**Policy Position**

# The role of mental health services in the provision of Alcohol and Other Drug responses in Victoria

May 2025

## About this work.

Mental Health Victoria (MHV) in partnership with the Royal Australian & New Zealand College of Psychiatrists – Victorian Branch (RANZCP), engaged Area Mental Health Services (AMHS) from across Victoria to develop this sector-based policy position.

This policy position is intended to complement the Victorian Alcohol & Drug Association's (VAADA) advocacy on *Mental Health Presentations in the AOD Sector*, while also informing the Victorian Government's development of its 10-year Alcohol and Other Drug Strategy. MHV and RANZCP seek to highlight the role of the mental health system in the provision of AOD treatment interventions to ensure this activity is recognised as an essential component of Victoria's AOD responsiveness and incorporated accordingly into strategic planning.

In shaping this position, MHV and RANZCP consulted via roundtable with Clinical Directors and their peers from Victorian tertiary health services to understand the experience of supporting individuals with substance use issues or co-occurring mental health and alcohol and other drug (AOD) conditions. MHV and RANZCP also undertook a mapping of existing service capacity and resource distribution across Victoria's tertiary mental health sector in an attempt to quantify the asset that exists within the system in ensuring the availability of a full range of treatment options for individuals with AOD treatment needs, and to gain insight into the impact this has on system performance.

The survey identified an increase in the number of people requiring AOD support from mental health services over the past 5 years, with methamphetamines, cannabis, and alcohol the most commonly reported substances used. It also highlighted that the role of mental health services in the delivery of responses to AOD presentations varies across Victoria with respect to resourcing, models of care and service offerings, governance and integration:

- 100% of responding services report having dedicated AOD specialist roles within the mental health program. However, there is a stark variability in the resourcing profile shaping the availability of evidence-based interventions.
- 100% of responding services report the availability of consultation liaison style AOD services. However, there is a disparity in the reach of these services (with some limited to emergency department and mental health settings and others available more broadly to all bed-based hospital departments).
- The resourcing profile of AOD consultation liaison services also varies from nursing only to specialist addiction medicine and multidisciplinary team resourcing, and there is variability in the model of care and governance arrangements for these services.
- Despite high rates of recorded and observed AOD presentations to emergency departments and concern about the lack of suitability of the treatment environment, not

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all services currently receive funding to operate a mental health and AOD hub within the emergency department.

- Tertiary health services support significant volumes of opioid substitution prescribing across the state. However, access to pharmacotherapy prescribing across hospital and community settings is inconsistent with variability in eligibility for access and noted demand management constraints.
- While some services support community pharmacotherapy prescribing to individuals with a substance use disorder, others operate a limited service to individuals presenting with co-occurring substance use and mental health needs as registered clients of the mental health service only.

Survey responses highlighted the impact of AOD demand on the mental health system is resource intensive, affects service performance, and contributes to the use of compulsory treatment and restrictive practices.

- Mental health services reported high rates of emergency Code Grey, Code Black and Behaviour of Concern responses to individuals presenting with acute intoxication with particular impact attributed to increased and prolonged use of methamphetamines.
- Services report increased use of compulsory treatment and restrictive practices (particularly restraint) for individuals presenting with an acute behavioural disturbance secondary to substance use.
- One service highlighted the impact of exposure to increased risk of occupational violence in both hospital and community settings when responding to AOD presentations.
- The incompatibility of treatment settings to ensure safety for the individual, the workforce, and other consumers was also highlighted.

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These insights align with contemporary evidence that identify acute and chronic substance use has been shown to be a significant complicating factor for the provision of acute and inpatient mental health assessment and treatment, with increased use of restrictive interventions:

- A 2017 Victorian audit study including a total of 232 consecutive admissions to a metropolitan Melbourne adult acute mental health inpatient unit in a three-month period has shown that restrictive interventions were used nearly eight times more often in people who used methamphetamines than their IPU peers[i].
- A Danish cohort study published in 2019 showed people with co-occurring mental health and substance use disorders and people receiving mental health treatment due to substance use are more likely to be mechanically restrained than non-substance using peers in the same treatment setting[ii].
- Two 2020 studies found substance use is associated with behaviours of concern and longer inpatient admissions (37.6 days compared with 16 days). One of these studies demonstrated linked recent methamphetamine use with higher rates of aggression and seclusion[iii] [iv].
- A 2019 Victorian study demonstrated that 40% of people on a CTO for at least 3 months had an additional diagnosis of at least one SUD, and people with additional substance use disorders were placed under orders sooner than consumers without an SUD recorded[v].

Responses also identified that service capacity to respond to AOD and co-occurring needs is variable and impacted by the availability of both internal and external capability and resources:

- While all responding services confirmed AOD screening processes at intake, not all have access to formal clinical resources to support withdrawal.
- Services reported variability in the impact of AOD presentations on length of stay. While most services report having relationships with community AOD services, the ability to streamline onward referral through coordinated discharge planning is variable and contributes to incidences of consumers both being exited from mental health treatment prematurely due to continued substance use, as well as incidences of increased length of stay due to limited availability of appropriate onward referral options – particularly rehabilitation.
- Managing sequencing of discharge planning of AOD supports with resolution of acute mental health symptoms contributes to longer lengths of stay particularly for services with less integrated care capacity, formal partnership with local AOD services, or proximity to detox and rehabilitation services.

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The sector roundtable included the presentation of perspectives from VAADA and the Hamilton Centre. It highlighted the need for improved coordination and distribution of treatment, care and support options to improve responsiveness to the Victorian community. Participants identified the need to improve access and continuity of care, and to address the risks posed by the current system's fragmentation.

A central theme was recognition that Victoria's mental health and AOD systems have historically operated as distinct and siloed service streams that do not meet the contemporary needs of the community. While there are examples of effective, integrated practice, these are often underfunded or geographically limited, compromising equitable access across the state. Many services and roles are stretched beyond their capacity in an effort to support consumers with acute and complex needs.

There was a clear call for a commitment from government to strategically plan for the delivery of the full continuum of treatment, care, and support options, and to design and deliver integrated models of care that reflect the complex and interrelated nature of mental health and AOD issues. This requires a deliberate and systemic redesign, including:

- a rethinking of the system architecture that underpins both sectors,
- design of contemporary models of care, and
- strategies to address capacity constraints across the workforce and services.

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## Policy priorities

MHV, RANZCP, and participating area mental health services advocate for three key policy priorities, which are discussed in detail throughout this position paper:

1. **Deliver an integrated system architecture**

   A deliberate and purposeful redesign of the system architecture is essential to support integration between mental health and AOD services.

2. **Deliver contemporary models of care**

   Acknowledge co-occurring need as a distinct health need and design and deliver models of care with intention to provide safe and effective treatment care and support.

3. **Address capacity constraints across the system**

   Equitable access to treatment, care and support options must be available to Victorians with co-occuring needs across both urban and regional Victoria.

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## Priority 1 - Deliver an integrated system architecture.

*"[There is a] fundamental issue of how seamlessly people can flow from specialist services including mental health and alcohol and drug hubs. There are silos that are built into the structure."*

***Key stakeholder***

Key stakeholders from both the AOD and clinical mental health sectors acknowledge that, for many consumers, access to care occurs more by chance than by design. The current experience is one of accidental overflow between systems, rather than a result of coordinated, intentional service planning. Purposeful and deliberate system design is essential to enable genuine integration to improve outcomes for individuals with co-occurring mental health and AOD challenges.

The mental health and AOD systems in Victoria have evolved separately – shaped by distinct funding arrangements, governance frameworks, and historical trajectories. These differences, rooted in historical, political, economic, and systemic factors, have contributed to fragmentation in care and fail to account for the prevalence of co-occurring issues and the need for multidisciplinary and coordinated responses.

It is an unrealistic expectation of, and burden to, consumers to navigate a disjointed system with inconsistent and insufficient capacity. Intentional structural reform that recognises dual diagnosis as a distinct clinical phenomenon is necessary to ensure individuals at any stage of change can receive seamless and integrated treatment, care and support.

A strong willingness to collaborate in the interest of improved experiences of care and outcomes and the existence of innovative, effective models of integrated care were evident throughout consultation. However, structural impediments to system coordination, the absence of forums to plan, and insufficiency of infrastructure remain as barriers to the dissemination of improvements across the state.

As one stakeholder shared:

> "*There are strong evidence-based models of care around how you do this work. The challenge is there's no forums or mechanisms for us to actually have the conversation about those effective models of care. There is no forum to actually have discussions around the problems that services are facing and thinking about how to resolve that. Instead, we're asked to say, well, how can we work together to pull together resources that are designed in a different way, funded and countered in a different way to sort of solve a problem that we're all struggling with."*

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A central theme identified by stakeholders is that there is ambiguity surrounding the intended scope of integration – and a need to clarify whether the objective is to achieve:

- better collaboration between providers (across 2 distinct systems relying on inter-personal or inter-organisational relationships and goodwill),
- integration at the point of care (through dual qualified practitioners in distinct systems),
- integrated services (achieved through formal partnerships and new models of care), or
- system integration (where the system is restructured to meet contemporary need requiring structural realignment of policy, governance, and funding).

We call on the Victorian Government to:

- Prioritise the establishment of the AOD Ministerial advisory committee committed to in the Statewide Action Plan, and ensure the terms of reference support collaboration between mental health and AOD key stakeholders.
- Clarify the intended scope of integration and align mental health and AOD system level functions.
- Deliver a comprehensive outcomes framework to guide integrated care implementation.
- Acknowledge, and integrate into system planning, the role of responsiveness to episodes of acute intoxication as a feature of the AOD treatment, care and support system delivered through mental health services.
- Map data related to current capacity and resources, using an agreed taxonomy, across both sectors through leadership and facilitation of the peak bodies representing these sectors.
- Ensure the next iteration of the mental health workforce strategy provides direction on the comprehensive skill set requirements and individual investment needed for skills appraisals, with prioritisation of the needs of regional and rural communities.
- Clarify business rules around diagnosing and recording Substance Use Disorders and ensure the soon to be released Mental Health Client Management System has the capacity to collect data that supports integrated care.

## Priority 2 - Deliver contemporary models of care

*"We are dealing with consumer cohorts who were pre-contemplative, and our system architecture has no availability, flexibility, to support consumers with that particular profile. Consider also the fact that we're dealing with complex comorbidity, we never just see one or the other, it's always combined."*

***Key stakeholder***

A key issue identified by both AOD and clinical mental health stakeholders, is the inability of current roles and services to consistently deliver coordinated and continuous treatment, care and support that meets the needs and preferences of individuals experiencing dual diagnoses. Consultation attendees reported strong evidence for improving service capacity and integration through workforce collaboration and agreed on solutions to enhance the current system.

The inability to transition smoothly through networks is a shared frustration. It was noted that individuals with co-occurring AOD and mental health needs are often interacting with services at times where they are pre-contemplative about change. While health interventions provide an opportunity to generate a motivation to address harmful substance use, sophisticated coordination is required to ensure access to the right point of care is available to the person in response. The current disconnection between the AOD and mental health systems has placed increasing pressure on service providers to scope stretch in order to provide continuity and completion of care. While the presence of mental ill health can be perceived to be a barrier to motivation for change, it should not be used as a threshold barrier to accessing services. Accordingly, the availability of purposefully designed services is required to ensure mental illness is not a barrier to addressing harmful substance use.

Additionally, roles within services are often not adequately equipped to respond to the complexity of dual diagnoses despite the capability to identify the need. As one stakeholder noted:

> *"For anyone that's worked in triage… we are only allocated 15 to 20 minutes for that first contact with a person, and it doesn't allow for the time to do good risk assessment on all those parameters."*

Contemporary models of care should consider how treatment can be delivered safely and effectively alongside the pursuit of the elimination of restrictive practices.

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We call on the Victorian Government to support:

- Establishment of an AOD and Mental Health working group by the Minister for Mental Health as an extension of the existing Ministerial Advisory Committees for AOD and mental health.
- Clarify and consider progress toward integration of community based AOD services and Mental Health and Wellbeing Locals (as a long-term goal), and integration of clinical AOD services with area mental health services delivered by health services more broadly for the delivery of treatment.
- Specialist resourcing to support safe detoxification and rehabilitation accessibility for individuals with a mental illness with clear quality, safety, and practice standards.
- Setting of activity targets that reflect the department's expectations for integrated care in AMHWs and develop a contemporary taxonomy of inputs that reflect best practice to be incorporated into the Statewide Client Management System Database to be recognised as core mental health activity.

## Priority 3 - Address capacity constraints across the system

*"You get to the point where people reach the decision to change, which can be quite challenging to get to that point. But then you find out there's a three to six month wait to get them into the rehab and that's a long time for people to be out in the community with minimal support when they're hoping to change. There's a couple of barriers as well to rehab. The first is the access of actual government funded rehab beds. Outside of that we do have access to the rehab programmes, but then they start charging like 80% of the Centrelink payments, so that is actually a bit of a barrier to the individuals looking for rehab, even if they are motivated to change."*

***Key stakeholder***

Both mental health and AOD sector stakeholders agree that access to services remains inequitable across Victoria – impacting consumers seeking treatment, care and support, and limiting the effectiveness of planning by service providers seeking to support them.

While approximately 80% of clients in AOD services either have a diagnosed mental illness or report symptoms consistent with a mental health condition[vi], there is an absence of service availability to respond to AOD need and simultaneously intervene to prevent a deterioration in mental state.

MHV and RANZCP's consultations identified that the organisation of the system necessitates that co-occurring needs be responded to consecutively rather than concurrently which contributes to incomplete episodes of care, high rates of readmission, and for some extended lengths of stay to meet the requirements of eligibility for the right next point of care.

We call on the Victorian Government to:

- Improve system planning by actively monitoring the number of referrals that are declined due to mental health or AOD complexity (or declined for other reasons).
- Expand statewide dual diagnosis rehabilitation capacity and consider contemporary evidence about the efficacy of both community and bed-based models.
- Improve coordination of rehabilitation access across regions.
- Modernise funding models to better reflect service activity and reintroduce flexible block funding to enable local responsiveness and service innovation.

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## Alignment with existing recommendations

The following recommendations, drawn from the 2025-26 RANZCP and MHV Budget Submissions are particularly relevant to this policy position:

- **Prioritise RCVMHS Recommendations 11 and 12**: Deliver co-designed rehabilitation and recovery-focused care models that address the needs of Victorians with complex co-occurring conditions.
- **Expand Crisis Intervention Options**: Enhance crisis intervention, both within and beyond emergency departments, fully implementing RCVMHS recommendations 8, 9 & 10.
- **Comprehensively invest in building a strong mental health workforce by**:
  - Analysing critical role shortages and developing a specialised, skilled workforce to meet existing and emerging demands
  - Fund and implement a Mental Health and Wellbeing Workforce Strategy.
  - Supporting organisational capacity to deliver traineeships, continuous professional development, and system innovation.
  - Partner with education providers to enable leadership opportunities for graduates and mid-level staff.
  - Implement RCVMHS Recommendation 2 focused on system-wide roles for people with lived experience of mental ill-health or psychosocial distress.

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## About the sector roundtable

In developing this policy position, RANZCP and MHV engaged clinical directors and addictions specialists from Victoria's tertiary mental health sector in a roundtable designed to describe the experience of the mental health sector in meeting the needs of Victorian's requiring treatment in response to acute presentations characterised by substance use or for co-occurring mental health and AOD needs.

The roundtable explored the enablers required to deliver successful sector integration for optimal patient care and also welcomed representatives of VAADA and the Hamilton Centre to participate in the discussion.

Over 50% of Area Mental Health Services were represented at the roundtable including:

- Alfred Health
- Austin Health
- Barwon Health
- Bendigo Health
- Eastern Health
- Grampians Health
- Mildura Base Public Hospital
- Monash Health
- Melbourne Health
- Northern Health
- Northwestern Mental Health
- Peninsula Health
- Royal Children's Hospital
- St Vincent's Hospital

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## About the sector survey

RANZCP and MHV undertook a scoping survey to quantify the value clinical mental health services contribute to meeting AOD demand through the provision of treatment.

Approximately 50% of AMHS participated in this survey including:

- Albury Wodonga Health
- Alfred Health
- Austin Health
- Barwon Health
- Bendigo Health
- Grampians Health
- Mildura Base Public Hospital
- Melbourne Health
- Monash Health
- Northern Health
- Peninsula Health
- St Vincent's Health
- Western Health

The survey was comprised of four key themes:

- **System assets – capacity and capability:** These questions aimed to quantify the value and the assets of the mental health system in addressing AOD need.
- **Service activity and insights:** These questions aimed to understand the activity undertaken by mental health services and will help frame discussions about effective models of care, resourcing, and to understand elements of system performance.
- **Integrated care within your service:** Integrated care is a reform priority. These questions aimed to understand how integrated care is operationalised and how consistent the approach is across the state.
- **AOD service capacity in your region:** These questions provided an opportunity to identify access to services across Victorian communities as well as consideration of geographic areas and governance across regions.

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## About Mental Health Victoria

Mental Health Victoria (MHV) is the peak body for mental health and wellbeing, dedicated to fostering collaboration with the aim of ensuring every Victorian has access to the enablers of positive mental health and wellbeing.

MHV Associates (member organisations) form a diverse and dynamic network representing the breadth of the mental health and wellbeing sector. This includes mental health service providers from the public health, private, and non-government sectors, and allied sector organisations.

MHV regularly brings together the voices of the mental health and wellbeing sector and community to engage and provide input into matters of public policy that shape Victoria's mental health system and outcomes.

## About The Royal Australian & New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness, and advises governments on mental health care.

The RANZCP is the peak body representing over 8500 members in Australia and New Zealand and, as a bi-national college, has strong ties with associations in the Asia and Pacific regions.

The RANZCP Victorian Branch supports 2122 members across the state, including 1484 qualified psychiatrists and 638 members psychiatrists in training and affiliates. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support people in their journey of recovery.

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