Building Bridges

Opportunities for Alcohol and Other Drug (AOD) sector collaboration to enhance outcomes for people with co-occurring mental health and AOD needs

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Acknowledgement of Country

VAADA acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the country of the Wurundjeri people of the Kulin Nation. We pay our respects to all Elders past and present and acknowledge their continuing and ongoing connection to land, waters and sky.

About VAADA

The Victorian Alcohol & Drug Association (VAADA) is a member-based peak body and health promotion charity representing organisations and individuals involved in prevention, treatment, rehabilitation, harm reduction or research related to alcohol or drugs. VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug (AOD) use across the Victorian community. Our vision is a Victorian community in which AOD-related harms are reduced and well-being is promoted to support people to reach their potential. VAADA seeks to achieve this through:

- Engaging in policy development
- Advocating for systemic change
- Representing issues our members identify
- Providing leadership on priority issues
- Creating a space for collaboration within the AOD sector
- Keeping our members and stakeholders informed about issues relevant to the sector
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drugs and related services

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VAADA acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.

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Executive Summary

The next phase of mental health reform for Mental Health and Wellbeing in Victoria aims to build on the initial work undertaken by the Victorian Government in response to the 74 recommendations from the Royal Commission into Victoria's Mental Health System (Royal Commission). This included recommendations on how best to support people in the Victorian community living with both mental illness and problematic alcohol and other drug (AOD) use, including through evidence-based harm minimisation approaches.

Since 2021, the Victorian Government has spent over $11B on preventing and supporting Victorians experiencing mental illness, including their families and supporters, across all life stages. To date, there is little evidence that outcomes for people with co-occurring AOD and mental health issues have been enhanced as a result of these reforms.

The Victorian Alcohol & Drug Association's (VAADA) 2024 report, Mental Health Presentations in the AOD Sector: Highlighting the challenge and working towards solutions, corroborated AOD sector survey data with Victorian Alcohol & Drug Collection (VADC) data from 2023-24, to confirm that the prevalence of mental health presentations in the AOD sector continues to remain high without adequate resourcing to meet co-occurring needs.

To date, reforms to enhance integrated treatment have been limited, with resourcing siloed to parts of the mental health and wellbeing sector. Similarly, there has been a lack of action to embed integrated treatment approaches across a broad range of reform activities.

This paper identifies opportunities to improve outcomes for people with mental health and AOD needs through including the AOD sector as part of the next phase of mental health reform. Drawing on the priorities outlined in the Victorian Government's 2nd stage plan, solutions and activities are proposed that will allow the AOD sector play an active role in supporting better outcomes and a more cohesive system for Victorians and their families impacted by AOD and mental health needs.

Victoria requires two strong sectors that are aligned and mutually supportive to respond effectively to this need. This is the only way to ensure that Victorians can get the right help at the right time wherever they may be.

Background

The Royal Commission made 74 recommendations over two reports (Interim and Final) to address issues identified in Victoria's Mental Health System. Since 2021, significant investments have been made to begin implementing the recommendations over a 10-year horizon.

Recommendations 35 and 36 specifically outline actions to improve the ability of the mental health and wellbeing system to support people with co-occurring mental health and AOD issues. However, evidence to date highlights that much

more must be done to improve outcomes, with integrated treatment needing to be implemented as standard practice across all parts of the mental health and wellbeing system.

In 2024, VAADA commissioned research to identify the prevalence of mental health presentations in the AOD sector. The report revealed:

- 83% of clients accessing AOD treatment services in Victoria were reported to have a diagnosed mental health disorder or display or describe symptoms of a mental health condition
- 82% of AOD service users were reported to display or describe symptoms of psychological distress
- 32% of AOD service users reported having experienced suicidal ideation
- 73% of clinical time was spent on providing mental health interventions
- Victorian AOD treatment services provide on average 50 hours per week of unfunded mental health crisis interventions to people seeking AOD treatment

These findings highlight the resourcing needed to treat and support co-occurring AOD and mental health conditions in the AOD sector.

In 2024, the Victorian Government announced its intention to develop an AOD Strategy. In consultations to inform a 10-year AOD plan, participants have consistently identified better integration between AOD and mental health as an urgent priority to strengthen how we address co-occurring needs in the community.

The 2nd phase of reform, in conjunction with Victoria's first AOD Strategy in 30 years, represents an important moment to focus on implementing integrated treatment across the mental health and wellbeing system. This paper identifies where these intersections exist, highlighting the needs of people with co-occurring conditions and the capacity of the AOD sector to support a shared response.

Methodology

The AOD sector has a long history of effectively supporting individuals with co-occurring mental health and AOD needs. Given this expertise and the role of AOD services in meeting co-occurring treatment needs, VAADA consulted with representatives from the AOD sector to identify opportunities on how best to harness this capability as part of continuing reform activity.

The Department of Health's next phase of reform priority actions formed the basis for reflection and assessment. Through this process, twelve areas for action have been identified as priority areas for AOD sector involvement.

The paper seeks to inform how to enhance the effectiveness of integrated treatment across the mental health and wellbeing system utilising AOD expertise. Ultimately this is about better enabling wellbeing outcomes for individuals, their families and communities across Victoria as part of the biggest public health reform in a generation.

Focus Area 1: Preventing suicide and the onset of suicidal distress

Why it matters:

Every day in Australia, 9 people die by suicide, and more than 150 people attempt to take their own lives[1]. The Australian Bureau of Statistics reports that in 2023, acute alcohol use was recorded as a factor in 17.8% of suicides and directly contributed to death in a further 1.9%. Acute psychoactive substance use was recorded as a factor in 16.7% of suicides and directly contributed to death in a further 12.3%. Further, data from 2019, reported in the Victorian Suicide Prevention and Response Strategy, states that 48% of suicide and self-inflicted injuries were due to four contributing factors;

- Child abuse and neglect
- Alcohol use among people over 15 years
- Illicit drug use among people over 15 years
- Intimate partner violence among females over 15 years of age.

The data clearly illustrates an overwhelming relationship between suicidal risk and substance use. VAADA's report Mental Health presentations in the AOD sector, reveals that an estimated 50 hours per week is spent on providing mental health crisis support in AOD services, including interventions to reduce suicide risk amongst those accessing AOD support. The AOD sector is not supported in this crisis intervention work.

VAADA and other AOD sector representatives were involved in the development of the Statewide Suicide and Prevention Response Strategy, which was launched in 2024. Despite being a critical partner for system change when it comes to responding to suicide risk, the AOD sector has not been involved in the implementation of this strategy to date. Further, the National Suicide Prevention and Response Strategy includes multiple levers related to the AOD sector and AOD use, including an increase in AOD treatment beds. This plan is yet to be implemented.

Suicide is preventable, and the AOD sector already plays a role in reducing the risk of suicide and self-harm by supporting people with AOD issues. VAADA's 2023-24 data reveals 32% of AOD service users reported having experienced suicidal ideation. Supporting the AOD sector to participate in the implementation of the Statewide Suicide and Prevention Response Strategy is a necessary next step, and essential if a target of zero suicides is to be achieved.

[1] https://www.mentalhealthcommission.gov.au/national-suicide-prevention-strategy

How the AOD sector can assist

Issues/Needs Identified	Opportunities
Unknown model of care for peer callback service.	Include AOD carers in multidisciplinary teams for peer callback service.
No designated funding for AOD peer workers.	Invest in the AOD peer workforce to support roll out of peer callback service and other peer led initiatives.
Ability of people with co-occurring AOD and mental health needs to access brief support model is unclear and untested.	Include harm reduction considerations in distress brief support model.
	Include harm reduction training for workforce delivering distress brief support model.
	AOD and mental health sector partnership approach to deliver distress brief support programs and other suicide related initiatives.
Unknown model of care for postvention bereavement programs.	Postvention bereavement programs need to ensure an integrated treatment lens.
Lack of standard AOD sector engagement in workforce development related to suicide prevention and response.	Prioritise AOD sector workforce training on suicide as part of the Victorian Suicide Prevention and Response Strategy and as part of the final Victorian AOD Strategy.
	AOD sector participation in capacity building as outlined in the Suicide Prevention Strategy.
	AOD sector participation in implementation of the Zero Suicide Framework.

Focus Area 2 : Promoting mental health and wellbeing

Why it matters

The promotion of positive mental health and wellbeing serves to prevent problem substance use. Multiple studies clearly identify links between substance use and poverty, homelessness, social isolation, trauma, grief, family violence, stress and adverse childhood experiences[2]. Evidence strongly confirm that these factors are also commonly connected with mental ill health and psychological distress[3].

The Victorian Eating Disorders Strategy locates the AOD sector at Tier 3 of a stepped care approach to the identification and management of eating disorders

[2] Zhu J, Racine N, Devereux C, Hodgins DC, Madigan S. Associations between adverse childhood experiences and substance use: A meta-analysis. Child Abuse Negl. 2023 Sep 7:106431. doi: 10.1016/j.chiabu.2023.106431. Epub ahead of print. PMID: 37689565.

[3] https://www.aihw.gov.au/mental-health/topic-areas/health-wellbeing/mental-illness-and-substance-use?utm

alongside primary and secondary mental health services[4]. This position is based on research suggesting that the lifetime prevalence of co-occurring substance use disorder in people experiencing an eating disorder is 1 in 5 or 21.9%. [5]

The interrelationship between substance use, mental health and personal wellbeing has recently been highlighted by the Yoorrook Justice Commission in its Final Report. In the context of First Peoples' experiences, Yoorrook states that "the use of alcohol and other drugs is linked to historical and ongoing harms of colonisation and alcohol and other drugs may be used to cope with cultural disconnection, intergenerational trauma and racism. 'Loss of cultural practices, identity, and community support can contribute to individuals seeking solace through substance use'. Its report also highlights an essential factor in Aboriginal healing – connection, centring it is a core determinant of wellbeing.[6]

We are in the midst of a loneliness epidemic. People who use substances are 7 times more likely to experience frequent loneliness than the general population[7]. Research also suggests that loneliness is more likely to be a driver of substance use, abuse and dependence as opposed to the use of substances being the driver of loneliness[8]. There is growing evidence on the value of connection as an antidote to substance use, a reality which has been addressed for decades by worldwide peer-based support groups such as Narcotics Anonymous. [9]

[4] https://www.health.vic.gov.au/practice-and-service-quality/victorian-eating-disorders-strategy
[5] https://nedc.com.au/eating-disorders/types/substance-use
[6] Yoorook
[7] Stickley A, Koyanagi A, Koposov R, Schwab-Stone M, Ruchkin V. Loneliness and health risk behaviours among Russian and U.S. adolescents: A cross-sectional study. BMC Public Health 2014;14:366. 6. Wilson C, Moulton B. Loneliness among older adults: A national survey of adults 45+. Washington, DC: AARP; 2010. 7. Ingram I, Kelly PJ, Deane FP, Baker AL, Raftery DK. Loneliness in treatment-seeking substance-dependent populations: Validation of the social and emotional loneliness scale for adults–short version. J Dual Diagn 2018;14:211-9.
[8] Reducing loneliness amongst people with substance use disorders: Feasibility of 'Groups for Belonging' Isabella Ingram1,2, Peter J. Kelly1,2, Catherine Haslam3 , Owen J. O'Neil3 , Frank P. Deane1,2, Amanda L. Baker4 , Genevieve A. Dingle
[9] Henning Pettersen, A., Landheim, A., Skeie, Ivar, et al. (2019) *How Social Relationships Influence Substance Use Disorder Recovery: A Collaborative Narrative Study.* **Substance Use & Misuse**, *54*(12), 1906-1919.

How the AOD sector can support this vision

Issues / Gaps Identified	Opportunities
Lack of AOD-specific training amongst allied professionals creates inconsistencies in care for substance users.	Include AOD-designed workforce development as mandatory training for workers in aligned sectors.
Stigma and abstinence-based models exclude some participants from social inclusion groups.	Resource the AOD sector to engage in community activities that destigmatise substance use; challenge abstinence-only engagement criteria.
Requirements for inclusion of AOD content in mental health in schools 'menu' unclear.	Strengthen AOD content options as part of school-based programs.
	Liaise with AOD prevention experts on content design.
	Consider funding mechanisms for enabling community-based AOD services to deliver school-based education sessions as requested.
Limited AOD workforce understanding of eating disorders; siloed treatment systems.	Proactive investment and implementation of workforce capacity building for the AOD sector on eating disorders as part of the Victorian Eating Disorders Strategy
	Strengthen cross-sector pathways with eating disorder support services.
Lack of clarity and transparency around models for social inclusion groups as relates to AOD use.	Review access to social prescribing trials for people who use substances and incorporate necessary adjustments;
	Ensure the AOD sector is involved in the delivery of social inclusion action groups.

Focus Area 3: Promoting First Peoples' social and emotional wellbeing

Why it matters:

First Peoples are overrepresented as service users within the mental health and AOD system in Victoria[10]. Data for emergency department presentations in 2023-24, shows the rate of self-harm for Aboriginal Victorians was 7.5 times the rate for non-Aboriginal Victorians while community mental health services were accessed at 4.7 times the rate.[11]. Data from the VAADABase project[12] shows that First Peoples comprised 9.5% of AOD service users in 2024-25, almost ten times their population. As referenced, the Yoorrook Justice Commission highlighted that use

[10] Yoorrook

[11] https://www.firstpeoplesrelations.vic.gov.au/victorian-government-aboriginal-affairs-report-2024/health-and-wellbeing/goal-14-aboriginal-victorians-enjoy-social-and-emotional-wellbeing#measure-1415-number-of-aboriginal-victorians-receiving-clinical-mental-health-services

[12] https://www.vaada.org.au/wp-content/uploads/2025/09/REP_AOD-Sector-Insights-Report_20242025.pdf

of AOD can be directly linked to the atrocities of colonisation and ongoing impacts of trauma.

Mainstream health services continue to fail to embody Aboriginal concepts of health and wellbeing[13]. According to the social and emotional wellbeing (SEWB) framework used by Aboriginal health services, mental health is a holistic concept that encompasses social, emotional, cultural, and spiritual dimensions. The goal of healing is based on connection as opposed to diagnosis, medication or treatment. There is no differentiation, based on these concepts, between healing for mental ill health versus substance use.

Non-Aboriginal mental health and AOD services need to adopt these concepts when providing services to Aboriginal people. Supporting AOD and mental health services to understand Aboriginal healing and the SEWB model of care will aid in bridging the gap between mainstream and Aboriginal services and improve outcomes for Aboriginal people when accessing mainstream services.

How the AOD sector can support this work

Issues/Gaps identified	Opportunities
Mainstream mental health and AOD services are not practising in a culturally safe way.	Resource VAADA to work with VAACHO to uplift Aboriginal cultural competency within mainstream AOD services and enhance connection between ACCOs and mainstream AOD services.
Mainstream mental health and AOD services have a limited connection with the ACCO sector.	Resource peaks to support cross sector development, collaboration and capacity building (two way learning).

Focus Area 4: Diversity and Inclusion

Why it matters

Consistent with experience across the mental health and wellbeing sector, diverse communities are disproportionally represented amongst those who experience substance-related harm. For example, research shows that LGBTIQ+ status is consistently associated with high prevalence of mental health and substance use disorders, in particular disparities in rates of depression and anxiety. [14] [15]

Further engagement is required to understand mental health and AOD support needs in culturally and linguistically diverse (CALD) communities in Victoria, including refugees and asylum seekers. This includes through the development of culturally informed and led models of care to address co-occurring needs.

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[13] *Hobden B, Bryant J, Davis R, Heard T, Rumbel J, Newman J, Rose B, Lambkin D, Sanson-Fisher R, Freund M. Co-occurring psychological distress and alcohol or other drug use among Indigenous Australians: Data from the National Aboriginal and Torres Strait Islander Health Survey. Aust N Z J Psychiatry. 2024 Aug;58(8):668-677. doi: 10.1177/00048674241244601. Epub 2024 Apr 6. PMID: 38581252; PMCID: PMC11308262.*

[14] https://pmc.ncbi.nlm.nih.gov/articles/PMC8213009/#:~:text=Introduction,1

[15] https://link.springer.com/article/10.1007/s00127-024-02714-1

CALD communities continue to be underrepresented within AOD treatment services.[16]

A common driver for substance use amongst CALD populations is the experience of trauma. Trauma can be experienced before migration, as a result of settlement challenges, post-migration social and economic marginalisation, and experiences of racial discrimination. These same factors have been linked to poor mental health and wellbeing.[17] There is an opportunity to proactively work across sectors to meet the unique needs of diverse communities through the implementation of the Diverse Communities Framework.

How the AOD sector can support this work

Issues/ Gaps Identified	Opportunities
Unmet co-occurring mental health and AOD needs amongst CALD communities.	Develop a program to support the AOD sector work in partnership with CALD communities to implement culturally responsive services that apply tailored and informed approaches to integrated treatment.
	Consider proportional allocation for integrated treatment projects through diverse community grants.
	Ensure community-led solutions are developed and implemented across the mental health and AOD service systems.
Disconnection between specialist LGBTQI+ service system and other mental health and AOD services.	Support both mental health and AOD workforces to better engage with LGBTQI+ services and align with best practice standards in working with sexual and gender diverse communities.
High prevalence of co-occurring mental health and AOD need amongst LGBTQI+ communities.	Resource LGBTQI+ organisations to lead solutions with mainstream services.

[16] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-cald-backgrounds

[17] https://eccv.org.au/wp-content/uploads/2023/02/ECCV-VAADA-Joint-Statement.pdf

Focus Area 5 and 7: Growing the workforce and workforce capability

Why it matters

Workforce capacity remains a high priority across healthcare post COVID-19. While multiple initiatives have been implemented in Victoria to address workforce gaps and the growth in service demand, resources to build and sustain workforce capacity have not been equitably applied across the AOD and mental health sectors.

Our Workforce, Our Future[18] sets the framework for capability standards across the mental health and wellbeing workforce. It includes "Understanding and responding to substance use and addiction" as one of 15 capabilities. The AOD sector currently lacks a workforce capability framework. There is a significant opportunity now to build workforce capability collectively, given there are shared needs to sustain workforce growth across the mental health and wellbeing system. To date, the AOD sector has not been enabled to undertake collaborative planning and learning to support this.

The mental health and wellbeing workforce strategy outlines, as Strategic Pillar 2: the need to Maximise, Distribute and Connect[19] and identifies action 2.2.2 "Integrate the workforce and care pathways across the aged care, disability, alcohol and other drug and primary and tertiary health care settings". The ability to deliver on this action will be incumbent on two strong sectors working together to strengthen workforce capability and pathways.

Innovative programs are required to grow our workforce rapidly to meet demand and the establishment of new services. The Graduate and Early Career Program aims to meet this requirement by employing newly qualified staff in Local mental health and wellbeing services across the State. Whilst these services employ and rely on an AOD workforce for their operation, this investment in workforce capacity is currently limited to mental health nurses, psychological registrars, occupational therapists, social workers and lived and living experience roles – not AOD professionals. Similarly investment in the AOD Traineeship Program has been diminishing since its inception.

[18] https://www.health.vic.gov.au/our-workforce-our-future
[19] https://www.health.gov.au/sites/default/files/2023-10/national-mental-health-workforce-strategy-2022-2032.pdf

How the AOD sector can support this work

Issues/gaps identified	Opportunities
Siloed integrated workforce development activities for co-occurring mental health and AOD need.	Include the AOD sector involvement in Local Implementation Teams to implement the Our Workforce, Our Futures framework.
	Align integrated treatment workforce capability uplift activities and resources across both sectors to meet workforce capability requirements.
Limited architecture to ensure integrated treatment is a core function across the mental health and wellbeing system.	Ensure the Collaborative Centre has AOD representation in its governance structures to enable the effective application of integrated treatment.
Ongoing challenges to ensure a sustainable regional and rural AOD and mental health workforce.	Continue regional and rural incentive fund and allocate resources equitably across both mental health and AOD sectors.
Establishment of new services and programs that require an AOD workforce for integrated treatment delivery.	Map AOD workforce across Local mental health and wellbeing services and consider as part of any review of the Local mental health and wellbeing system.
	Ensure AOD-specific roles are included as early career programs, including AOD Traineeship Programs.

Focus Area 8: Lived and living experience leadership, workforce and services

Why it matters

Lived experience is the foundation of the AOD sector. Many the AOD sector's programs, services and supports have been built on people's experiences of AOD use, support and recovery, which has evolved as a cornerstone of the system we have today. Whilst the landscape of service delivery has adapted to include other perspectives on AOD use, VAADA's 2023 AOD Workforce Survey revealed a staggering 85% of respondents identify as having a lived experience with alcohol or other drugs as either a substance user, family member or significant other [20], a unique and valuable asset the AOD sector offers.

Pleasingly, our sector's lived and living experience (LLE) strength has been recognised through the engagement of the Self Help Addiction Recovery Centre (SHARC) and Harm Reduction Victoria (HRVic) in the implementation of mental health reform recommendations related to LLE. The recently released Lived and Living Experience Discipline Frameworks[21] and the implementation of a series of

[20] https://www.vaada.org.au/wp-content/uploads/2023/10/VAADA-Workforce-Development-Survey-Report-V6_web.pdf
[21] https://www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives

workforce development activities related to peer workers and enhancement of the LLE workforce have all been done in collaboration with AOD LLE experts. Systemically however, the usefulness to advance LLE capability across AOD and mental health services is constrained by the imbalance in resourcing allocations. to. Currently, there are few designated LLE peer worker roles in AOD services, including a lack of AOD family support workers. Without balanced resourcing, the ability of individuals to experience seamless coordinated care from peers between systems is fraught.

Mental health LLE peaks and advocates have recently expressed concerns about a reduction in the resources and systems to support the growth of LLE as envisioned by the Royal Commission. Following an influx of resources and activities related to mental health reform, now is a pivotal point to reinforce LLE leadership within reform activity to ensure the vision of the Royal Commission can be achieved.

How the AOD Sector can help

Issues / Gaps Identified	What would help
AOD sector lacks standard funding for LLE peer and family support workers limiting the vision of LLE leadership.	Establish equitable, ongoing funding for LLE roles in AOD services.
	Fund and embed family peer roles across AOD services to mirror mental health sector approaches.
No overarching structure to lead, govern, or coordinate LLE implementation across sectors.	Establish LLE leadership entities, including Our Agency, backed by recurrent funding and system-level support.
The concept of “allies” in LLE integration is underdeveloped and lacks practical direction.	Define responsibilities for allies by providing training and accountability mechanisms in non-LLE organisations, including peak bodies, to prioritise safety.
Risk of unsafe environments if non-LLE organisations are not held accountable.	Promote AOD and mental health LLE organisational readiness training.
	Support mainstream AOD and mental health organisations to prepare for engagement with an enhanced LLE workforce.

Focus Area 10: Service Rollout

Why it matters

In response to the need to increase options for support where people work, live and play, this focus area covers actions related to enhancing community-based service models. This includes services to support the ‘missing middle’ and for people with complex and enduring needs.

All services that will be rolled out will see people who use substances. These services must align with integrated AOD and mental health treatment principles. The establishment of the first 15 Mental Health Locals has been a significant achievement of mental health reform to date, with the delivery of integrated

treatment being a key concept in their design and implementation. The employment of an AOD workforce within these new services across all disciplines, including LLE, is essential for their successful operation.

The needs of family, friends and supporters were highlighted as a gap in the mental health system and have led to the establishment of eight Wellbeing Connect Centres across Victoria since the Royal Commission. These services are designed to meet the needs of families of people with mental health and substance use needs. Currently, only one of the consortia set up to deliver these Connect Centres includes an AOD service provider.

Similarly, the establishment of AOD and mental health hubs within some hospital emergency departments has allowed for enhanced integrated responses to people with co-occurring mental health and AOD use issues when accessing emergency departments. Again, the successful delivery of these services relies on a highly skilled AOD workforce, specifically addiction medicine specialists and nurses within these settings.

Presently, bed-based mental health and wellbeing services do not operate a standardised model of care across the State. Most bed-based services will have variable staffing profiles, resourcing and ways of working. According to AIHW data in 2022-2023, people diagnosed with mental and behavioural disorders due to the use of psychoactive substances were ranked fourth for overnight hospitalisations, in hospitals with specialist mental health care[22]. Based on this data, the yet to be commenced bed-based reforms will require AOD expertise in the development of new models of care to meet the needs of those accessing inpatient care.

Substance use disorders are highly prevalent among forensic patients[23]. Forensicare, the operator of forensic community and prison-based forensic mental health services, pleasingly identifies this in their revised model of care[24]. However, it relies on community-based AOD services as part of the support and treatment continuum, despite the AOD sector not being resourced to support these specialist services.

General population surveys have documented that approximately 75% of individuals with a substance use disorder have experienced trauma at some point in their lives[25] . VAADA's report on mental health presentations in the AOD sector revealed that 51% of clients presented with moderate or severe psychological distress (as defined by a K10 score of 25 or above), a likely manifestation of trauma. The establishment of a Statewide Centre for Trauma in Victoria was an opportunity to enhance the understanding of trauma and co-occurring mental health and AOD use; however, Transforming Trauma Victoria (TTV) has not been designed to support the AOD sector nor engage with AOD expertise to ensure services offered are in line with integrated treatment principles. The lack of operational funding for TTV limits the potential to address this oversight.

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[22] https://www.aihw.gov.au/mental-health/topic-areas/admitted-patients#Principal-diagnosis
[23] https://onlinelibrary.wiley.com/doi/pdf/10.1111/dar.13344
[24] https://www.forensicare.vic.gov.au/wp-content/uploads/2023/09/FC73-Model-of-Care-Act-Update-WEB-002.pdf
[25] https://pmc.ncbi.nlm.nih.gov/articles/PMC3188414/

How the AOD Sector can support this work

Issues / Gaps Identified	Recommendations / Needs
No standards for integrated treatment delivery in Local mental health and wellbeing services.	Align service planning with the vision of creating an integrated system.
Risk of siloed treatment models; insufficient cross-system collaboration.	Prioritise integration mechanisms between AOD and mental health systems as part of design and at point of operation.
Fragmented care pathways, especially for withdrawal or rehabilitation referrals.	Build formal partnerships and referral pathways between mental health and wellbeing services and specialist AOD providers.
Current AOD workforce capacity insufficient to meet future demand.	Invest in training and recruitment to grow the AOD workforce and specialist expertise.
	Develop an AOD workforce strategy and industry plan for Victoria.
Risk of service delays or needs not being met if AOD sector is underprepared.	Support organisational capacity-building within the AOD sector to address system gaps as part of system redesign.
Risk that service expansion proceeds without planning for true integration.	Embed integrated treatment systems into the infrastructure, design and governance of all new services.
Wellbeing Connect Centre models of care and governance structures have not been co-designed with AOD expertise.	Ensure opportunity for the AOD sector and AOD families, carers and supporters to be involved in evaluation of Wellbeing Connect Centres.

Focus Area 12: Mental Health Crisis Response Reforms

Why it matters

People who use substances are over-represented in mental health crisis responses. AIHW data between 2023-24 reveals that across most States and Territories, the principal diagnosis grouping for mental health in emergency department presentations was mental and behavioural disturbance due to psychoactive substance use, and the rates of presentation continue to increase[26]. Similarly, between these years there has been an increase in ambulance transfers to emergency departments for people using substances.[27] [28]Data captured from the AOD sector revealed that AOD services provide on average 50 hours per week of unfunded mental health crisis interventions to people seeking AOD treatment.

[26] https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments/state-and-territory-data
[27] https://vahi.vic.gov.au/system/files/2025-07/MH%20and%20AoD%20Report%20-%20Jun%202025.pdf
[28] https://www.ambulance.vic.gov.au/sites/default/files/2025-05/AV-Clinical-Insights-Newsletter-Autumn-2025.pdf

How the AOD sector can support this work

Issues/Gaps Identified	Opportunities
Lack of standardised clinical guidelines to address common drivers of behavioural disturbance for substance users in mental health crisis settings.	Enable AOD services and researchers to develop practice guides and partner in creating innovative solutions to meet the needs of people who use substances and who present in crisis settings
Lack of clarity around model of care to be used within safe spaces.	Ensure safe spaces embed harm reduction principles.
	Ensure all workers in safe spaces have training in AOD and establish support pathways to AOD services, including planning for AOD support after hours.
	Enhance the AOD peer workforce to enable adequate staffing of safe spaces.
Lack of formal connection between Ambulance Victoria and AOD service sector in relation to engaging with people in crisis presenting with co-occurring mental health and AOD issues.	Resource VAADA to work with Ambulance Victoria as part of plans to meet Recommendation 10.
	Utilise data from Sobering Centres to understand rates of co-occurring mental health and AOD issues amongst those accessing service.

Focus Area 13: System re-design

Why it matters

The Royal Commission identified that models of care provided were not fit for purpose and required adjustment to enhance consistency and holistic responses as part of a seamless experience for individuals. The provision of integrated treatment as standard practice in the mental health and wellbeing system is a core feature of this focus area. Activities including the role of the Hamilton Centre, and redesign of community mental health and wellbeing services all require collaboration for positive outcomes.

People with co-occurring mental health and AOD needs frequently access both mental health and AOD services and move between systems to have their varying needs met[29]. VAADA's recent report revealed 83% of clients accessing AOD treatment services in Victoria were reported to have a diagnosed mental health disorder or display or describe symptoms of a mental health condition.[30] The Royal Commission final report indicates that 29,571 consumers accessed both mental health and AOD services between 2014-2019[31]. Optimizing access to both

[29] https://rcvmhs.archive.royalcommission.vic.gov.au/
[30] https://www.vaada.org.au/wp-content/uploads/2025/03/FINAL_Mental-Health-Presentations-in-the-AOD-Sector_20032025.pdf
[31] https://rcvmhs.archive.royalcommission.vic.gov.au/

systems by ensuring they share a similar set of standards and resourcing to support integrated treatment is essential to enable best outcomes for individuals.

The AOD sector has a strong foundation in the provision of community based treatment and therefore a significant number of non-government organisations (NGOs) currently deliver AOD services. An opportunity exists when developing NGO partnership models to identify NGOs that provide AOD services in place-based locations as priority partners. This will create the best foundations for the provision of integrated treatment in Victorian communities.

How the AOD sector can support this work

Issues / Gaps Identified	Recommendations / Needs
Systems operate separately, causing fragmentation in care.	Align system standards for integrated treatment to improve client outcomes.
	Resource the AOD sector to enable alignment with integrated treatment standards and protocols in partnership with the mental health and wellbeing sector.
Identify strengths of the NGO sector in providing AOD treatment.	Progress partnership development between health services and NGOs that provide AOD treatment as a mechanism for achieving integrated care.
Currently, underdeveloped collaboration between the mental health and wellbeing and AOD sectors.	Resource cross-sector planning mechanisms that facilitate system leadership to support long-term integration goals.

Focus Area 15: Regional governance and supporting complex care

Why it matters

The Royal Commission envisioned a future mental health and wellbeing system with support delivered where people live, work and play, and thus recommended the establishment of Regional Boards that would enable local communities to identify, design and deliver services based on their own needs. This prioritises coordinated governance as an essential element to achieving integrated treatment, care and support.

There are multiple examples of cross-sector initiatives that have had limited success as a result of siloed governance. For example, the Victorian Dual Diagnosis Initiative (VDDI) was able to influence significant changes within AOD and mental health settings; however, the single sector auspice arrangements that saw VDDI representatives employed via Area Mental Health Services regularly constrained equitable capacity building efforts across the 3 sectors (mental health, AOD and community mental health)[32]. This inequity was most overt at

[32] VDDI review

times when the auspice agency faced workforce challenges. Shared governance ultimately offers an opportunity for circumstances like these to be averted.

A key deliverable of the Regional Boards was to establish multiagency panels. The Royal Commission envisioned that these panels coordinate the delivery of multiple mental health and wellbeing services for people living with mental illness or psychological distress, including children and young people, who may require ongoing intensive treatment, care and support. It can be reliably assumed that a high proportion of individuals that may require a multiagency panel response will have co-occurring AOD issues, based not only on rates of co-occurring mental illness and AOD use but also based on data from the Multi and Complex Needs Initiative (MACNI) a similar conceptual model which reported in 2024, that 70% of individuals involved in the initiative, experienced AOD need[33].

How the AOD sector can support this work

Issues/ Needs Identified	Opportunities
Regional governance structures are not modelling integrated care.	Require AOD representation on Regional Boards to enable integrated treatment.
Lack of AOD sector involvement in co-design of multiagency panels.	Include AOD sector in development, design and delivery of multiagency panels.

Focus Area 16: System planning

Why it matters

The key deliverables for this focus area relate to the development of a statewide service and capital plan for the mental health and wellbeing system. The plan intends to design a roadmap for the future of the mental health and wellbeing system based on a set of 10 principles. Principle 7, 'deliberately designed integration', focuses on utilising a collaborative community network approach to service delivery, which promotes integration[34]. This principle includes specific reference to enabling AOD and mental health integration through 'viewing mental health and wellbeing services as an integrated package of services'. Included in the suite of activities already delivered is the Hamilton Centre and clinical network; however these services are not funded to deliver services equitably to both the AOD and mental health sectors.

Based on the findings informing the capital plan, the largest future demand area will be community service delivery and designing 'fit for purpose' bed based services. The expertise of the AOD workforce is required to meet this demand in alignment with principle 7 of the plan.

[33] MACNI review
[34] Statewide service and capital plan

How the AOD sector can help

Issues / Gaps Identified	Recommendations / Needs
Current capital planning excludes adequate AOD sector engagement.	Embed AOD participation in all stages of service and capital planning processes.
	Apply Principle 7 (deliberate design for integration) consistently across all capital initiatives.
Services like the Hamilton Centre are not accessible to AOD services.	Extend the remit of the Hamilton Centre to include AOD services in alignment with Principle 7.
Risk of misalignment between infrastructure capacity and actual demand trends.	Prioritise community-based design and flexibility in bed-based services; ensure AOD input in forecasting and planning.
Integration principle inconsistently applied in capital developments.	Enforce adherence to Principle 7 across all capital-funded projects.
Missed opportunities for systemic collaboration without a strategic approach.	Use the AOD Strategy as a vehicle for structural integration across the mental health and wellbeing system.

Focus Area 17 and 18: Quality and safety and Implementing the Act

Why it matters

Within Australia, people with mental and behavioural disorders due to AOD use are the 4th most commonly held group in involuntary mental health treatment in community and residential settings after Schizoaffective, Schizophrenia and delusional disorders.[35] There remains no standard model of care for those with enduring and high need co-occurring mental health and AOD needs, who are also more likely to be on compulsory treatment orders[36]. Victoria currently operates two dual diagnosis-specific inpatient treatment units (Westside Lodge and Bendigo Dual Diagnosis Service); however, these units consist of only 28 beds in total and therefore typically have long waiting lists, are abstinence-based models of care and offer only 3-6 month stays.

Since its release in 2023, a significant amount of work has been undertaken to implement the Mental Health and Wellbeing Act 2022 (MHWB Act) within the mental health and wellbeing sector. There is acknowledgement, given the breadth of changes to the Act, particularly relating to the inclusion of rights-based principles, that this work will require ongoing effort. As we enter the next phase of reform, consideration needs to be given to how the MHWB Act can enable integrated treatment. At present, the AOD sector has not been included in any workforce development activity to understand the Act and the changes it

[35] https://www.aihw.gov.au/mental-health/topic-areas/involuntary-treatment
[36] https://www.mhvic.org.au/images/PDF/MHV_RANZCP_AOD_Policy_Position_FINAL.pdf

makes to practice, despite real implications for individuals impacted by the Act who access both AOD and mental health systems of care.

The inclusion of rights-based principles is a significant change to the Act and aims to ensure that mechanisms included in the Act are enacted with the person at the centre. Inclusion of the health-led and dignity of risk principles is key when considering an integrated AOD and mental health response. Stigma towards people who use substances has been identified as a barrier to successful outcomes, and moving towards a health-led principle provides an environment to shift away from a moral failing narrative. Further, the dignity of risk principle aligns well with the AOD sector concept of harm minimisation and enabling the mental health workforce to understand the nature of AOD risk will aid in people's experience of an integrated approach.

Safety for all is an inherent right when accessing healthcare services. Therefore, the use of seclusion and restraint, compulsory treatment, occupational violence and workforce wellbeing all need to be considered in tandem. Mental Health Victoria and the Royal Australian New Zealand College of Psychiatrists recently collaborated to identify patterns of AOD use in mental health settings and identified high rates of Code Grey and Black responses to individuals presenting with acute intoxication and increased use of compulsory treatment and restrictive practices amongst this population. [37]

The same report also identified through mental health workers, the incompatibility of treatment settings to ensure safety for all. Evidence suggests that people who use substances are regularly placed on Community Treatment Orders (CTO), with one 2019 study identifying 40% of people on a CTO for at least 3 months had an additional diagnosis of at least one substance use disorder[38]. Given this data, collaborative cross-sector innovations must be enabled to achieve any goals of reduction in restrictive interventions.

How the AOD sector can support this work

Issues/Needs Identified	Opportunities
AOD sector not aware of changes to MHWB Act, which has implications for integrated practice.	Include VAADA in list of peak bodies to support sector engagement in the implementation of the MHWB Act.
New MHWB Act includes actions that impact individuals with co-occurring mental health and AOD need, however there is a lack of AOD expertise in governance structure.	Ensure Mental Health & Wellbeing Commission includes AOD expertise in governance structure to ensure complaints related to provision of integrated treatment are managed with accurate expertise.
Lack of a shared understanding of MHWB principles in practice as they apply to people with co-occurring mental health and AOD need.	Resource the AOD sector to participate in the co-design of materials that outline the MHWB Act principles in practice. Particularly the

[37] https://www.mhvic.org.au/images/PDF/MHV_RANZCP_AOD_Policy_Position_FINAL.pdf

[38] v Vine R, Tibble H, Pirkis J, Spittal M, Judd F. The impact of substance use on treatment as a compulsory patient. Australas Psychiatry. 2019 Aug;27(4):378-382.

	health led principle and dignity of risk principle.
	Resource the AOD sector to deliver training related to the principles of the MHWB Act in relation to the above principles.
Women with co-occurring mental health and AOD needs have limited options for gender sensitive treatment post inpatient mental health stay.	Support the creation of a gender based AOD framework to align with activities that ensure safety for women in the mental health system.
People with co-occurring mental health and AOD needs are over-represented in occupational violence incidents within mental health and wellbeing settings.	Support AOD practice leaders to develop appropriate responses related to acute behavioural disturbances and occupational violence in the context of substance use.
People with co-occurring mental health and AOD needs are anecdotally overrepresented amongst those impacted by seclusion and restraint.	Engage the AOD sector in efforts to reduce seclusion and restraint through transparent data about rates of seclusion and restraint amongst those who use substances with innovative solutions that mitigate risk.
	Ensure AOD sector expertise is involved in the development of guidelines around management of chemical restraint in mental health and wellbeing settings.
	Activities to reduce rates of seclusion and restraint, including reviews of data on seclusion and restraint via the Chief Psychiatrists office, proactively include AOD expertise.
Limited AOD expertise in current bed-based services.	AOD sector to deliver workforce development support to mental health workforce on engaging AOD users.
	Co-design integrated treatment model of care for Secure Extended Care Unit's and Community Residential Care Units.
People with complex and enduring co-occurring mental health and AOD needs cannot access many AOD services.	Explore and co-design responses for people with high AOD and mental health needs to fill the current service gap for this group.
	Incorporate harm reduction training for community mental health workers to support those on CTO's who do not have a goal of abstinence.
	Include the AOD sector in exploration of alternatives to CTOs for people with AOD and mental health issues.

	Co-design with AOD professionals and LLE representatives, guidance, guidelines and training to support reduction of compulsory treatment.
Separation of system architecture within the Department that allows for effective cross-sector collaboration	Include the Chief Addiction Medicine Advisor in the new quality and safety system architecture across all governance areas.
Disconnection between the Aboriginal and mainstream mental health and AOD sectors	Resource peak bodies and ACCOs to meaningfully collaborate.

Conclusion

People who have co-occurring mental health and AOD needs access both mental health and AOD services in Victoria. The Royal Commission's inquiry into the mental health system brought the AOD sector into scope as a key partner in creating change.

The Royal Commission envisioned a future where Victorians who experience both mental illness and AOD use will receive integrated and comprehensive treatment, care and support, free from barriers and with respect to the rights of all to access the healthcare they need. As illustrated in this paper, there is still much more work to do to achieve this vision. Through the next phase of reform and the release of the Victorian AOD Strategy, genuine opportunities exist for cross sector collaboration to achieve this change.