advised the ANAO that while decisions were made by consensus, the Policy Partnership had not been an effective body for shared decision-making between Aboriginal and Torres Strait Islander people and governments.

Note g: As at September 2025, meeting papers were not distributed at least one week ahead of each meeting for any of the six meetings. In November 2023, the Policy Partnership agreed that government members would circulate certain papers two weeks ahead of each meeting, which was not done. Several Policy Partnership members advised the ANAO that meeting papers were not circulated in sufficient time to enable members to prepare for meetings. Several members advised the volume and formatting of papers created challenges to parties understanding all matters.

Note h: In November 2022, Gayaa Dhuwi was funded through a procurement to provide secretariat and policy support for the Policy Partnership to June 2025. In December 2024, the Australian Government announced funding to extend the Policy Partnership for 2025–26. In September 2025, DHDA invited Gayaa Dhuwi to respond to a request for tender for secretariat, administration and policy support for the Policy Partnership in collaboration with DHDA, and to deliver enabling services to establish and manage a 'Small Initiatives' fund until June 2026.

Source: ANAO analysis.

Appendix 5 Evaluation findings relevant to performance information

1. Findings from the evaluations of three measures (Culture Care Connect (CCC), the National Suicide Prevention Leadership and Support Program (NSPLSP) and Targeted Regional Initiatives for Suicide Prevention (TRISP)) identified a lack of fit-for-purpose performance data, limiting the ability to inform progress against program objectives and outcomes (see paragraph 3.33) (Table A.2).

Table A.2: Summary of evaluation findings relevant to performance information

Measure	Relevant themes and findings	Relevant recommendations
CCC Report finalised June 2025	**Poor data capture:** • Limited evidence of information and data being gathered by CCC sites to support suicide prevention and service planning and enable future investment. **Resourcing and capacity constraints within CCC sites:** • Additional resourcing required to support program analysis and data management. **Need for improved reporting processes:** • Some CCC sites expressed the need for greater guidance on data to be collected and clear links to CCC reporting requirements.	Co-design of mechanisms for capturing and sharing the data and evidence on what works in CCC service provision.
NSPLSP Report finalised September 2025	**Inconsistent data focused on activities and outputs:** • Project data was not consistently reported over the evaluation period, most available data focused on activities and outputs, and reported data was likely to underestimate actual outputs. • The format and volume of information in performance reports varied, which complicated interpretation of performance at the activity and program level. **Gaps in reporting arrangements:** • The minimum data set used for reporting did not fully capture critical project activities, such as relationship building and collaboration. • Reporting arrangements lacked flexibility to fully capture the impact of projects and were not well suited to projects working with Aboriginal and Torres Strait Islander people. **Lack of feedback and guidance on reporting:** • Providers were uncertain about how reported performance information is used, by whom and why, and wanted greater guidance on reporting requirements and feedback on reported information.	• Additional guidance and feedback to providers on reporting requirements and how data is used. • Changes to reporting arrangements to reflect foundational activities and better convey project nature and impact. • Efforts to improve outcomes-based reporting should align with the National Suicide Prevention Outcomes Framework.[a]

Measure	Relevant themes and findings	Relevant recommendations
TRISP Report finalised February 2024	**Lack of data to assess program outcomes:** • Lack of measurable and fit-for-purpose outputs and outcomes data limited monitoring and evaluation. • Primary Health Network (PHN) reporting was focused on commissioning and delivery of services rather than outcomes. **Need for performance monitoring framework and improved reporting:** • There was a lack of specificity in agreement milestones and a limited TRISP reporting framework; • PHNs reported TRISP activities into broader PHN progress reports. Useable data and evidence in reports was minimal, with no capacity to differentiate TRISP activities or outcomes from other PHN activity. **Data capture mechanisms not fit for purpose:** • Service providers using TRISP funding were required to submit data via the Primary Mental Health Care Minimum Data Set (PMHC MDS) which is not useful for capturing community capacity and sustainability in suicide prevention, a core function of TRISP.[b]	• The Department of Health, Disability and Ageing (DHDA) implement a program data matrix for monitoring and evaluation purposes; and include the capture of qualitative and quantitative evidence or program outputs and outcomes. • DHDA conduct an outcomes evaluation to be completed in three years to measure benefits of the TRISP program over time.

Note a: The NSPLSP evaluation report did not include recommendations but included 'future considerations'.

Note b: The PMHC MDS is for PHNs and DHDA to monitor and report on the quantity and quality of service delivery, and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government. It primarily assesses individual-level outcomes and captures clinical-based activities. (DHDA, 'Primary Mental Health Care Minimum Data Set', available from https://pmhc-mds.com [accessed 24 September 2025]).

Source: ANAO analysis of DHDA documentation.