Submission to the Productivity Commission in response to The Mental Health and Suicide Prevention Agreement Review: Interim Report

Submission by The Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney and PREMISE Next Generation NHMRC Centre of Research Excellence in Prevention of Mental Illness and Substance Use, The University of Sydney

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About the Matilda Centre

The Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney is a multidisciplinary research centre committed to improving the health and wellbeing of people affected by co-occurring substance use and mental disorders. Established in 2018, the Matilda Centre for Research in Mental Health and Substance Use aims to generate innovative and workable solutions to address substance use and mental disorders, which are currently the leading global causes of burden and disease in young people. The centre is home to over 120 academics and research support staff. The work of the centre is guided by the Matilda Youth Advisory Board and in partnership with lived experience.

We work closely with research collaborators to share skills, synergise data and harness new technologies to develop and trial innovative prevention and early-intervention programs for co-occurring substance use and mental disorders.

We are committed to;

- bringing together globally recognised researchers with a shared commitment to the prevention, early intervention and treatment of mental and substance use disorders
- leading research to build the evidence base for a thriving and empowered younger generation
- engaging with decision-makers and people with lived experience to enact real change
- acting as a focal point and link between University of Sydney researchers, policy leaders and clinicians.

The Matilda Centre hosts the PREMISE Next Generation NHMRC Centre of Research Excellence in Prevention of Mental Illness and Substance Use. Funded in 2024 by the Australian National Health and Medical Research Council, PREMISE is our 3rd Centre of Research Excellence. It aims to provide a world-first synergy of the leading prevention research and translation programs in mental health and substance use and create the next breakthroughs in prevention.

Executive summary

The Matilda Centre and the PREMISE Next Generation Centre of Research Excellence thanks the Productivity Commission for the opportunity to provide feedback on the Interim report. We note the interim report finds progress towards the Agreement's intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal. We are encouraged by the draft recommendations including the calls for the release of the National Stigma and Discrimination Reduction Strategy and a renewed co-designed National Mental Health Strategy focused on improving collaboration across government bodies and the broader policy environment, with clear outcome measures and evaluation built in.

We are pleased to provide evidence in response to the information requests (4.1; 4.2) and provide input on the draft recommendations and key areas raised in the draft report.

In particular, the Matilda Centre and PREMISE Next Generation;

- ***strongly supports the call for an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug (AOD)*** use and mental ill health and suicide. Mental ill health, suicide and AOD issues frequently co-occur, share common risk factors, and interact. Therefore, greater investment in prevention and early intervention, along with ambitious structural reforms are essential to provide integrated mental health, AOD, suicide and self-harm prevention and treatment across different government services. The Matilda Centre appreciates the focus on building capacity of the mental health and suicide prevention workforce and providing support and appropriate clinical treatment to people with co-occurring alcohol and other drug use and mental ill health and suicidality. Also, investment of additional pathways, outside of traditional mental health and suicide services, is essential to support the many people who may not have access to, or present to, traditional services. However, we also suggest that tying alcohol and other drugs in with mental health and suicide prevention should focus on comorbidity. This would reduce the risk of overextending the resourcing and capacity of this agreement.

- ***strongly supports the draft recommendation that survey data be routinely collected*** (we suggest at least every 3 years), and a national consistent approach is implemented, including timely data sharing and encouraging data harmonisation practices across national surveys and other data-sets. Accurate estimates of prevalence, severity, functioning and service use are vital for enumerating the burden associated with mental health conditions, for generating policy responses and for planning models of health service delivery. The Matilda Centre are world recognised leaders in providing accurate and up to date analyses of data on the national prevalence, and treatment rates, for mental health disorders and co-occurring conditions. However, there are often many years (often decades) between surveys and other delays, leading to gaps in national prevalence measurements of up to 15 years. Timely responses to trends over time in mental health, suicide and drug use require increased long-term investment in regular data collection and analysis, as well as the ability to link data across national surveys and the health care system.

- ***genuine engagement and influence of people with living/lived experience.*** The involvement of people with lived/living experience of mental health conditions,

including those with psychosocial disabilities, peer workers and general consultants, in the development of strategy and policy is critical to ensure that policies and practices are relevant and effective. The Matilda Centre has implemented powerful and embedded models of research co-design, including the Youth Advisory Board which contribute significantly to the development and effectiveness of prevention and other programs. The Matilda Centre also hosts the Mental Health Think Tank chaired by Distinguished Professor Maree Teesson AC. The Mental Health Think Tank has issued a renewed call to action for increased investment and reform to prioritise a mentally healthy future following an examination of the investment to date of Government expenditure.

Key points:

- Development of a person-centred, integrated mental health system including provisions for co-occurring suicide, self-harm and/or alcohol and other drug issues.
- Better coordination across services, particularly mental health and AOD services.
- Affordable, accessible services that respond to people's needs.
- Release and implementation of the National Stigma and Discrimination Reduction Strategy.
- Co-design of the policy architecture of the next National Agreement including supported meaningful governance positions with clear objectives and implementation goals.
- Investment in workforce capacity building across the mental health, suicide and AOD sectors.
- National survey data on prevalence along with short- and long-term health outcomes should be routinely collected (at least every 3 years), and a national consistent approach is implemented, as well as co-ordinated, timely data sharing and harmonisation practices.
- Engagement with priority populations to co-develop the strategy including, but not limited to, Aboriginal and Torres Strait Islander peoples, lesbian, gay, bisexual, transgender and queer (LGBTQ+), people living in regional and rural communities.
- A focus on the impacts of trauma and childhood adversity, and how they overlap with mental health and suicide.
- Strengthening efforts for the prevention, early intervention, and treatment of mental health conditions among young people in particular.

The Matilda Centre would welcome further opportunities to provide further evidence and/or engage in discussions regarding the information provided in this submission.

Responses to information requests and draft recommendations.

In 2022 the National Mental Health and Suicide prevention agreement set out an ambitious plan to implement systemic, whole-of-government reforms that would improve mental health outcomes for all people living in Australia and progress the goal of zero lives lost to suicide. We note that the interim report finds that progress towards the Agreement's intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal.

We are encouraged by the draft recommendations and hope to see the next agreement deliver the ambition of a mental health system that is comprehensive, coordinated, whole of person-focused, and compassionate.

The renewed Strategy should also include increased investment in prevention, early intervention, and effective treatment and management of mental health conditions that are commensurate to their burden of disease. As highlighted in recommendation 4.1 and 4.2, it is vital that the renewed National Mental Health Strategy be co-designed with people who have living/lived experience of mental health conditions and their families, carers and support network. Along with inclusion, and investment of, family and carer support services in the next agreement (draft recommendation 4.5). There is clear evidence that people supporting or caring for someone with a mental health disorder experience poorer quality of life and are at higher risk of developing mental health and/or alcohol and drug disorders of their own (Birkeland et al., 2018; Di Sarno et al., 2021; Mardani et al., 2023). Therefore, providing better support, prevention, and early intervention for this high-risk group offers dual benefits: it helps prevent mental disorders among carers and enhances recovery outcomes for individuals experiencing mental health or related conditions.

We also support the draft recommendation (5.1) that a new schedule to strengthen Aboriginal and Torres Strait Islander social and emotional wellbeing and a schedule for suicide prevention (6.1) to support action under the new National Suicide Prevention Strategy.

Established governance roles for people with living and lived experience of mental health disorders (Recommendation 4.7) will help ensure the foundation of renewed Strategy is strengthened (Recommendation 4.2). However, these governance roles should utilise best practice principles for genuine meaningful engagement that is supportive and not tokenistic. The renewed Strategy should also include clear evaluation and outcome measures to ensure that meaningful change is occurring (Recommendation 4.15).

Detailed responses to certain recommendation and calls for information are provided below.

Draft recommendation 2.1. By the end of 2025, the Australian Government should publicly release The National Stigma and Discrimination Reduction Strategy

We strongly endorse recommendation 2.1 and call for the Australian Government to urgently release and implement the National Stigma and Discrimination reduction strategy. As noted in the Productivity Commission in the Interim Report (page 9),

stigma and discrimination continue to have a devastating effect on people with lived and living experience of mental ill health and suicide. Negative and stigmatising public attitudes towards people with mental health conditions is common in Australia, particularly towards those with complex mental health conditions such as psychosis, schizophrenia, and personality disorders (Earnshaw et al., 2025; Reavley et al., 2014). These negative attitudes lead to significant psychological distress and a reluctance to seek support among those with mental health and/or substance use issues (Cheetham et al., 2022; Kershaw et al., 2024). This strategy should be released and implemented as a priority.

It is also important to consider and address the impact of double stigma. As stigma towards people who use drugs is also common in Australia (Deen et al., 2021), people with co-occurring mental health and drug use-disorders often experience double stigma which creates additional barriers to help-seeking and treatment (Balhara et al., 2016; Evans-Lacko & Thornicroft, 2010; Hawke et al., 2025). This compounding effect of stigma has been found among health professionals as well as for people with co-occurring disorders through elevated self-stigma (Avery et al., 2013; Francis et al., 2020; Harnish et al., 2016).

Reducing the impact of stigma and discrimination will ultimately save lives through improved treatment seeking and access to support services, improved health and wellbeing outcomes, and reduced mental health and substance use burden, ensuring people can participate fully in their lives.

Draft recommendation 4.1. Developing a renewed National Mental Health Strategy

We strongly support recommendation 4.1 to develop a renewed National Mental Health Strategy to guide ambitious long term reform objectives over the coming decades. The renewed Strategy should have a clear vision, priorities and actions which are coordinated by the National Mental Health Commission and prioritise long-term goals to deliver sustainable, system-wide reform. Mental health is a life-long concern that intersects with education, employment, housing and justice, requiring a coordinated, cross-sectoral response. A forward-looking strategy enables the development of a skilled workforce, consistent service delivery and equitable access across regions. Short term implementation cycles within the National Mental Health Strategy will support ongoing evaluation and adaptation ensuring services are person-centred and responsive to emerging needs.

A renewed National Mental Health Strategy is essential to address the evolving mental health landscape in Australia, particularly for young people experiencing mental health and co-occurring conditions. High-level support for a genuine co-design process as demonstrated through numerous government funded Matilda Centre projects (e.g., *Cracks in the Ice*, *Consultation for the NSW framework for young people's health and wellbeing*) is critical to ensuring meaningful outcomes and clear evaluation measures (Champion et al., 2018; Kershaw et al., 2021; Rowe et al., 2024). This process needs a dedicated emphasis on the social determinants of mental health and consideration of the needs of priority groups including Aboriginal and Torres Strait Islander peoples, refugees, LGBTQ+ communities, people with disabilities, people living in rural and remote, and those experiencing financial stress. The strategy must be well-resourced, grounded in research and aligned with the Australian Government's *Measuring What Matters Framework* to ensure mental health is treated as a key indicator of national wellbeing (Australian Government, 2023; Teesson et al., 2025).

Australia's Mental Health Think Tank (2025) presents the case for embedding youth mental health into national policy priorities. Central to the statement is the Progress Report, which highlights critical gaps in mental health outcomes, service access and systemic support for young people. This evidence-based snapshot offers measurable indicators of current system performance and gaps, enabling policymakers to track progress and accountability. By integrating these insights, a National Mental Health Strategy could be responsive, and outcomes focused.

A renewed National Mental Health Strategy is essential to address the evolving mental health landscape in Australia, particularly for young people experiencing mental health and co-occurring conditions. High-level support for a genuine co-design process as demonstrated through numerous government funded Matilda Centre projects (e.g., *Cracks in the Ice*, *Consultation for the NSW framework for young people's health and wellbeing*) is critical to ensuring meaningful outcomes and clear evaluation measures (Champion et al., 2018; Kershaw et al., 2021; Rowe et al., 2024) This process needs a dedicated emphasis on the social determinants of mental health and consideration of the needs of priority groups including Aboriginal and Torres Strait Islander peoples, refugees, LGBTQ+ communities, people with disabilities, people living in rural and remote, and those experiencing financial stress. The strategy must be well-resourced, grounded in research and aligned with the Australian Government's *Measuring What Matters Framework* to ensure mental health is treated as a key indicator of national wellbeing (Australian Government, 2023; Teesson et al., 2025).

It is vital that affordable and accessible services that respond to people's mental health needs be available across Australia. This includes prevention, early intervention, treatment services and psychosocial support along with additional pathways including digital and non-digital options which meet people where they are. A dedicated focus on the social determinants of mental health for priority populations that often experience intersecting social risk factors this includes (but not limited to) First Nations peoples, refugees, asylum seekers and displaced persons, racial and ethnic minorities, lesbian, gay, bisexual, transgender and queer (LGBTQ+) groups is needed in the renewed National Mental Health Strategy.

Focus on positive mental health, provision of early intervention and prevention supports, and improving mental health and preventing suicide should be embedded across all levels of government, areas of responsibility, and portfolios, during service design and policy development.

RESPONSE TO INFORMATION REQUEST 4.1

Stakeholder view on the inclusion of an additional schedule in the next Agreement to address the co-occurrence of problematic alcohol and other drug (AOD) use, mental ill health, and suicide.

The Matilda Centre strongly recommends that an additional schedule to address the co-occurrence of problematic alcohol and other drug (AOD) use and mental ill health and/or suicide be included in the next agreement.

A schedule focused on co-occurrence of AOD, mental health and suicide is essential to reducing harm, addressing evidence and service gaps, and improving health and wellbeing. The schedule should take a strengths-based harm reduction approach,

informed by people with lived and living experience (and their carers), to educate and empower individuals and communities to make informed decisions and minimise AOD related harms including impacts on mental health, as well as AOD education and prevention

Co-occurring conditions are common, not the exception

As acknowledged in the interim report, alcohol and other drug use is integrally linked with mental health and/or suicide (Fisher et al., 2020). Alcohol and/or drug use disorders, depression, suicide, anxiety, and psychosis frequently co-occur, share common risk factors, and interact. An integrated approach to substance use, mental ill health and suicide research, prevention and treatment is critical (Lawrence et al., 2015; McGorry et al., 2011; Sunderland et al., 2025; Werner-Seidler et al., 2017). The Matilda Centre supports ambitious structural reforms to integrate mental health, substance use, suicide and self-harm prevention and treatment across different government services. The revised strategy should include self-harm, recognising the substantial overlap between suicide attempts and non-suicidal self-injury. Instances of suicidal thoughts, planning, attempts, and self-harm without suicidal intent all represent critical points for intervention that could contribute to reducing overall suicide rates (Teesson et al., 2025).

The most recent analysis of the 2020–22 Australian National Survey of Mental Health and Wellbeing showed that mental and substance use disorders commonly co-occur in the Australian population. Close to one in three (29.1%) Australian adults who meet diagnostic criteria for a lifetime mood or anxiety disorder also meet criteria for a lifetime diagnosis of a substance use disorder. Inversely, close to one half (47%) of Australian adults who meet diagnostic criteria for a lifetime diagnosis of a substance use disorder also meet criteria for a lifetime diagnosis of a mood or anxiety disorder. Those with higher levels of psychological distress, higher service use and higher rates of suicidality were at greater odds of experiencing co-occurring disorders, with dose–response relationships appearing between number of co-occurring disorders and the experience of distress, service use and suicidality (Sunderland et al., 2025). Overall, as noted by Sunderland et al. (2025) the experience of co-occurring disorders is endemic.

Specific considerations for co-occurring AOD conditions

As outlined in a review commissioned by Suicide Prevention Australia:

"AOD use has a complex and multidimensional role in the development of suicidal thoughts and behaviours. The literature demonstrated a consistently robust relationship between AOD use and risk of suicidality. The presence of chronic AOD use (incl. AOD use disorders) and acute AOD intoxication, were both implicated in increased risk for suicide and were common amongst people who had attempted and/or died by suicide. Problematic AOD use appeared to interact with other life stressors and contextual factors to influence suicide risk, including sex, age, minority or Indigenous/First Nations identity, and co-occurring mental health conditions..." (Fisher et al., 2020, p. 6).

Similar to the considerations around creation of a separate suicide prevention schedule, whilst there is significant overlap between mental ill-health, AOD use and suicide – there are also distinct elements that need to be considered for AOD use.

There is considerable unmet need for AOD treatment in Australia with only 30-48% of those who would benefit from treatment able to access it (Ritter & O'Reilly, 2025). On average Australians live with substance use problems for 11 years before their initial contact with treatment services (Birrell et al., 2025). This delay represents a substantial period of time within which a person may develop secondary physical and mental health disorders, or in which existing co-occurring conditions may worsen. For some, this delay may prove fatal. There is no doubt that the inability of the AOD sector to meet demand is due to the chronic and severe underfunding of AOD services in both the public and non-government sectors.

The tragedy of this situation is further amplified by the fact that Australia leads the way with respect to research examining the integrated treatment of AOD and mental health conditions. Evidence-based early intervention and treatment programs exist, yet access to these cutting-edge treatments is limited. For example, Australia conducted a world first clinical trial demonstrating the efficacy of an integrated treatment for post-traumatic stress disorder (PTSD) and substance use disorder, two chronic and debilitating conditions that frequently co-occur, and are frequently accompanied by suicidality (Mills et al., 2012). Since this time, the efficacy of this intervention, called COPE (Back et al., 2015), has been demonstrated in a further four randomised controlled trials internationally, and further implementation trials (Back et al., 2024). It is the only integrated treatment recognised by the American Psychological Association for the treatment of this co-occurring condition. Further Australian research has examined a modified version of this treatment as an early intervention to be delivered during adolescence when these conditions typically have their onset (Schollar-Root et al., 2022). Despite this strong evidence-base COPE is not available in routine clinical practice in Australia, as there are limited mechanisms in place to support the translation of research into practice. Implementation of programs such as these is essential to the delivery of integrated, person-centred care and to ensuring a collaborative approach that addresses service gaps.

Existing co-morbidity treatments and guidelines should be utilised

Since the 2007 NSMWHB, there have been significant advances in treatment of co-occurring mental and substance use disorders (Marel et al., 2022). The Australian Comorbidity Guidelines and associated training materials are a government-supported initiative to increase workforce capacity to provide treatment and care for people experiencing co-occurring mental and substance use conditions, including those with extensive trauma histories (Marel et al., 2022). These outstanding practice initiatives to address co-occurring conditions have not been matched by a clear policy focus. The last National Comorbidity Initiative was over 20 years ago (Australian Institute of Health Welfare, 2005). The prevalence of co-occurring disorders in Australia and elsewhere has not declined since the previous survey conducted in 2007 (Halladay et al., 2024). In fact, rates for those aged 16–24 years have increased by 44% (Sunderland et al., 2025). Further, global and local research shows that mental health and substance use disorders commonly co-occur with physical health conditions (Halstead et al., 2024; Momen et al., 2020). This is a national imperative.

Despite the clear need, most mental health and suicide prevention initiatives do not include AOD use as a priority. There remains a significant and critical gap in addressing AOD use within the context of mental health and suicide prevention in Australia. Significant inroads have been made to improve the capacity of the AOD workforce to respond to mental health issues among their clients via Australian Government Department of Health, Disability and Ageing funded national guidelines on the management of co-occurring mental health conditions in AOD treatment

settings (3rd edition: (Marel et al., 2022)) and a suite of accompanying training programs and resources (available at **comorbidityguidelines.org.au**). They are the only such Guidelines worldwide and recognised as best practice nationally and internationally. >45,000 hard and fully accessible electronic copies (translatable into >22 languages; accessed by >800,000 unique visitors) have been distributed to practitioners, services and students nationally; >15,700 people have undertaken the training since 2018, which is also embedded into >200 vocational and educational training (VET) courses nationally; and forms part of mandatory training within NGO, public and private treatment services nationally. An evaluation of the e-learning program was overwhelmingly positive: 95% of participants reported gaining knowledge or skills to address co-occurring conditions in their practice, 89% reported using skills they had learned in clinical practice, and 94% found the training useful (Marel et al., 2023). It is critical that such resources continue to be made available to the AOD field to ensure best practice approaches are implemented to enhance treatment outcomes.

Increasing workforce capacity

Successful resources, such as the Comorbidity Guidelines, can be used to build on and leverage existing efforts to build the capability of the mental health and suicide prevention workforce, including the peer and Aboriginal and Torres Strait Islander workforces, to provide support and appropriate clinical treatment to people with co-occurring AOD use, mental ill health and suicidality (Marel et al., 2022). Based on the success of our workforce development activities in the AOD sector, the Australian Government has funded the Matilda Centre to develop complementary guidelines for the mental health sector that aim to build the capacity of this workforce to manage AOD use and use disorders among their clients to best support recovery and prevent relapse. However, for this resource to have impact at the clinical level, it will be imperative that further investment is provided to undertake translational activities similar to the training programs described above for the AOD sector.

Key recommendations for a schedule to address the co-occurrence of problematic alcohol and drug use:

- Include funding in bilateral agreements for mental health and AOD workforces, prevention, and early intervention, and accountability/governance mechanisms.
- Funding to establish health collective services to address whole of person needs, including co-location of AOD and MH services alongside other health services including GPs and allied health specialists (social workers, dietitians), e.g. Macquarie Health Collective.
- Incorporation of MH staff specialists within existing AOD services, e.g. psychiatrists
- Building capacity of the mental health and suicide prevention workforce (e.g. through continued funding of the Comorbidity Guidelines)
- Providing support and appropriate clinical treatment to people with co-occurring AOD concerns, mental ill health and suicidality.
- All levels of government to work collaboratively to research and data with relevant stakeholders in a timely manner, to assist in identifying gaps and improving responses.
- Investment and evaluation of additional pathways for prevention and early intervention, including digital and non-digital options, for co-occurring mental health, suicide and AOD conditions.

- Funding to support research embedded in clinical practice to rapidly identify emergent areas of need and to fast-track implementation of novel treatment approaches (e.g. COPE)
- Targeted research funding to understand prevalence, risk and protective factors for co-occurrence of mental health and substance use disorders including greater investment in long-term national data surveys, development of a nationally consistent approach and inclusion of living/lived experience researchers.
- Targeted investment in leveraging existing epidemiological datasets (e.g., NSMHWB) through co-design of research questions and approaches with policy-makers, researchers, youth and those with lived/living experience of mental health and substance use that will best inform prevention and treatment responses for co-occurrence

We would welcome further opportunities to engage in discussions about how these schedules could work together to deliver a more effective, person-centred health system.

We note however, this is only one way to address a significant gap and need. To reduce the risk of overextending the resourcing and capacity of this agreement, we suggest that tying alcohol and other drugs in with mental health and suicide prevention should focus on co-occurrence of these conditions.

RESPONSE TO INFORMATION REQUEST 4.2

Examples of barriers to the genuine participation and influence of people with lived and living experience in governance and how successful inclusion and engagement can be achieved and measured.

We note the Commission's finding that there was limited involvement of people with lived and living experience in the governance structures of the strategy and strongly urge that the next agreement be co-designed with people with lived and living experience and their carers and support network. The peak/median age at onset of mental and substance use disorders is 14.5/18 years (Solmi et al., 2022), meaning that the bulk of disease burden occurs during adolescence. Mental and substance use disorders are preventable and adolescence represents a critical opportunity to intervene, yet significant knowledge gaps remain. Young people with lived and living experience can provide unique insights to inform policy responses, yet significant barriers to achieving meaningful youth participation in governance prevail (Prior et al., 2022).

Barriers to genuine and meaningful participation operate across individual, team, organisational and systemic levels (Jones et al., 2023; Sheikhan et al., 2023). A foundational barrier is the inconsistent conceptualisation of lived experience participation, which underpins other barriers such as tokenism, power imbalances, stigma, and research being 'done to' those with lived experience (Hawke et al., 2023; Jones et al., 2023). Other commonly reported barriers include a lack of resources and governance structures to adequately support capacity building and ongoing participation, limiting the ability for those with lived experience to progress to leadership roles (Happell et al., 2020; Jones et al., 2023; Sheikhan et al., 2023). Broader barriers such as funding gaps and inflexible funding requirements also prohibit meaningful engagement throughout the participation life cycle, often limiting participation to discrete, time-bound initiatives led by individuals rather than sustained organisational commitment (Happell et al., 2020; Hawke et al., 2023; White et al., 2023). Most concerningly, these barriers can contribute to an unsafe environment for those with lived experience, which can have adverse effects on their wellbeing (Dembele et al., 2024). Without governance structures that have been co-designed with or led by those with lived experience, organisations may be limited to operating at low-level participation and inadvertently reinforcing these barriers (Hawke et al., 2025). To ensure meaningful and sustained engagement, it is vital to implement organisational and systemic governance approaches that prioritise shared goal setting, ongoing measurement and evaluation, and adequate allocation of resources (Sheikhan et al., 2023). Such supports are vital in developing impactful collaborations between those with lived experience, community organisations, and institutions (Hawke et al., 2023).

The Matilda Centre addresses such barriers through embedded co-design models and governance structures that prioritise lived and living experience, as outlined in our 2025–2029 Strategic Plan. Key initiatives include the Youth Advisory Board (YAB) (Prior et al., 2022), Youth Engagement Network (YEN), Lived Experience in Research Network (LEARN), and the Youth Mental Health Advisory Team (YMHAT), all of which ensure diverse voices are actively engaged in shaping mental health and substance use research and has led to improved effectiveness of research programs.

Resources may provide helpful guidance on how to measure successful inclusion and engagement of people with lived and living experience in governance include:

1. "Leading the change. A Toolkit to evaluate lived experience inclusion and leadership" by The Mental Health Commission of New South Wales.
2. Safe Research Partnership with People with Lived & Living Experience by CMHDARN and Lived Experience Australia.
3. Guidelines for the design and implementation of youth participation initiatives to safeguard mental health and wellbeing by the Matilda Centre's Mentally Healthy Futures Project.
4. Co-production: putting principles into practice in mental health contexts by Cath Roper, Flick Grey and Emma Cadogan.

Draft recommendation 4.11. Survey data should be routinely collected.

The Matilda Centre strongly supports recommendation 4.1 that survey data be routinely collected. Accurate estimates of prevalence, severity, functioning and service use are vital for enumerating the burden associated with mental health conditions, for generating policy responses and for planning models of health service delivery. Currently we have gaps in national prevalence measurements of up to 15 years.

The Australian National Survey of Mental Health and Wellbeing found that 36% of young people aged 16-25 years meet criteria for a mental health or substance use disorder (Slade et al., 2025), suicide attempts have doubled in prevalence since 2007 (Arya et al., 2025), and despite greater awareness and expanded mental health services (Harris et al., 2025) young Australians aged 16-25 years are experiencing more severe and more complex mental health challenges (Sunderland et al., 2025). At the same time, there are rapid changes in the availability and accessibility of illicit drugs, as well as the emergence of new drugs (Sutherland et al., 2024). Thus, timely responses to short- and long-term trends in mental health, suicide and drug use require long-term investment in data collection and analysis, as well as the ability to link data across the health care system.

Along with funding the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing study, it would be beneficial to increase the frequency of these surveys. Instead of every 5 years, it would be advantageous to match the National Health Survey (i.e. every 3 years) to better align data collections and ensure that major shifts in population mental health are not missed (Lycett et al., 2023). Extending and enriching the survey by including measures that development (i.e. pro-social and pro-environmental behaviour) as well as social and structural determinants (e.g. Individual, relational and contextual risk and protective factors would enrich the data collected and assist with informing prevention and early intervention efforts (Lycett et al., 2023).

Additionally, it would be advantageous to invest in collection and synergy across surveys and data sources for co-occurring drug use and mental health conditions. This investment in collecting prevalence, impacts and outcomes of co-occurring mental health, suicide, self-harm and AOD use is critical for preparing and implementing effective prevention, treatment and harm reduction strategies. By identifying risk patterns for mental health and AOD use including examining individual, community and societal risk factors, this will accelerate the identification of key targets for prevention and early intervention (Alegría et al., 2023).

Further, the prevalence of risk factors for mental and substance use disorders and suicide is not uniform across populations. Priority populations that often experience higher prevalence of mental ill health and co-occurring conditions include; Aboriginal and Torres Strait Islander peoples, young people, those who identify as LGBTQ+, and those living in regional and remote communities. Research shows that youth of lower socio-economic status (SES) are 22 times more likely to use alcohol at risky levels and 5 times more likely to smoke, than higher SES youth (Australian Institute of Health Welfare, 2020). Youth living rurally are approximately twice as likely to die from suicide (Fitzpatrick et al., 2021), and have higher rates of daily smoking, and daily alcohol use compared to youth living in metropolitan areas (Australian Institute of Health Welfare, 2020). In addition, LGBTQ+ young people are 2-3 times more likely to experience depression, anxiety and suicidality compared to their non-gender diverse and heterosexual peers (Ventriglio et al., 2022). Concerningly, regional, disadvantaged and LGBTQ+ youth face greater barriers to accessing care and interventions are rarely adapted to local contexts (Alam et al., 2019). To better match mental health and substance use prevention resources to the unique experiences of young people in underserved communities and geographically isolated areas, greater implementation of place-based prevention approaches, conducted in collaboration with, and for, young people and local communities, is urgently needed (Dart, 2019).

It is important to note that while ongoing surveys and population monitoring is critical, we should also make better use of existing data through data harmonization. Data harmonization can assist with monitoring and tracking historical trends, helping to generate better forecasts for future trends.

All levels of government should be encouraged to work collaboratively to appropriately share findings from research and data analysis with relevant stakeholders, to assist in identifying gaps and assist with improving supports provided.

Key recommendations:

- Regular national prevalence surveys conducted at least every three years measuring mental disorders, suicidal behaviour and AOD use in the general population.
- Dedicated research funding to co-develop and embed appropriate survey instruments within national surveys for priority populations (e.g., CALD, LGBTQ+) combined with improving survey data collection techniques to identify key gaps and provide guidance to best respond to community needs as per implementation of the National Mental Health Research Strategy (National Mental Health Commission, 2022).
- Investment to understand factors related to service availability, accessibility and treatment quality amongst those in regional and rural areas, and high-risk populations (e.g., LSES).
- Targeted investment in leveraging existing epidemiological datasets (e.g., NSMHWB) through co-design of research questions and approaches with policy-makers, researchers, youth and those with lived/living experience of mental health and substance use that will best inform prevention and treatment responses.
- Targeted research funding to understand prevalence, risk and protective factors for co-occurrence of mental health and substance use disorders including greater investment in long-term national data surveys, development of a nationally consistent approach and inclusion of living/lived experience researchers.

Additional areas for consideration

- **Childhood experiences and supporting those who have experienced childhood adversity**

Childhood experiences of adversity and maltreatment are among the most powerful risk factors for mental health problems and suicide. To meaningfully improve population mental health and reduce suicide rates, these early-life exposures must be prioritised in national and state-level strategies. Because maltreatment typically occurs early in life, there is a critical window for early intervention that can yield substantial long-term benefits for individuals and society. Effective action requires a multi-tiered, multi-faceted approach, underpinned by strong collaboration between federal and state governments.

Our research has revealed that in Australia, a substantial proportion of mental health conditions and suicide attempts are attributable to childhood maltreatment (abuse and neglect). Specifically, childhood maltreatment accounts for 21% of all cases of depressive disorders, 24% of anxiety disorders, 27% of alcohol use disorders, 32% of drug use disorders, and 41% of suicide attempts (Grummitt et al., 2024). These figures underscore the urgent need to make the prevention and early intervention of childhood maltreatment a central priority in mental health and suicide prevention policy.

While we acknowledge that the Agreement recognises people experiencing, or at risk of, abuse and neglect as a priority population, we recommend more explicit and targeted commitments. This includes serious investment to prevent childhood maltreatment by addressing the root stressors faced by parents and families, such as ensuring stable and affordable housing, access to childcare without a waitlist, and timely treatment for parents' mental health and substance use problems (Fortson et al., 2016; Klevens et al., 2015). Evidence-based programs such as home visitation and parent programs (Han & Oh, 2022) must be scaled up, with efforts to reduce stigma and improve access. Expanding integrated care hubs would allow families to access health, financial, legal, and other supports in a single location, easing the burden on families and addressing complex needs (Hiscock et al., 2024). Additionally, ensuring all primary care settings and schools are trauma-informed would have a substantial impact in promoting recovery from early traumatic experiences and preventing further harm. In schools, this would involve training of all staff, ideally combined with programs that include psychoeducation and promote healthy coping skills for students exposed to adversity. One example is the OurFutures Mental Health program, an Australian first, trauma-informed program to prevent depression and anxiety among adolescents.

- **Prevention and Early Intervention**

75% of mental health conditions emerge before the age of 25, and 50% before 15 years of age (Kessler et al., 2005). In Australia, **approximately 40% of young people aged 16 to 25 experience a mental health or substance use disorder in any given year –** this is the highest rate among all age cohorts and nearly double that of the general population (Slade et al., 2025). This rate rapidly increased from 24% when last measured in 2007. Growing rates of mental disorders among youth is a global trend (McGorry et al., 2024). While treatment and prevention efforts must

continue across the lifespan it is critical we prioritize children, adolescents and young adults, their parents and carers. Mental disorders are not inevitable; many cases of mental disorders, AOD disorders, and suicide can be prevented. The earlier we intervene, the more suffering and burden to the healthcare and education systems can be averted.

Two approaches could be adopted to address increasing mental disorder prevalence; (1) expand services to meet growing demand, and (2) provide preventative measures to address the root causes of mental ill health (Pierce et al., 2025). We argue both are of critical importance to address mental health, suicide and associated AOD use at a population level. Increasing prevalence of mental ill health, suicide and continued harm from AOD use will not be averted through treatment alone. Current approaches are falling short in part because decision-makers tend to respond to conditions after they emerge, rather than proactively address their root causes or invest in prevention.

Amongst young people, fewer than one in four of those at risk of substance use or mental disorders seek help and there are unacceptably long delays to seeking treatment, so that by the time a person does reach treatment, their disorder is often well entrenched (Birrell et al., 2025; Chapman et al., 2015). Effective prevention and early intervention can significantly reduce disease burden by halting, delaying, and interrupting the onset and progression of disorders (Calear & Christensen, 2010; Champion et al., 2013; Faggiano et al., 2014; Munoz et al., 2010; Teesson et al., 2012). Australia is leading the world in mental health prevention research. A recent systematic review of programs delivered in education settings found that more than half of all included studies were from Australia (n=27), compared to n=9 in the USA (Hayes et al., 2025). There is a significant opportunity to capitalise on this unique Australian expertise and extend the benefits of this knowledge to all Australians.

Yet despite the existence of effective evidence-based AOD, mental health and suicide prevention programs, there is a significant gap between what we know works and what is implemented. Several implementation barriers hinder widespread dissemination of effective programs, including restricted government funding and coordination across health and education for prevention initiatives, lack of training in professional communities, and restricted knowledge of, or support for, prevention in the general public and policy arenas (Catalano et al., 2012). Additional barriers to the effective implementation of school-based mental health and AOD programs include low confidence, lack of support, lack of knowledge and awareness about the strategies and programs that are evidence based, and time constraints (Stapinski et al., 2017).

It is imperative we invest in, and up-scale, those prevention initiatives with a strong evidence base. We recommend new requirements for mental health and AOD education be developed. These requirements would help education and health settings implement programs that have been shown to be effective at reducing mental ill health and AOD harms, and are equitable, inclusive and accessible. These programs must also be culturally safe for Aboriginal and Torres Strait Islander students and inclusive of LGBTQ+ and neurodiverse young people, who disproportionally experience risks associated with mental health and substance use disorders. Interventions for the prevention of mental disorders can save money through reduced healthcare costs and increased productivity, while also improving quality of life. Modelling shows the potential for positive returns on investment for preventive health efforts, which could in turn contribute to the sustainability of such efforts (Grummitt et al., 2023).

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