MENTAL HEALTH PRESENTATIONS IN THE AOD SECTOR

Highlighting the challenge and working towards solutions

March 2025

Acknowledgement

VAADA acknowledge 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.

VAADA also 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.

Who is 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

Executive Summary

People use substances for various reasons. Often the use of substances is enmeshed with mental ill health and psychological distress. This interrelationship can exacerbate the harms of alcohol and other drug (AOD) use, increasing risks, challenging recovery journeys and complicating the way professionals provide treatment.

The 2020 Royal Commission into Victoria's Mental Health System identified the need to change the way the mental health and wellbeing system responds to co-occurring mental health and AOD issues. This included recommendations to improve outcomes for people living with mental illness and substance use or addiction (Recommendation 35) and to establish a new state-wide service for people living with mental illness and substance use or addiction (Recommendation 36). While the establishment of the Hamilton Centre to enhance integrated treatment capacity and capability across the mental health and wellbeing system is a step towards achieving the latter, resourcing existing AOD service provider capability to improve outcomes for people living with mental illness or substance use or addiction has been limited to date.

In 2024, the Victorian Alcohol & Drug Association (VAADA) commissioned research to enhance our understanding of the role AOD services already play in providing integrated treatment. Cleugh Consulting was engaged to support the collection of data from Victorian AOD services about the mental health interventions they provide to clients who present for AOD treatment. The goal was to build our understanding as to whether the system at present is adequately meeting co-occurring needs through planning and resourcing. Meeting resourcing requirements is essential if we want to achieve a truly integrated mental health and wellbeing system in the interests of Victorians who seek assistance for their substance use.

To build our understanding of the nature of mental health presentations within the AOD sector, and capture the valuable role the AOD sector plays in supporting people with co-occurring mental health and AOD issues, Cleugh Consulting undertook an AOD Agency Survey that incorporated client and program data for the period 1st July 2022 – 30th June 2023. This data was supported by additional qualitative data gathered via interviews with AOD agency staff, people with a lived experience of mental illness and substance use, and family members who supported them. VAADA also cross-referenced survey data with the Department of Health, Victorian Alcohol and Drug Collection for the same period which was provided by the Victorian Agency for Health Information (VAHI).

Of significance, the research found:

- 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 to have 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.

The research, correlated with the voices of people who have accessed AOD treatment services and experienced both AOD and mental health conditions, underscores the need to appropriately resource specialist AOD providers as part of Victoria's mental health and wellbeing system reform, to genuinely achieve system integration.

It is pleasing that current consultations on the development of an AOD Strategy for Victoria continue to centre system integration between mental health and AOD services as necessary to ensure that people receive a holistic approach to care that addresses their needs wherever they may seek assistance. This offers hope that the vision of the Royal Commission to improve outcomes for people living with mental illness and substance use or addiction in Victoria can still be achieved.

Background

It has been established that AOD and mental health issues frequently co-exist in clients presenting to both AOD and mental health treatment services. The Royal Commission into Victoria's Mental Health System noted that between 50% to 76% of AOD clients experience at least one co-occurring mental disorder [1].

Enhancing systemic responses for people dealing with co-occurring mental health and AOD issues has been the focus of a range of State and Commonwealth government initiatives over the past two decades. These include the 'Key Directions' framework (2007) [2]; the Improved Services Initiative (2008); and the Comprehensive, Continuous, Integrated System of Care (CCISC) [3] Model pilot (2021) amongst others (see Table 1). Despite some successes, the discontinuation of piloted initiatives, poor transitions between planned approaches and a lack of effective governance in attempts to build integrated treatment capability across jurisdictions, has impacted systemic coherence on how to best address the needs of people experiencing the co-occurrence of substance use issues and mental ill health.

Table 1: Prior integrated care initiatives

Initiative	Description	Years Active	Outcome
Dual Diagnosis – Key directions and priorities for service developments Published by the Victorian Dept. of Health.	The goals of this initiative were to provide clear policy, funding and contractual arrangements; to encourage AOD and mental health services to work together, and improve outcomes for clients and their families.	2007 - 2010	Services in both AOD and MH sectors reported against shared service outcome measures. This promoted relationships and collaborations between services in both sectors, such as shared intake systems and shared care models that improved the client journey. Its discontinuation meant that services in both sectors had no ongoing incentive to work together, and the implementation of centralised intake and assessment procedures in 2014 further wound back joint systems.
Improved Services Initiative (ISI). A Commonwealth funded national program resourcing AOD agencies. Between 2014 -2017 it was known as the Substance Misuse Service Delivery Grants Fund (SMSDGF)	Its objectives were specifically aligned with capacity building activities, and with building sustainable linkages and strategic partnerships to support the provision of dual diagnosis care. Other objectives included facilitating workforce development opportunities and disseminating targeted and relevant information to the AOD sector.	2008 - 2017	Funded AOD services were required to use audit tools (such as the EZ Compass Tool [4] developed by Ken Minkoff and Chris Cline and the Dual Diagnosis Capability in Addiction Treatment - DDCAT)[5] and on a yearly basis demonstrate service gains made towards becoming dual diagnosis capable. Other gains included partnership development between AOD and mental services and the implementation of MH screening tools in AOD services. This funding also enabled a number of AOD services across the sector to implement capacity building/service improvement activities such as the review of relevant policies and procedures, program development and upskilling of staff, all of which were subsequently lost.
Victorian Dual Diagnosis Initiative (VDDI), funded by the Victorian Department of Health. (mental health funding)	The aim of this initiative was to assist mental health and AOD clinicians, agencies and sectors to develop their capacity to respond effectively to people with co-occurring AOD and mental health concerns	2002 - ongoing	The structure of the VDDI included a co-ordinating Leadership Group (VDDILG), an education and training unit (ETU), the VDDI Rural Forum and the Homeless Youth Dual Diagnosis Initiative (HYDDI) which provided a range of services to the AOD sector. These included encouraging the development of working relationships between AOD and mental health agencies, training, consultations and modelling of good practice through direct clinical intervention and shared-care arrangements. Whilst the funding for this initiative has not been discontinued, the majority of it has been reabsorbed into direct treatment provision in mental health services. The ETU was defunded, the VDDILG dissolved in 2023 and 2 of the 4 metropolitan regions do not operate. Whilst the Hamilton Centre is now funded to undertake some of these activities in the mental health sector, there has been no formal handover of resources and/or intellectual property between the two entities so much of this information has been lost.
Comprehensive Continuouse Integrated System if Care (CCISC) Pilot. Funded by the Victorian Dept. of Health and implemented by First Step.	The CCISC is an evidence-based AOD and MH framework developed by Ken Minkoff and Chris Cline. It is a model that can be implemented in any treatment system, agency and program, designed specifically to optimise the delivery of person-centred care.	2021	Benefits of this 12-month project included staff training, improving shared language between the sectors and highlighting issues of effective data collection between them. The project was evaluated as being so successful that First Step has elected to continue this work despite no ongoing funding.

The inability to sustain more effective system integration during this time, as identified by the Mental Health Royal Commission, was also highlighted in VAADA's recent report 'Care and Complexity: towards a re-designed Victorian AOD Service System' [6]. This report identified some key issues that result from the siloing of service provision for people experiencing co-occurring issues. This includes difficulty accessing the right treatment, difficulties navigating available supports, along with a rigidity in the funding of treatment types that does not support wraparound models of care.

Research on patterns of mental health and AOD co-occurrence support the need for ongoing initiatives to address integrated care. In 2019, the National Suicide and Self-Harm Monitoring Project concluded that illicit drug use was responsible for 23% of the years of healthy life lost to 'suicide and self inflicted injuries amongst men, with alcohol responsible for 22% of cases [7].

Further, the National Drug Strategy Household Survey (NDSHS) found that, compared with adults without a mental illness, those with a mental illness were more likely to drink alcohol at risky levels, twice as likely to smoke daily and 1.8 times as likely to use any illicit drug. The results for psychological distress are similar, with the NDSHS finding high or very high levels of psychological distress meant people were more likely to drink alcohol at risky levels, 2.3 times as likely to smoke daily, 4.1 times as likely to vape or use e-cigarettes, and 2.5 times as likely to use any illicit drugs [8].

Best practice on integrated care calls for working collaboratively between systems and within organisations, including through service design, resourcing and governance to enable success. In the context of the Mental Health Royal Commission best practice requires that AOD expertise be leveraged to support all relevant recommendations. While the Hamilton Centre delivers on Recommendation 36 from the Royal Commission and supports the mental health and wellbeing sector through the delivery of a suite of integrated care training modules, research, primary and secondary consultations and addiction specialist care for those individuals under the care of Area Mental Health Services, the broader AOD service system remains a minor partner in the design, delivery or response to improving outcomes for people experiencing co-occurring mental health and AOD issues.

In 2022 Turning Point and the Hamilton Centre worked with the Monash University Design Health Collab to undertake research via a series of consultations with relevant stakeholders (practitioners, clinical leaders and people with lived and living experience) from both the mental health and AOD sectors. The first consultations focused on work to support the establishment of the Statewide Centre, and discuss the design of a best practice model of integrated care [9]. The second was to understand the barriers and enablers to integrated care transformation within mental health service settings [10]. There were numerous recommendations made from this work that included adopting strategies such as working to establish integrated governance, clarifying roles and responsibilities, education and training across both sectors and the use of shared information systems.

A review of integrated care approaches undertaken by Cheetham, Arunogiri and Lubman [11] suggests that addressing the impacts of co-occurring problems requires consideration of new approaches to treatment, service delivery and policy. They also noted the efficacy of brief interventions for high prevalence disorders, and that appropriately trained clinicians "can deliver integrated care without huge investments in co-location of services, organisational change or large scale efforts to build workforce capacity." The researchers further identified that workforce training and capacity building efforts are unlikely to be sustainable without investment in both the AOD and mental health sectors and the inclusion of integrated working in service specifications, such as joint service outcomes, similar to those implemented in the Key Directions policy adopted in 2007.

Understanding mental health presentations in AOD settings

While the phenomenon of co-occurring substance use and mental illness is well documented in literature, understanding the rates of mental illness amongst people attending for AOD treatment and support in Victoria is not well evidenced.

To address this data gap, and enhance our understanding of how the AOD sector contributes to addressing co-occurring needs, VAADA engaged Cleugh Consulting in 2024 to undertake research on mental health presentations in AOD services to:

1. Gain evidence on the number of people presenting to AOD services with mental health needs (and the nature of their needs).
2. Understand the resourcing demands on AOD services in meeting the mental health needs of those presenting for alcohol and other drug treatment.
3. Identify strengths and challenges in the AOD sector's response to co-occurring AOD and mental health presentations.

Methodology:

Twenty-nine AOD agencies voluntarily reported client and program data for the period 1st July 2022 – 30th June 2023, through an online Agency Survey. Additional qualitative data was gathered via interviews with AOD agency staff (22), people with a lived experience of mental illness and substance use or dependence (8), and family members who supported them (2).

Following the collection and analysis of these data sources, VAADA accessed data from the Department of Health, Victorian Alcohol and Drug Collection for the same period. Whilst the parameters for the two measures were slightly different, VAADA compared and contrasted the two sources of information to provide the following insights on co-occurring mental illness and substance use within the Victorian AOD system.

Findings:

Finding 1 - Very high rates of mental health presentations in AOD treatment settings.

Agencies were asked to share data on the percentage of clients attending their service who self-reported a mental health diagnosis or described symptoms that were consistent with a mental health diagnosis against treatment types. Data gathered found that:

8 out of every 10 clients in AOD services were reported to present with a mental health diagnosis or describe symptoms without a formal diagnosis

Of that percentage, 46% had received a formal diagnosis and 37% described symptoms but had no formal diagnosis.

Victorian Alcohol and Drug Collection data reinforced this finding, concluding that 88% of clients presented to AOD treatment agencies with a psychological health condition present in 2022-2023.

Finding 2 - The most common mental health diagnosis in AOD treatment settings include high and low prevalence disorders.

Participating AOD treatment services were asked to list the top three most common mental health conditions (both high and low prevalence) based on their service data during the financial year period 2022-23.

The four most common mental health conditions are captured in Table 2, with anxiety and personality disorders being the most prevalent conditions followed by psychotic and bi-polar disorders.

This challenges a commonly held assumption that AOD agencies predominantly see people with high prevalence conditions, and that those with a low prevalence mental illness are seen in other sectors.

Table 2: Most common presenting mental health conditions

Mental Health Condition	Organisations reporting the condition in the top three most common presentations (N=28)	
	%	N
Anxiety Conditions	93	26
Personality disorders	93	26
Psychotic disorders	89	25
Bi-polar disorder	86	24

Finding 3 - A significant proportion of clinical time in AOD treatment settings is used to provide support to people with mental health conditions.

Participating agencies assessed that individuals with co-occurring presentations require higher intensity interventions that has a direct impact on their capacity to provide delivery of AOD treatment. On average, survey respondents estimated 73% of their clinical time was spent on providing mental health interventions. The most common interventions used by AOD services to treat mental health symptoms were mindfulness and meditation techniques, motivational enhancement and cognitive behavioural therapies.

73%

AOD clinicians report 73% of their clinical time spent on providing mental health interventions

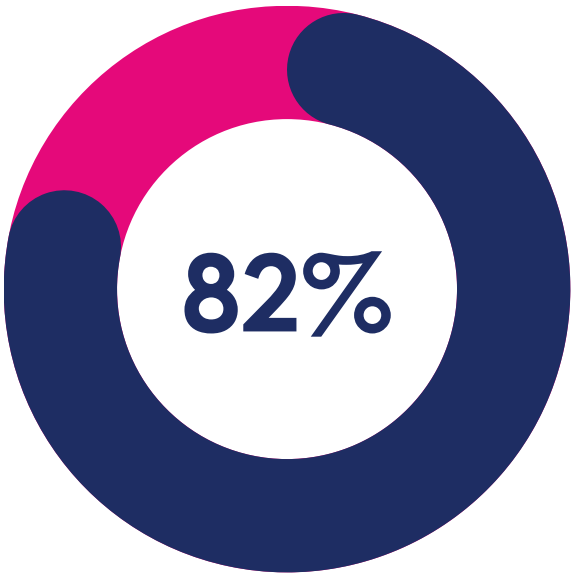
When asked about the mental health conditions that take up the most clinical time, participants ranked anxiety conditions, personality disorders, trauma conditions and depressive conditions as the top four.

Data provided by participating AOD agencies was further analysed to reveal that AOD services on average provide approximately 50 hours per week on mental health crisis support. If extrapolated and applied on average to funded AOD service providers in Victoria, this represents more than 200,000 hours of mental health crisis intervention (or at least 100 full time equivalent staff) provided by AOD services each year without appropriate resourcing. This highlights the extent to which the Victorian AOD sector supports the specialist mental health sector, by playing a vital (yet unfunded) role in meeting the needs of people with mental illness.

Agencies spend **50 hours per week** on average providing mental health crisis support

Finding 4: Very high rate of psychological distress reported in AOD treatment settings.

There is a growing recognition that there is a difference between experiences of mental illness and experiences of psychological distress. For the purpose of this research psychological distress is defined as the experience of someone having deeply unpleasant feelings, symptoms or experiences. These experiences may or may not be due to mental illness.



Agencies reported 82% of AOD services users were reported to display or describe symptoms of psychological distress

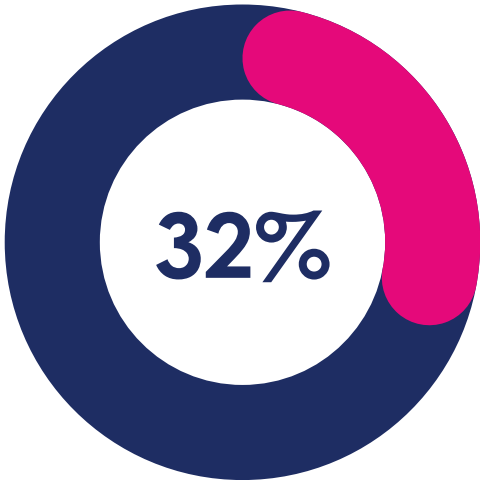
Victorian Alcohol and Drug Collection data indicated that a 51% aggregate of clients presented with moderate or severe psychological distress (as defined by a K10 score of 25 or above). The nature of these experiences has significant implications for how AOD services need to respond to mental health and wellbeing needs, including the nature and length of intervention, and hence the type of resources required.

Finding 5: Those accessing AOD treatment experience a high rate of suicidal ideation.

Suicide and substance use have a strong bi-directional relationship with substance abuse becoming a driver for suicide and as a contributing factor for acting on suicidal ideation as a result of lowered impulse control.

For the purposes of this study, suicidal ideation was defined as 'thoughts about wanting to take one's own life or wishing to be dead'. This can range from fleeting thoughts to more persistent preoccupation about suicide, including planning.

On average, agencies reported **32% of AOD clients have experienced suicidal ideation** from 1 July 2022 - 30 June 2023



Agencies, on average, reported 32% of AOD clients to have experienced suicidal ideation for the period 1st July 2022 – 30th June 2023. In some treatment types reported on, the percentage of clients experiencing suicidal ideation was as high as 80%. Of note, VAHI data did not record presentations of suicidal ideation, which should be seen as an area for data improvement.

A 2020 meta-analysis of cohort studies conducted by researchers from the Matilda Centre at the University of Sydney found that life stressors consistently interacted with AOD use to increase the risk of suicide, and to have a role in the transition from ideation to acts of suicide [12].

Figures from the Victorian Coroner's court indicate that for 2023 there were 547 deaths recorded from overdoses. Of these, 114 or around 21% were deemed to have been intentional, with a further 38 listed as being 'unable to be determined' [13].

Finding 6: There are strengths and challenges in the Victorian AOD sector that need to be considered

A range of focus groups were conducted to explore the strengths and challenges experienced by those working in the AOD sector and individuals with lived and living experience of substance use and mental ill health. The findings from these consultations have been summarised and separated into system and service level strengths and challenges with the intention of locating solutions in appropriate parts of the system.

Table 3: The service level strengths and challenges that participants shared.

Service Level	
Strengths	**Challenges**
Described as accessible, capacity to intervene early, use supported referral pathways and advocacy through referral processes and the capacity for flexible support to be provided for co-occurring issues. ***'We now have an agreement with the local central intake to do intakes directly if they feel the client will fall through the gap, this is often the case for people with complex needs.' (Clinician participant)***	Included repeated assessments, poor co-ordination between AOD and mental health supports and a general dissatisfaction with the AOD intake system. ***'I waited more than three months before I was referred, my circumstances had changed by then, my mental health was heaps worse.' (Lived experience participant)***

System Level	
Strengths	**Challenges**
Identified as the AOD sector's holistic, person-centred approach, strong cross-sector collaboration and clinical expertise. ***'They [AOD service] connected my mental health and AOD needs together...most of them [interventions] work for both mental health and AOD (needs), like meditation, good sleep…when I was less anxious, I'd want to use less' (Lived experience participant)***	Involved resourcing constraints, different AOD and mental health practice frameworks (including different language, service approaches and interventions). Data management systems that are time consuming to utilise and lack of access to shared data was also seen as being problematic. Sector capacity building needs were similar to those at the service level and incorporated increased employment of mental health professionals in AOD services, improved co-ordination of care across the sectors (including the development of shared guidelines) and research demonstrating integrated treatment effectiveness. ***'It's a great model [integrated AOD and mental health treatment]. I have an AOD worker, and GP and Psychiatrist who all talk together with me, we all communicate about plans and discuss medication changes. My GP always books double appointments because he knows me and it gives us more time to discuss the issues…. Everyone knows what everyone else is doing, they include my partner too'. (Lived experience participant)***

Conclusion

Data collected through this research highlights the invaluable role the AOD sector plays in meeting the needs for those experiencing co-occurring mental health and AOD issues. The data reinforces known anecdotal evidence that a high proportion of consumers accessing AOD treatment services are also experiencing mental illness, psychological distress or suicidal ideation and that a significant portion of AOD clinical time is devoted to mental health crisis intervention. AOD services are not only managing the AOD needs of the consumers but also spending a significant proportion of their funded time addressing wellbeing risk amongst those presenting for treatment by providing integrated responses.

AOD services are calling for urgent change, to ensure that system architecture and resources are appropriately provided to support integrated treatment. The intention must be to deliver on the vision of the Royal Commission to improve outcomes for people living with mental illness and substance use or addiction in Victoria. With the reform process continuing and with the first AOD Strategy in Victoria in three decades being finalised this vision can still be achieved.

Recommendations

Provide enhanced levels of resourcing to AOD agencies to support with mental health needs. This should focus on directly resourcing treatment of the most prevalent mental health conditions (identified through this research), while ensuring adequate and streamlined access to tertiary mental health assessment and treatment for people in acute need or distress. This includes by:

1. Expediting the review of the Drug Treatment Activity Unit pricing model to appropriately price the cost of embedding mental health support into AOD treatment as part of integrated models of care.

2. Adequately resourcing AOD services to support people in acute distress to navigate access to tertiary mental health services, to enhance system integration.

3. Establishing a collaborative MH and AOD Expert Advisory Group to oversee, design, evaluate and document the implementation of integrated treatment and share best practice examples of MH/AOD collaborative partnerships across both systems of care.

4. Enabling the AOD sector to actively participate in reducing the rates of suicide through implementation of the suicide prevention and response strategy.

5. Resourcing workforce development activity specifically for the AOD sector on suicide intervention, risk assessment and response.

6. Enabling better interconnection of client management systems and data sharing between mental health and AOD services

7. Commissioning further research to better understand the extent and makeup of mental health work within the AOD sector, the value, function and gaps as part of a stepped care model.

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