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MONASH University
MONASH ADDICTION RESEARCH CENTRE

Submission on the Productivity Commission's interim report on the National Mental Health and Suicide Prevention Agreement

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About

Turning Point is a national addiction treatment centre, dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs, and gambling, integrated with world-leading research and education. Turning Point is part of Eastern Health and is formally affiliated with Monash University. Turning Point reduces the harms caused by alcohol, drugs and gambling and promotes recovery through integrated activity that: increases access to support and evidence-based practice using innovative technologies; delivers high quality evidence-based practice and supports health care professionals nationally and internationally to do the same; educates and trains the workforce to deliver programs to a broad range of populations; and underpins policy and practice relevant research and the provision of key national population level data that informs expert comment and policy advice to state and federal governments.

The **Monash Addiction Research Centre (MARC)** brings together world-leading expertise from across Monash University and the sector to provide solutions to the challenges of addiction. MARC draws on the multidisciplinary strengths and capabilities of researchers across the University to develop and test novel, scalable prevention and treatment approaches. MARC's mission is to provide national solutions to addiction, leveraging expertise in basic and social science, clinical, and epidemiological research to develop new knowledge to shape government policy and evidence-based approaches.

1. Summary of recommendations

This Productivity Commission review into the National Mental Health and Suicide Prevention Agreement (the Agreement) is timely, given the current evaluation of the Commonwealth's Drug and Alcohol Program, the forthcoming update to the National Drug Strategy, the Commonwealth parliamentary inquiry into alcohol and other drug (AOD) harms, and a move toward a whole-of-health National Health Reform Agreement.[1] This confluence of events presents a window of opportunity to uplift AOD investment so it is more strategic, nationally coordinated, and jointly supported under clear arrangements between federal and state/territory governments.

Turning Point and the Monash Addiction Research Centre welcome the opportunity to provide feedback on the Productivity Commission's interim report into the Agreement. We make the following recommendations:

1. Incorporate AOD into the Agreement—consistent with the high co-occurrence of AOD and mental health conditions and the intention to integrate it and other areas—by adding a dedicated AOD Schedule.
2. Support the new AOD Schedule with a comprehensive uplift in investment to promote cost-saving prevention and early intervention, including improving treatment for the roughly half a million Australians who would benefit from, but are currently not accessing AOD treatment.
3. Link the Agreement to the National Health Reform Agreement, consistent with the recommendation of the Huxtable review to adopt a whole-of-health National Health Reform Agreement that spans primary, secondary, and tertiary health services.
4. Include nationally consistent AOD outcome measures, which should be linked to the AOD Schedule.
5. Consider recommendations 1, 2, 3 and 4 in the context of:
    a. the current evaluation into the Commonwealth's Drug and Alcohol Program funding.
    b. the forthcoming update to the National Drug Strategy, due in 2027—noting we currently have 8 different, disconnected national AOD strategies.
    c. the need to re-establish national AOD governance structures, given previous structures under COAG were disbanded with the introduction of the National Cabinet.

[1] Department of Health, Disability and Ageing, *Health Ministers Meeting* (Communique, 6 December 2024) <https://www.health.gov.au/sites/default/files/2024-12/health-ministers-meeting-hmm-communique-6-december-2024.pdf>; Anthony Albanese, 'Meeting of National Cabinet – The Federation Working for Australia' (Media Release, Prime Minister of Australia, 6 December 2023) <https://www.pm.gov.au/media/meeting-national-cabinet-federation-working-australia>.

2. Current investment, strategy and governance issues

We can't afford not to invest in AOD services, given the $80+ billion dollar hit to our economy every year.[2] Yet none of Australia's nearly 80 health agreements that currently operate outside the National Health Reform Agreement are dedicated to AOD. Among these agreements is the National Mental Health and Suicide Prevention Agreement (hereafter the Agreement), which consists of bilateral agreements between the Commonwealth and each state and territory government, all due to expire on 20 June 2026.

In our submission to the federal *Inquiry into the health impacts of alcohol and other drugs*, we highlighted the need for AOD sector inclusive national governance arrangements, nationally coordinated strategies and planning, and joint Commonwealth and state/territory investment mechanisms to support evidence-based initiatives known to generate significant returns.[3] However, this inquiry lapsed as a result of the May 2025 federal election.

2.1. Current federal funding mechanisms

A key issue with the current Agreement is the lack of AOD integration. Schedule A to the Agreement provides an outline of the activities to be undertaken to implement the commitment to a whole-of-government approach and identifies priority areas for integration including alcohol and other drugs among others.[4] However, only Victoria and Western Australia's bilateral agreements include any AOD commitments, and even these are limited, inconsistently linked to national strategies, and poorly integrated with broader mental health reforms.

The agreement between the Commonwealth and Victoria does not specifically reference, nor is it linked to, any national or state AOD strategies or plans, however, it commits both to trial expanded aftercare referral pathways from AOD and others services, and to "collaborate with PHNs to ensure accelerated transition to [Victoria's] Adult and Older Adult Local Mental Health and Wellbeing from [the Commonwealth's] Head to Health adult mental health centre services and primary care mental health services while working towards one service system by 2026." This includes a Commonwealth commitment of up to $33.1 million p/a to continue operations of the 14 mental health clinics that were funded as a pandemic measure and commissioned through PHNs, while this transition occurs. It is not clear what proportion of this investment supports AOD treatment offered by funded services.

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[2] Rethink Addiction and KPMG, *Understanding the Cost of Addiction in Australia* (Report, 2022) 7 <https://www.rethinkaddiction.org.au/the-cost-of-addiction>.

[3] Turning Point, Eastern Health and the Monash Addiction Research Centre, Submission No 91 to Standing Committee on Health, Aged Care and Sport, *Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia* (October 2024) <https://www.aph.gov.au/DocumentStore.ashx?id=64373a03-c7b0-4e22-9369-238106612ad2&subId=768190>.

[4] Australian Government, *National Mental Health and Suicide Prevention Agreement* (Agreement, 2022) A-1 <https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf>.

The bilateral agreement between the Commonwealth and Western Australia is the only one that specifically references linked strategies and plans with an AOD focus, however, all of them are its own state-based strategies and plans, and the national AOD strategies are not mentioned.[5] And despite this, AOD is only mentioned twice. First, through both jurisdictions committing "to work collaboratively to align the *Western Australia Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025* and the *National Mental Health Workforce Strategy* and broader national workforce plans and strategies." But the *National Mental Health Workforce Strategy* does not have a single mention of alcohol or other drugs, and the *National Alcohol and Other Drug Workforce Development Strategy*, which isn't referenced, lapsed in 2018. Second, to "establish the Western Australian Joint Service Planning and Governance Committee (the Committee) to provide high level leadership regarding local system planning to contribute to reform of the mental health, alcohol and other drug system in Western Australia."[6]

In short, existing mental health agreements between the Commonwealth and states and territories do not adequately address the needs of the AOD services, nor are they linked to national AOD strategies and agreed implementation plans.

Other issues with the current Agreement include:

- ***Insufficient funding and accountability.*** Only a small fraction of total government spending on mental health is covered under the Agreement, leading to limited accountability and transparency.[7]
- ***Neglect of psychosocial support.*** The Agreement has failed to provide adequate psychosocial support for individuals not covered by the NDIS, leaving many without the necessary assistance.[8]
- ***Inadequate crisis support and outcome measurement.*** Crisis support services are insufficient, and there is a lack of measurable goals and outcomes to assess the effectiveness of the Agreement.[9]

The Commonwealth's Drug and Alcohol Program (DAP), introduced more than a decade ago (FY14–15), consolidated several previous Commonwealth AOD funding streams into a single program delivered via grants and PHN commissioning, excluding state/territory and National Indigenous Australians Agency funding. The DAP is currently being evaluated due to ongoing concerns, including:

[5] *Bilateral Schedule On Mental Health And Suicide Prevention*, Commonwealth–Western Australia, signed 10 April 2022, 4, 7-8 <https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement>.
[6] Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 8 <https://apo.org.au/node/325261>.
[7] Productivity Commission, *Mental Health and Suicide Prevention Agreement Review* (Interim Report, 24 June 2025) 5, 114, 127 <https://www.pc.gov.au/inquiries/current/mental-health-review/interim>.
[8] Ibid 112.
[9] Ibid 112-114.

- ***Fragmented and inefficient funding.*** Multiple funding streams and short-term grants create heavy administrative burdens, and hamper strategic planning and outcome measurement.
- ***Lack of coordination and strategic investment.*** The DAP operates in isolation from broader Commonwealth–state agreements, missing opportunities for cohesive, system-wide AOD planning and investment.
- ***Data gaps and poor outcome tracking.*** National data systems like the Alcohol and Other Drug Treatment Services National Minimum Data Set are incomplete and not fit-for-purpose, limiting insight into service needs and impact.
- ***Underserved priority populations.*** First Nations,[10] LGBTIQ+,[11] and CALD[12] communities face high rates of AOD harm yet lack access to culturally safe and community-led services. Rural and regional communities also lack access to services and helplines are an under-used service model that overcomes stigma and geography as access barriers.

2.2. Strategic reform and outcome measurement

The *National Drug Strategy 2017-2026* identifies national priorities relating to alcohol, tobacco, and other drugs, but investment across the three pillars of supply, demand and harm reduction is unbalanced:

- 64.3% of the total combined drug budget is spent on law enforcement (i.e. supply reduction);
- 27.4% is invested in treatment and 6.7% in prevention (i.e. demand reduction); and
- 1.6% in harm reduction.[13]

A federal inquiry into law enforcement recommended this weighting be equalised, with increased investment in the demand and harm reduction pillars.[14] There would be significant benefits to doing so, given we know every dollar invested in treatment for substance use (including opioid agonist therapy, outpatient programs and residential programs) returns $7,[15] and every dollar invested in AOD counselling returns up to $23.[16]

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[10] 'First Nations People's Use of Alcohol, Tobacco, E-Cigarettes and Other Drugs', *Australian Institute of Health and Welfare* (Web Article, 29 February 2024) <https://www.aihw.gov.au/reports/first-nations-people/first-nations-use-alcohol-drugs>.

[11] Nic Robinson-Griffith et al, 'Exploring Perceptions of Alcohol and Other Drug (AOD) Service Workers Regarding the Inclusion of Transgender and Gender Diverse (TGD) Clients in Accessing Public Residential Treatment in Victoria, Australia' (2025) *International Journal of Transgender Health* 1. Adam Hill et al, *Private Lives: The Health and Wellbeing of LGBTIQ People in Australia* (Report, No 3, 2020) 61 <https://www.latrobe.edu.au/arcshs/work/private-lives-3>.

[12] Victorian Alcohol and Drug Association (VAADA), *CALD AOD Project* (Final Report, March 2016) <https://www.vaada.org.au/wp-content/uploads/2018/03/CALD-AOD-Project-final-report.pdf>.

[13] Alison Ritter et al, *The Australian 'Drug Budget': Government Drug Policy Expenditure 2021/22* (Monograph, No 36, 4 June 2024) 11 <https://apo.org.au/node/327038>.

[14] Parliamentary Joint Committee on Law Enforcement, Parliament of Australia, *Australia's Illicit Drug Problem: Challenges and Opportunities for Law Enforcement* (Final Report, May 2024) xiii <https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/IllicitDrugs/Report>.

[15] Susan Ettner et al, 'Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment ''Pay for Itself''?' (2006) 41(1) *Health Services Research* 192, 205.

[16] Alexandra Voce and Tom Sullivan, *What are the Monetary Returns of Investing in Programs That Reduce Demand for Illicit Drugs?* (Report, No 657, 8 September 2022) 7 <https://www.aic.gov.au/publications/tandi/tandi657#>.

This strategy is also currently one of eight different national AOD strategies, with little coherence between or coordination across them. Similarly, there are several national mental health strategies/plans,[17] and the National Mental Health Strategy is now over 30 years old,[18] which is why draft recommendation 4.2 of the productivity Commission's interim report calls for a renewed National Mental Health Strategy.

This recommendation also notes that to support the next Agreement, "the Australian Institute of Health and Welfare [AIHW] should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention."[19] Outcome measures should encompass those relating to alcohol and other drugs, including related ambulance attendances, hospitalisations, and deaths, and be built into the AOD Schedule.

2.3. Current governance arrangements

Since the dissolution of the Intergovernmental Committee on Drugs and the National Drug Strategy Committee and its subgroups, and the disbanding of both the Council of Australian Governments and the Ministerial Drug and Alcohol Forum in 2020, Australia has no coherent governance structure to facilitate dialogue between the AOD sector, law enforcement, levels of government, funding and commissioning bodies, and related sectors and systems.

This disbanding of national AOD governance structures has resulted in a fragmented approach to AOD policy with limited opportunities for federal, state, and territory information sharing, collaboration, and learning. This limits Australia's capacity to deliver a nationally consistent approach to prevent and minimise AOD harms, improve access to treatment and harm reduction, and ensure equitable health and justice outcomes across jurisdictions. It also hinders efforts to effectively monitor trends, track progress against the National Drug Strategy, identify best practice, and ensure contemporary, evidence-based policymaking.

The Australian National Advisory Council on Alcohol and Other Drugs was established to provide confidential advice to the Minister for Health on current and emerging AOD issues. But this channel alone cannot adequately represent and leverage the breadth of the AOD sector's clinical, policy, lived experience, and research expertise, and there is a need to return to more inclusive national AOD governance arrangements to support adequate stakeholder engagement and expert-informed, evidence-based decision-making.[20]

[17] These include: National Mental Health Workforce Strategy 2022–2032, National Mental Health and Suicide Prevention Plan, The Fifth National Mental Health and Suicide Prevention Plan, National Suicide Prevention Strategy 2025–2035, Vision 2030 for Mental Health and Suicide Prevention in Australia, The National Children's Mental Health and Wellbeing Strategy, National Mental Health Research Strategy.
[18] *Mental Health and Suicide Prevention Agreement Review* (n 7) 131.
[19] Ibid 21.
[20] Turning Point, Eastern Health and the Monash Addiction Research Centre, Submission No 91 to Standing Committee on Health, Aged Care and Sport, *Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia* (October 2024) 5-6.

3. Toward a nationally coordinated, integrated, whole-of-health response to AOD harms

Globally, substance use disorders accounted for almost one-fifth of suicide-related disability-adjusted life years in 2010, with alcohol use disorders alone accounting for 13.3% of this burden.[21] There is also a high co-occurrence of mental health conditions and AOD use disorders,[22] with at least 47% of people seeking AOD treatment having a current mental health concern, and at least a third having multiple co-occurring conditions.[23]

Stigma remains an enormous barrier to help-seeking, with many waiting years, even decades, before seeking help for their struggles with alcohol and/or other drugs. The median time to first treatment for alcohol dependence, for example, is an astonishing 18 years.[24] And the longer people wait, the more harms escalate, and the more costly treatment becomes.

As the Productivity Commission review's interim report notes, the intention of the Agreement has always been to integrate AOD,[25] but "the [current] approach to alcohol and other drugs is different across jurisdictions; some have integrated it into the mental health and suicide prevention space while others treat it separately. A schedule to the next agreement, focused on alcohol and other drugs, could be one way to enable national leadership and consistency."[26] The need for a dedicated AOD Schedule is also underpinned by the fact that "governments are only required to report against the initiatives for collaboration in the bilateral schedules, not the Agreement's objectives and outcomes."[27] It would also reflect the fact addiction medicine and psychiatry are recognised specialties supported by a highly specialised workforce and dedicated service system.

For all these reasons, Turning Point supports the Agreement being re-envisioned as a National Mental Health, *AOD* and Suicide Prevention Agreement, with a new, dedicated AOD Schedule.

Essential to the success of this new AOD Schedule is that it is supported by a comprehensive uplift in investment to promote cost-saving prevention and early intervention, including

[21] Alize Ferrari et al, 'The Burden Attributable to Mental and Substance Use Disorders as Risk Factors For Suicide: Findings From the Global Burden of Disease Study 2010' (2014) 9(4) *PLoS One* e91936.
[22] *Mental Health and Suicide Prevention Agreement Review* (n 7) 62.
[23] Christina Marel et al, *Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings* (Guidelines, 2022) 18 <https://comorbidityguidelines.org.au/pdf/comorbidity-guideline.pdf>.
[24] Chapman et al, 'Delay to First Treatment Contact for Alcohol Use Disorder' (2015) 147 (February) *Drug and Alcohol Dependence* 116, 118.
[25] *Mental Health and Suicide Prevention Agreement Review* (n 7) 100.
[26] Ibid 141.
[27] Ibid 9.

treatment for the roughly half a million Australians who would benefit from, but are currently not accessing, AOD support.[28]

Current Commonwealth investment in AOD services through the Drug & Alcohol Program is thought to be only around $800 million over the forward estimates—a fraction of state and territory investment. There is a strong case for the Commonwealth to do more to address escalating AOD-related harms and the significant human and economic costs associated with them.

The Commonwealth contributes significantly more to Local Hospital Networks through the National Health Reform Agreement / National Health Funding Pool, however, these funds are directed to tertiary services that respond at the severe end of complexity and harms, and it is not clear how much goes toward AOD services.[29]

As recommended by the Huxtable review[30] and the Productivity Commission review's interim report,[31] the Agreement should be linked to an expanded, whole-of-health National Health Reform Agreement that spans primary, secondary and tertiary health. This should include AOD services and their dedicated AOD Schedule.

The Huxtable review noted that "a pressing priority is to assign functions and actions for mental health within the National Health Reform Agreement. Currently the [National Health reform] Agreement acknowledges a shared commitment to improve mental health outcomes (Clause 6) but agreed actions are in the separate and subsequent National Mental Health and Suicide Prevention Agreement. The National Health Reform Agreement should reference the actions that the parties will take to improve mental health outcomes across the health system, integrating mental health strategies into optimal models of care, financing, innovation and performance elements of a new [National Health Reform] Agreement."[32]

Accordingly, recommendation 3 of the Huxtable review calls for the National Health Reform Agreement to "reaffirm the commitments to improving mental health outcomes through the separate National Mental Health and Suicide Prevention Agreement, utilising the mechanisms agreed through the National Health Reform Agreement, including models of

[28] Alison Ritter and Keelin O'Reilly, 'Unmet Treatment Need: The Size of the Gap For Alcohol and Other Drugs in Australia' (2025) 44(3) Drug and Alcohol Review 772, 777.
[29] The National Health Funding Pool's Annual Report notes AOD services are out of scope for activity based funding in New South Wales, South Australia, Tasmania, and Victoria, but does not mention whether this is the case for other states and territories. The National Health Funding Body tracks activity based funding investment across five categories: emergency department services; acute admitted services; admitted mental health services; sub–acute and non–acute services; and non–admitted services. The National Health Funding Body also tracks block funding across five categories: teaching, training and research; small rural hospitals; non-admitted mental health; non-admitted home ventilation; other non-admitted services; highly specialised therapies. Administrator, National Health Funding Pool, Annual Report 2022-23 (Report, 22 December 2023) 81, 108, 180, 204 <https://www.publichospitalfunding.gov.au/publications/national-health-funding-pool-annual-report-2022-23>.
[30] Huxtable (n 6) 1.
[31] Draft recommendation 4.3. *Mental Health and Suicide Prevention Agreement Review* (n 7) 22.
[32] Huxtable (n 6) 62.

care, financing, innovation and performance monitoring, to progress agreed actions in the area of mental health."

Consideration should also be given to how the new AOD Schedule could:

- occur in tandem with the re-establishment of national AOD governance arrangements;
- be linked to an overarching national strategy, including whether the 8 different national AOD strategies we currently have could benefit from some consolidation, and linkage to state and territory strategies/plans; and
- ensure consistent AOD outcome monitoring.

The National Suicide and Self-harm Monitoring System was established to address suicide and self-harm in Australia.[33] However, there is a need to consider how national AOD monitoring can be improved and data monitoring systems better integrated. One example where acute AOD harms are collected is through the National Ambulance Surveillance System coordinated by Turning Point with Monash University and every jurisdiction's ambulance service.

AOD outcome measures must be readily accessible for policy planners, AOD service providers, and health professionals to inform data-driven policy, service and system planning, evaluation, and improvement. For example, in Victoria, *AODstats.org.au* is a freely available statistical and epidemiological resource and monitoring tool, funded by the state government. *AODstats* provides data on a range of AOD (i.e., alcohol, illicit and pharmaceutical drug use) harms including ambulance attendances, hospital admissions, serious road injuries, and deaths, as well as availability through the number of liquor licences in local government areas.[34]

Turning Point successfully developed a proof of concept national AOD stats platform a number of years ago for the Commonwealth Department of Health and Aged Care, demonstrating its potential for national scale-up.[35] Other relevant examples include the Alcohol, Tobacco and Other Drug Compendium, curated by AIHW that collects data on a range of AOD outcomes and is another avenue for maximising the use of key national data.[36]

[33] 'Suicide & Self-Harm Monitoring', *Australian Institute of Health and Welfare* (Web Page, 16 July 2025) <https://www.aihw.gov.au/suicide-self-harm-monitoring>.
[34] 'Explore AODstats Data Sets', *AODstats* (Web Page, 2025) <https://aodstats.org.au/explore-data/>.
[35] Jessica Killian et al, *DrugStats Australia: Project Extension* (Turning Point Report, May 2018).
[36] 'Alcohol, Tobacco & Other Drugs in Australia', *Australian Institute of Health and Welfare* (Web Report, 27 June 2025) <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/about>.