VICTORIAN ALCOHOL & DRUG ASSOCIATION

Submission: Victorian suicide prevention and response strategy

August 2022

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

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Attention: Mental Health and Wellbeing Division, Department of Health

Victorian Suicide Prevention and Response Strategy

The Victorian Alcohol and Drug Association (VAADA) welcomes the opportunity to contribute to the Suicide Prevention and Response Strategy. The strategy, along with the Victorian Suicide Prevention Framework 2016-2025, can provide a means of fostering social conditions that protect against suicide, identifying and mitigating risk factors for suicide, and acute and targeted support and interventions to groups at greater risk of suicide.

Suicide is devastating. The impacts of suicide are long-lasting and widespread, affecting families, friends, colleagues and communities as a whole. Importantly, deaths by suicide are preventable.

While suicide can affect anyone, some populations are at greater risk. It is often the case that these populations experience multiple and compounding risk-factors including disadvantage and poverty, histories of violence and/or neglect, trauma, poor mental health and Alcohol and Other Drug (**AOD**) issues.

The causes of suicide are complex, often involving a combination of 'background' factors such as those listed above as well as foreground drivers: acute stressors that, when combined with the background factors, may precipitate suicidality.

A whole-of life-approach

Suicide does not occur in a vacuum and AOD is but one contributing factor among many. As an example of this complexity, AOD use may be a significant contributing factor to an individual's suicide but it may not be that individual's AOD use that was the problem. A childhood characterised by destructive parental AOD use (and the trauma associated with this) can contribute to suicide risk just as much as an individual's own use.

To address suicide effectively, a 'whole-of-life' approach that understands and accounts for this complexity is needed.

There are key points in the life-course where interventions can and should be targeted. Doing so would have a dramatic impact on reducing harm. Some of these points will relate to histories of severe alcohol use in families but others will relate to school experiences, youth and adolescent development issues, experiences of violence including sexual and family violence, experiences of poor mental health and experiences of trauma.

If efforts are only focused at the acute end (i.e. 'downstream'), once an individual is already experiencing suicidality, this would represent a significant failure.

Prevention is better than cure and nowhere is this truer than suicide.

As a society, we must take informed and substantive steps toward addressing the myriad factors that contribute to suicide.

So while VAADA's submission to the Strategy addresses the issues relating to AOD and the AOD sector, we also acknowledge the importance of a society-wide effort to understand, respond to and prevent suicide in Victoria.

Recommendation #1: Adopt a 'whole-of-life' approach to suicide response and prevention that understands and responds to the complex drivers and risk factors that contribute to suicide throughout the life-course.

AOD and suicide

AOD use and intoxication are common contributing factors in suicide. As this Strategy's discussion paper notes, alcohol use was reported in between one- and two-fifths of suicide cases from 2010 to 2015 in Victoria.[1] Furthermore, findings from a recent Australian meta-analysis by the Matilda Centre identified positive associations between AOD use and suicide across all categories of AOD use disorders.[2]

The report describes the association between AOD (use and use disorders) and suicide as 'consistent and robust'.[3] The findings include:

- General alcohol consumption is associated with 65% increased risk of suicidal behaviours.
- Suicide risk increased by 30.7 times people with multiple AOD use disorders (compared to those with no AOD disorder).
- Between 19-63% of people who die by suicide have a personal history of diagnosed AOD use disorder.
- Between 26-44% of people who present to emergency departments following a suicide attempt have acute alcohol intoxication.
- A dose-dependent relationship exists where higher levels of intoxication are associated with even greater risk of suicide attempt compared to lower levels of intoxication.

The report also notes that AOD use 'interacts with pre-existing psychological vulnerabilities… [and] may trigger or exacerbate events which precipitate suicidal behaviour… such as intimidate partner breakdowns, divorce/separation, unemployment and financial hardship.'[4]

In terms of impact, statistics by the Australian Institute of Health and Welfare from 2015 show that alcohol use was responsible for 20% and illicit drug use for 18.5% of years of healthy life years lost due to suicide and self-inflicted injuries.[5]

While the association between AOD and suicide is clear, details of the AOD-suicide 'nexus' are not well understood. AOD can be implicated in suicide in various ways, including:

- AOD as a primary method (i.e. suicide by drug overdose);
- AOD as a preparatory/secondary method (i.e. used to reduce inhibition during suicide attempt);

[1] Chong et al (2020) 'Acute alcohol use in Australian coronial suicide cases 2010-2015', *Drug and Alcohol Dependence*, vol. 212: 108066.
[2] Fischer et al (2020) 'The role of alcohol and other drugs in suicide behaviour and effective interventions to reduce suicidal thoughts and behaviours,' *The Matilda Centre for Research in Mental Health and Substance Use*, University of Sydney.
[3] Ibid: p. 15.
[4] Ibid: p. 16.
[5] Australian Institute of Health and Welfare, (2019) 'Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015', Canberra.

- AOD as proximal to suicide (i.e. present but not implicated as a direct cause);
- AOD use as a risk factor: both chronic use and acute intoxication increase the risk of suicidality and death by suicide.
- AOD as potentiating other risk factors for suicide, such as physical and mental health, financial hardship, and general wellbeing.

As a review paper by the Matilda Centre states:

> There are many factors which contribute to risk of suicide including biological, psychological, social, environmental and cultural… As AOD use often plays a role in a diversity of factors, it is challenging to make precise determinations about its relationship to suicidality.[6]

Because AOD's role in suicide is variable, prevention and response efforts need to be able to respond to this complexity. However, there is some good news. The review paper goes on to state: '[w]hile the evidence base for effective AOD interventions for suicide prevention is limited, lacking evaluation studies and requires further research, some promising results in reducing suicidality were yielded.'

It is important to note that as a risk factor, AOD use is highly modifiable (i.e. it can change over time). This means that, compared to other, non-modifiable risk factors – for example, a personal history of self-harm – AOD use is highly amenable to intervention at both individual and social levels. That is, addressing AOD and AOD-related harms via support, intervention and treatment can reduce suicide risk for an individual, and targeted and evidence-based policies and systems can reduce AOD-related suicide risk at the population level.

As such, the AOD service system as part of the broader health and wellbeing system, has a significant role to play in reducing suicide in Victoria.

[6] Suicide Prevention Australia and Mental Health and Suicide Prevention Research and Education Group, The University of Sydney's Matilda Centre for Research in Mental Health and Substance Use (2022) *Closing the loop: alcohol and drugs in suicidality and effective interventions*, Suicide Prevention Australia and.

Summary of recommendations

Recommendation #1: Adopt a 'whole-of-life' approach to suicide response and prevention that understands and responds to the complex drivers and risk factors that contribute to suicide throughout the life-course.

Recommendation #2: Increase investment to support the Coroners' Court of Victoria to support and expand their data collection and monitoring on suicide and other key areas including AOD.

Recommendation #3: Conduct an immediate review of AOD service funding including of the Drug Treatment Activity Unit and commit to implementing recommendations in full.

Recommendation #4: Ensure leadership from the AOD, Harm Reduction and Lived-and-Living Experience sectors are included in ongoing activity related to the Strategy, including implementation and monitoring.

Recommendation #5: The Victorian Government should introduce mandatory 'policy-related suicide impact statements' across all areas of government.

Recommendation #6: Invest in and support community-led stigma reduction activities in AOD and other key areas.

Recommendation #7: Include two additional principles: 'Supporting a well-resourced, well-trained and responsive cross-sectoral workforce' and 'Prioritising early intervention'.

Recommendation #8: Increase investment in AOD treatment in service provision, in particular, pharmacotherapy, aftercare, suicide risk screening, and outreach and prevention, including reinstatement of funding for 100 additional AOD support workers that recently expired.

Recommendation #9: Include evidence-based reforms to reduce harms associated with alcohol and gambling, including regulation of rapid home delivery of alcohol, stronger regulation of marketing (particularly data-driven advertising on social media), and restrictions on alcohol outlet opening times and density.

Recommendation #10: Develop and implement evidence-based reforms to reduce AOD-related denial of service in social and community services, including requiring referral to an appropriate service when denial-of-service occurs.

Recommendation #11: The Victorian government start providing links to AOD-specific supports on relevant government documents, statements and press-releases.

Recommendation #12: Ensure AOD organisations can support their workforce in event of suicide of a client by supporting them to develop protocols on supervision, debriefing, case review and reflective practice.

Recommendation #13: Establish better pathways for people with AOD needs to access suicide-related supports. For example, by improving psychiatric referral pathways in AOD services.

Vision

1a. The Royal Commission suggested 'towards zero suicides' as a vision for the strategy. Is this appropriate?

Yes.

1b. If not, what vision for suicide prevention and response would you like to see Victoria work towards?

The 'towards zero suicides' vision is an appropriate vision for the strategy. However, VAADA notes that the wording of the vision will not matter without real, substantive and radical change in this area.

As with so many social problems, what matters with suicide is what occurs on the ground: the availability and suitability of services, the actioning of prevention and early intervention initiatives, and the proper resourcing and prioritisation of initiatives and systems that respond to distress, despair and isolation.

Interventions should occur wherever they can make a difference and in a variety of forms, be it therapeutic interventions or policy initiatives that reduce suicide risk at the population level. Initiatives should not solely focus on the individual but address the many causal factors that drive suicide, for example, the spread of gambling, access to alcohol, lack of harm reduction services, key stressors in education environments, etc.

VAADA is much more interested in seeing substantive change in these areas than the precise wording of the strategy's vision.

Priority populations

2.a In this discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate?

Yes – the list is appropriate. VAADA is pleased to see 'people living with substance use and addictions' on the proposed list of Priority Groups.

It is important to note that while 'substance use' refers specifically to AOD, 'addictions' also covers behavioural addictions such as gambling and video games.

2.b If not, which other higher risk groups do we need to prioritise for targeted and comprehensive action right now?

While 'people living with substance use and addictions' is listed as a priority population in the discussion paper, VAADA is concerned that AOD will not be sufficiently prioritised in the Strategy.

People living with substance use and addiction require targeted and comprehensive action to reduce their risk of suicide. However, they also require action that is tailored and responsive to their needs.

Priority areas

3. What priority areas should be included in the strategy to create the biggest impact and help us to achieve our vision?

VAADA supports the priority areas identified in the Discussion Paper, and makes comment on the following areas:

Intersectional and targeted approaches for groups disproportionately affected by suicide

Achieving 'Intersectional and targeted approaches' requires addressing the siloing that is present across much of the social and community service system, including AOD. Support needs to be provided to sectors to participate in collaborative projects to better integrate service systems, improve accessibility of services (including co-located and wrap-around provision) and reduce duplication.

Data and evidence to drive outcomes

Increased investment in and reform of current AOD data collection must be prioritised in the Strategy. One of the greatest challenges in AOD is the lack of clear, comprehensible and uniform data. This means that organisations in the AOD sector are always working partially blind.

Leadership and data expertise are crucial to data reform. The Strategy's focus on data and evidence should include the establishment of a committee to oversee and drive development of improved data collection and monitoring of suicide, including AOD-related data.

The Coroners' Court of Victoria has been one of a few sources of reliable AOD-related data in Victoria. Increased investment in the Court's data collection and monitoring activities (across suicide, mental health and AOD) is needed to improve our understanding of the AOD-mental health-suicide nexus.

Recommendation #2: Increase investment to support the Coroners' Court of Victoria to support and expand their data collection and monitoring on suicide and other key areas including AOD.

Workforce and community capabilities and responses

The AOD workforce (including those working outside the AOD sector, such as AOD nurses in Emergency Departments) requires increased investment in capacity building around identifying and responding to suicide risk including the management of those with chronic suicidal ideation.

One critical issue for the AOD sector is the current status of the mechanism of funding drug treatment – the Drug Treatment Activity Unit.

The 2015, Government commissioned ASPEX report, which examined the state of the Victorian AOD sector, identified the inadequacies of the current DTAU funding model. The report identified the limitations of the tool, primarily its low-value and inflexible nature which led to substantial funding gaps for some activity types.

It is clear that the DTAU no longer accounts for the costs associated with delivering services, not to mention services workforce training and development needs. The workforce needs of the AOD sector expand each year to cater for growing demand in forensic, family violence, child protection, homelessness, CALD, LGBTIQ, pharmaceuticals and dual-diagnosis, not to mention suicide prevention and response.

If the AOD sector is to constructively contribute to Victoria's efforts to prevent and respond to suicide, the issue of service funding must be addressed. VAADA recommends the Victorian Government commence an immediate review of the DTAU that takes into account evidence-based costs of service delivery.

Recommendation #3: Conduct an immediate review of AOD service funding including of the Drug Treatment Activity Unit and commit to implementing recommendations in full.

Whole-of-government leadership, accountability and collaboration

VAADA strongly supports this priority area. Collaboration, in particular, is crucial to this strategy. As the discussion paper notes, suicide does not discriminate. It is an important that all social and community service sectors participate in Victoria's efforts to prevent and respond to suicide.

It is also critical that leadership from the AOD, Harm Reduction and Lived-and-Living Experience sectors be included in the finalisation, implementation and monitoring of the Strategy.

In addition, VAADA recommends a focus on 'whole-of-government accountability'. It is clear that government decisions and policies affect suicide at the population level, as the relationships between alcohol and suicide and gambling and suicide demonstrate.

VAADA suggests a renewed focus on suicide-related harms associated with particular policy interventions. The introduction of 'Policy-related suicide impact statements' would go some way to addressing this gap in accountability. In essence, these would involve and assessment and disclosure of a policy's potential for harm in this area prior to its introduction.

This would help change the government's role from reactive to more proactive in the area of suicide.

Recommendation #4: Ensure leadership from the AOD, Harm Reduction and Lived-and-Living Experience sectors are included in ongoing activity related to the Strategy, including implementation and monitoring.

Recommendation #5: The Victorian Government should introduce mandatory 'policy-related suicide impact statements' across all areas of government.

A responsive, integrated and compassionate system

Even prior to the COVID-19 pandemic, Victoria's AOD sector lacked responsiveness and integration. Wait times for AOD services have been identified as a significant barrier to people with AOD service needs.

There are a range of issues that negatively impact the capacity of Victoria's AOD system to be responsive, integrated and compassionate. These include a lack of pharmacotherapy prescribers and dispensers; substantial wait-times; poor linkages between different AOD treatment types; and a lack of available AOD service in regional Victoria.

One significant and perennial barrier to achieving a responsive, integrated and compassionate system is stigma towards AOD users.

People living with substance use and addictions experience an array of harms, including significant stigma and discrimination. Experiences of AOD-related stigma and discrimination are immensely harmful and associated with 'degradation, shame and anger… and made [participants] feel worthless and hopeless'. [7] Experiences of stigma are associated with reduced help-seeking and service engagement.

For AOD clients, suicidality may be dismissed as a symptom of intoxication. This is an example of compounding stigma: where the stigma of AOD leads to the minimisation of suicidality.

Stigma is the primary barrier to achieving a compassionate service system. Addressing the stigma associated with suicide *as well as* that associated with risk factors for suicide, such as AOD, mental health and disadvantage is therefore crucial to achieving a responsive, integrated and compassionate system. .

Recommendation #6: Invest in and support community-led stigma reduction activities in AOD and other key areas.

VAADA's 2022-23 Budget Submission goes into more detail of the issues the Victorian AOD sector faces in relation to achieving a responsive and fit-for-purpose AOD service system.

Principles

4. What principles should guide the development and implementation of the strategy?

[7] Lancaster et al (2017) 'Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use: A report for the Queensland Mental health Commission', *Queensland Mental health Commission*.

VAADA strongly supports the example principles listed in the discussion paper and recommends adding to additional principles:

- 'Supporting a well-resourced, well-trained and responsive cross-sectoral workforce'
- 'Prioritising early intervention'

The first of these would demonstrate the wide-ranging responsibility for sectors to respond to suicide as well as ensuring sectors across the social and community services are supported to do so.

The second acknowledges the common risk factors present for suicide, AOD and mental health such as childhood trauma, financial hardship, lack of family supports and difficulties in education. A principled commitment to early intervention means taking active and substantial steps towards addressing these.

Recommendation #7: Include two additional principles: 'Supporting a well-resourced, well-trained and responsive cross-sectoral workforce' and 'Prioritising early intervention'.

Suicide prevention and response initiatives and actions

VAADA's comments here address some of the initiatives needed within the AOD space. Other initiatives and actions in other areas are also needed but it is not VAADA's position to comment upon them.

There are a range of Initiatives and actions that can be undertaken in the area of AOD to improve suicide prevention and response.

5.a In addition to the Royal Commission's recommended initiatives, what other initiatives should be included in the strategy?

AOD leadership involved in actioning this strategy. Strong AOD sector and AOD lived-and-living experience representation on the government's ongoing management and implementation of this strategy.

Increasing the capacity of the Coroner's Court to collect and analyse data relating to suicide that cuts across AOD, mental health and other relevant areas. The Coroner's Court is well-positioned to collect this data and conduct the analyses and has been critical in supporting and shaping the social and community service sector's engagement around suicide.

- *Increased investment in the AOD treatment sector* – Excessive wait-times to access AOD services have been an issue in Victoria for a long time. The arrival of the COVID-19 pandemic saw both waitlists and average wait times balloon.
  For a person in the midst of an acute AOD crisis (that will likely involve mental health among other issues), being told they will have to wait eight weeks to access the service they need now is devastating.
  A common characteristic of suicidality is hopelessness. And being told to wait eight weeks is delivering hopelessness to a vulnerable cohort. A lack of available and suitable service when and where a person needs it should not be contributing to the suicide burden.

- *Increased investment in aftercare support* – Suicide risk is significantly elevated in the weeks following discharge from a service. Data from the Coroner's Court of Victoria from 2014 show that of Victorians who suicided in 2009-10 (n369), one third (n122) were drug dependent at the time of suicide.[8]
  The majority of these had engaged with health services *within six weeks of death*, mainly GPs and community mental health services. However, AOD services were less frequently involved. These

[8] Dwyer et al (2014) 'Suicide among drug dependent people, 2009-2010', Turning Point: Talking Point Series (delivered 27 August 2017).

statistics reveal just how vulnerable the AOD cohort is following discharge. Given suicides following discharge from an AOD service were significantly less common, further research is needed to understand the protective role AOD services may play against suicide following discharge.
In addition, it is clear that further investment in aftercare following discharge is needed in both AOD and other service areas.

- *Improved suicide risk screening in AOD services* – Intake and assessment at AOD services is a crucial time for assessing suicide risk as well as identifying factors that may contribute to suicidality. However, current Intake and Assessment processes are already onerous and include requirements to assess for other risks such as family violence (following the MARAM reforms). AOD services would require support from the government to increase suicide risk assessment at intake and assessment.

- *Increased outreach and prevention* – Prevention and early intervention activities have a powerful effect on suicide risk as well as a range of other risk factors. Common age of onset for mental health and AOD use commonly coincide. This presents a dangerous cocktail of risk for suicide, as adolescence is a time of significant challenges and transitions (without the added impacts of AOD and/or mental health issues). Many AOD youth programs offer a more holistic approach to wellbeing and, in doing so, cover the multiple intersecting needs of the young people engaged. This model allows for the early identification of development of resilience and agency that are essential for being able to work through difficult issues that, if unsupported, can lead to suicidality.

- *Increased regulation of alcohol and gambling* – AOD and gambling both contribute to suicide risk, and in turn, both contribute to other highly modifiable risk factor for suicide such as financial hardship. The recent decision by the Victorian government to expand alcohol home delivery flies in the face of the growing body of evidence demonstrating the high levels of risky drinking associated with home delivery, including increased risk of self-harm and suicide.
  The Victorian government should implement a suite of measures to reduce the availability of alcohol by regulating liquor outlet density and opening times, alcohol delivery services, enforcing the responsible service of alcohol, and introducing minimum unit pricing. These initiatives would significantly reduce the alcohol's contribution to suicide-related harms in Victoria. An equivalent tightening of gambling regulations (including effective regimes of enforcement) would also reduce suicide risk.

Recommendation #8: Increase investment in AOD treatment in service provision, in particular, pharmacotherapy, aftercare, suicide risk screening, and outreach and prevention, including reinstatement of funding for 100 additional AOD support workers that recently expired.

Recommendation #9: Include evidence-based reforms to reduce harms associated with alcohol and gambling, including regulation of rapid home delivery of alcohol, stronger regulation of marketing (particularly data-driven advertising on social media), and restrictions on alcohol outlet opening times and density.

Recommendation #10: Develop and implement evidence-based reforms to reduce AOD-related denial of service in social and community services, including requiring referral to an appropriate service when denial-of-service occurs.

5.b What opportunities should be created for the Victorian community to be part of the change to reduce the stigma associated with suicide, increase understanding and awareness and prevent suicide?

Preventative and community work

Funding for preventative and community work in the AOD sector. AOD-related stigma is deeply embedded across Australian society as well as within specific populations. Stigma acts as a significant barrier to service engagement and AOD-related help-seeking.

Currently, very few AOD organisations are funded to undertake health-promotion work (compared to other sectors such as LGBTIQ+ health). Dedicated funding for health promotion in AOD would improve community engagement and assist in addressing widespread AOD-related stigma.

See Recommendation #7.

Media

Links to AOD support services are regularly absent from or inaccurate in media reportage relating to AOD. For example, it is common for links to mental health services to accompany media stories on AOD.

To address this, the Victorian government should start ensuring AOD-specific links are included at the bottom of government and political press releases. This will increase the media's compliance with this standard when reporting.

Recommendation #11: The Victorian government start providing links to AOD-specific supports on relevant government documents, statements and press-releases.

5.c In addition to training, what else is needed to support frontline workforces and other social and health services workforces to respond compassionately to: people experiencing suicidal thoughts and behaviour; suicide attempt survivors; and families and carers?

Frontline workers are often already overburdened with compliance activities such as screening for child safety risk and family violence. While screening for suicide risk is important, workers should be supported with adequate EFT to comply with screening requirements rather than have additional compliance duties added to their workload without additional compensation or capacity.

See Recommendation #7.

5d. How can we better educate and build the capacity of workplaces to reduce the risk of suicide and better support staff? What capabilities or supports are required?

Suicide is a sensitive issue for many, including those in the workforces that support people in need. A fine balance is required to ensure that any matters related to suicidal behaviour are managed in a way that acknowledges sensitivity, has a human focus whilst allowing for a systemic approach.

The death of any individual at the time of seeking service, may be seen as a service provider failure. Unfortunately at times this may be the case, however, establishing a system around suicide that is only about risk mitigation, can minimise the human aspect, generate fear, and interfere with change.

With this in mind, any capacity building for workforces, including the AOD sector should include opportunities for supervision, reflective practice, debriefing, review and response. To support staff in their work and to better respond to issues relating to suicide, the workforce should have the opportunity for non-judgmental and supportive reflection.

Establishing better pathways for people with AOD needs to access support for suicide. Currently, where a client discloses suicidality, a community AOD worker is required to ring psychiatric triage to make a referral for that person. This can take significant time and can results in a gap in care.

In light of the risks associated with the AOD-suicide nexus, such cases should be categorised as high priority (category A or B on the current MH triage scale), which triggers an immediate response. AOD services need to be resourced to make these arrangement with their local AREA Mental Health service.

Recommendation #12: Ensure AOD organisations can support their workforce in event of suicide of a client by supporting them to develop protocols on supervision, debriefing, case review and reflective practice.

Recommendation #13: Establish better pathways for people with AOD needs to access suicide-related supports. For example, by improving psychiatric referral pathways in AOD services.

5.e What higher risk industries/workplaces should we prioritise for immediate suicide action and why?

Those that the data show are at higher risk if suicidality and death by suicide.

5.f For people who have been bereaved by suicide, what are the most compassionate and practical responses we can implement? How might this differ across various communities/groups?

The inclusion of lived experience of bereavement by suicide, including those from various community groups.

Final comments by VAADA

Despite the clear association between AOD and suicide, AOD remains a neglected area of suicide prevention and response.

An illustrative example is the recent bilateral funding agreement on suicide between the Federal Government and Victoria.[9] This saw investment of approximately a quarter of a billion dollars over five years. However, this money has been allocated to the mental health sector: the AOD sector did not receive any increased investment. This clearly limits engagement with the AOD system as a place where enhanced support and intervention could be engaged to improve suicide prevention and response.

The marginalisation is detrimental as AOD services are best placed to address AOD-related harms including those relating to suicide. Many AOD clients do not identify as having a mental illness and so may be reluctant to engage with mental health services. Further, the methodologies used in AOD service—trauma-informed care and psycho-social interventions—have been tailored to the needs of AOD clients.

Of course, AOD and mental health are interrelated, and both are important risk factors for suicide. But this does not mean AOD and mental health are *interchangeable* either as an experience or in regard to service provision.

AOD use should not be understood as sub-category of mental health. AOD has a distinct and complex relationship to suicide (as does mental health). The co-occurrence of AOD and mental health magnify the risk of suicide and requires a specialised response that incorporates both MH and AOD approaches.

VAADA expresses its strong support for the development of this strategy and would welcome the opportunity to provide further input into the development, implementation and monitoring of the strategy.

Please contact me if you have any queries.

Sincerely,

Sam Biondo
Executive Officer
Victorian Alcohol and Drug Association

[9] Government of Australia, (2022) 'Bilateral schedule on mental health and suicide prevention: Victoria'