Strengthening support for people with co-occurring mental health and alcohol and drug issues

2026

Ginny Toombs

WORKING FOR
A JUST TASMANIA

AnglicareTAS
Choice, support and hope

SOCIAL ACTION & RESEARCH CENTRE

BSC-143703 2026

Contents

Acknowledgement of Country

Anglicare Tasmania acknowledges and pays respect to the Tasmanian Aboriginal community as the traditional and original owners and continuing custodians of this land, Lutruwita/Tasmania, on which this project has taken place. We acknowledge Elders past and present, and Aboriginal people who have participated in and are connected with this research.

Acknowledgements

The assistance of the staff of Anglicare Tasmania's Community Services in the preparation of this report is gratefully acknowledged. Thank you for the important work you do, and to the people you work with for their strength and resilience.

Thank you to other Anglicare colleagues for your support and guidance.

About Anglicare Tasmania

Anglicare, in response to the Christian faith, strives to achieve social justice and to provide the opportunity for people in need to reach fullness of life.

Our values

Hope
Confidently reaching for fullness of life.

Compassion
Showing empathy and care for those in need.

Justice
Promoting the fair distribution of resources and opportunities.

Respect
Recognising the inherent value and dignity of every person.

Anglicare Tasmania's Social Action and Research Centre

The Social Action and Research Centre investigates how and why Tasmanians are affected by poverty and inequality. We use what we learn to advocate for changes that improve people's lives.

Our qualitative research centres on the lived experience of Tasmanians. It often features the voices of people who use Anglicare services and our frontline workers.

Our quantitative research uses data to demonstrate social trends.

We brief government and stakeholders on our research and create opportunities for networking and collaboration.

Content advice

Please be advised that this report includes content that relates to people's experiences of mental health concerns, alcohol and drug use and navigating service systems. There are references throughout the report to mental health issues, including suicide. Please take care when reading this material, and if needed speak with a support person you know or call a telephone support line.

Lifeline – 13 11 14

National 24/7 Alcohol and Drugs Hotline – 1800 250 015

Suicide Call Back Services – 1300 659 467

13YARN – 13 92 76

Kids Helpline – 1800 551 800

QLife – 1800 194 527

Note on terminology

This report has preferred the term 'co-occurring mental health and alcohol and drug issues' as this is considered more accessible language than 'dual diagnosis' or 'comorbidity'. This is intended to be inclusive of mental health problems, trauma, psychological distress, disorders/diagnosis and substance use, misuse and addiction (VAADA 2023).

'Co-occurring mental health and alcohol and drug issues' refers to people experiencing co-occurring mental health issues (including suicidal thoughts and/or behaviours) and substance use or addiction, with or without a formal diagnosis for one or both. This definition acknowledges the diversity of people's experience (State of Victoria 2022).

The term comorbidity has not been preferred for use throughout this report, in favour of the use of 'co-occurring'. Where 'comorbidity' is used it is generally because the quoted source used that term.

Executive summary

This report examines barriers in accessing care and opportunities for improving support for Tasmanians experiencing co-occurring mental health and alcohol and other drug (AOD) issues. Research was undertaken by Anglicare Tasmania's Social Action and Research Centre in 2025, building on findings from Mind the Gap.

Key findings

High prevalence: Australian research indicates that between 50% and 76% of people entering AOD treatment have a co-occurring mental illness, and 53% of people in mental health treatment programs have used AOD in the past 12 months. A sample of data from Anglicare's statewide ADATS programs shows a high level of co-occurring mental health issues, at 65.85% of clients.

System fragmentation: mental health and AOD services in Tasmania largely operate in silos, often requiring clients to address one issue before receiving support for the other. This results in a lack of continuity of care and an approach that may not always consider the person's holistic needs.

Regional inequity and affordability: access to managed withdrawal is a major barrier to AOD treatment, particularly for people in the North and North West of Tasmania. Clients also face barriers to accessing GPs and psychologists due to gap fees, waitlists, and limited bulk-billing options.

Stigma: stigma from health providers and the community make accessing appropriate care more difficult.

Complex life factors: housing insecurity, trauma, and other circumstances in people's lives can impact recovery, and make person-centred support essential.

What works: integrated treatment models that address co-occurring mental health and AOD issues simultaneously are supported by evidence and national guidelines. Evidence demonstrates benefits of multidisciplinary teams, co-location, and service partnerships in improving support and client outcomes.

Recommendations

Anglicare Tasmania recommends that the Tasmanian Government:

1. urgently expands access to managed withdrawal treatment, particularly for people in the North and North West of Tasmania

2. includes a priority in its next mental health strategy to develop integrated treatment for people with co-occurring mental health and AOD issues

3. provides a progress update on the integration of mental health and AOD treatment under the *Reform Agenda for Alcohol and Drugs in Tasmania*

4. fast tracks the delivery of the Mental Health Precincts at the Launceston General Hospital (LGH) and North West Regional Hospital (NWRH)

5. funds additional investment in transitional and long-term supported accommodation to meet the needs of people living with mental health conditions and works with the Australian Government to scale up investment in long-term social housing.

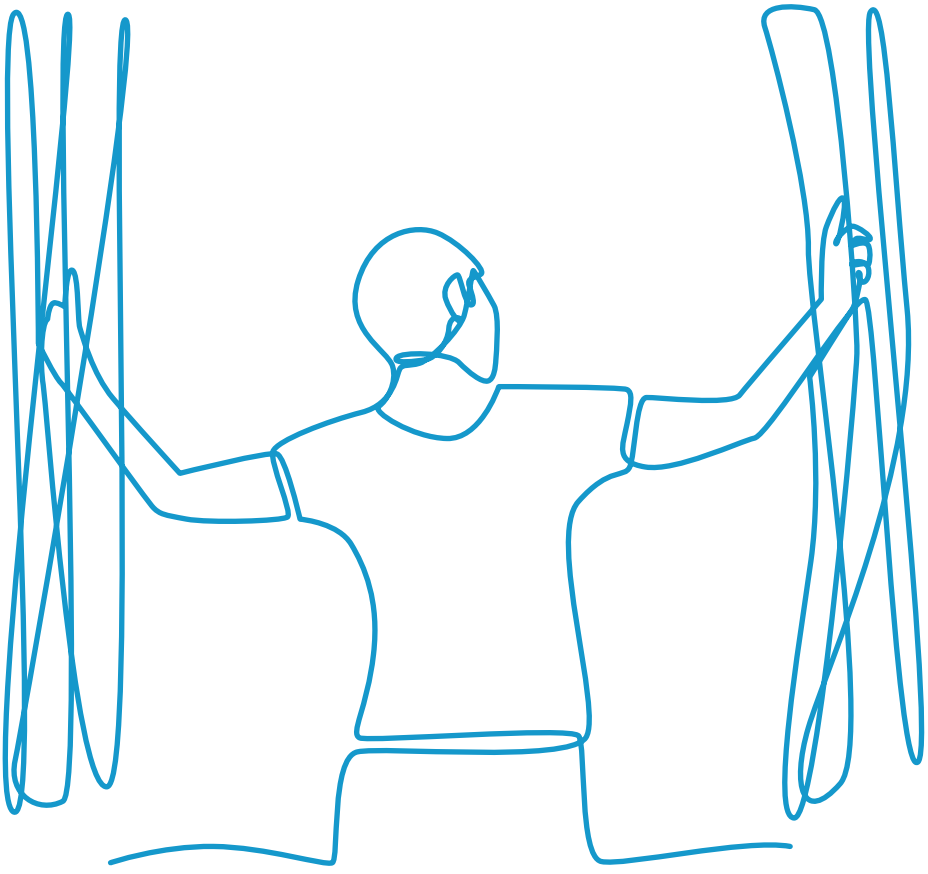
Background and context

Why we did this research

In 2025, Anglicare's Social Action and Research Centre undertook research into gaps in the mental health service system, with a focus on the experiences of clients in housing and community service programs in the north of Tasmania. The research report, Mind the Gap, identified key gaps and barriers and considered the extent to which initiatives planned for the North, such as the Launceston General Hospital (LGH) Mental Health Precinct, would address them.

Limited access to appropriate services for people experiencing co-occurring mental health and alcohol and drug issues in Tasmania was identified during this research. Mind the Gap highlighted some of the barriers for people seeking support for co-occurring issues but could not fully address the issue statewide, as it focused on the north of Tasmania. This issue required further targeted research and advocacy to detail the barriers statewide and propose action to better support people with co-occurring mental health and alcohol and drug issues.

Anglicare Tasmania recognises that people may be facing several co-occurring issues, however this report focuses specifically on alcohol and drug and mental health.



How we did this research

The research sought to answer the following questions:

- What barriers do practitioners of Anglicare's mental health and alcohol and drug programs observe when supporting clients with co-occurring mental health and alcohol and drug issues?
- What is needed to improve access to appropriate support and improve outcomes for these clients?

Please note that names and other details have been changed in client stories throughout this report for privacy.

Quantitative and qualitative data

This report draws together insights from the following data sources:

- semi-structured interviews with practitioners in Anglicare's Drug and Alcohol Treatment Service ('ADATS') statewide,[1] Care Coordination Service statewide,[2] Universal Aftercare Service ('UAC') statewide (formerly known as 'the Way Back Support Service'),[3] Mental Health Recovery Program ('Recovery') in the north and south of Tasmania,[4] Break O'Day Alcohol and Drug Service in north-east Tasmania,[5] and the Needle and Syringe Program ('NSP') in the North West [6]
- content analysis and thematic review of qualitative data gathered through interviews with practitioners across programs
- analysis of deidentified demographic data from Anglicare's ADATS, Care Coordination, UAC, and Recovery programs for the period 1 July 2024 to 30 June 2025
- analysis of deidentified 'mental health comorbidity' data from ADATS for the period 1 December 2025 to 31 January 2026
- analysis of data on rates of mental health conditions and substance use disorders in Tasmania and nationally from the Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS)
- literature review of relevant literature in relation to co-occurring mental health and alcohol issues, including regarding treatment options, best practice guidelines, and examples of program delivery from other jurisdictions in Australia.

1 ADATS is supported by funding from Tasmania's PHN (Primary Health Tasmania) through the Australian Government's PHN Program.

2 The Care Coordination service is supported by the Crown through the Department of Health Tasmania.

3 Universal Aftercare is supported by funding from Tasmania's PHN (Primary Health Tasmania) through the Australian Government's PHN Program.

4 Recovery is supported by the Crown through the Department of Health, Tasmania.

5 Break O'Day Alcohol and Drug Service is supported by the Crown through the Department of Health Tasmania.

6 The NSP is supported by the Crown through the Department of Health Tasmania.

Prevalence of mental health conditions and alcohol and drug use in Tasmania

A person may be affected by symptoms of mental health concerns without necessarily meeting the criteria for a diagnosed mental disorder. Mental health is affected by socioeconomic factors including access to services, living conditions, and employment status (ABS 2023). In 2020-2022 the National Study of Mental Health and Wellbeing found that of people aged 16-85 years in Tasmania:

An estimated
52.9%
had a 'lifetime mental disorder'[7], compared to **42.9%** nationally

An estimated
29.3%
had a 'lifetime substance use disorder' (ABS 2023)

The ABS defines a mental disorder as a clinically significant disturbance in a person's cognition, emotional regulation or behaviour, including anxiety, affective and substance use disorders (ABS 2023). It is difficult to obtain accurate data on the prevalence of the co-occurrence of any mental health disorder with a substance use disorder, as substance use disorder is itself defined as a mental disorder. The ABS National Study of Mental Health and Wellbeing reports on the comorbidity of 12-month substance use disorder with only some other mental disorders – anxiety and affective (ABS 2023).

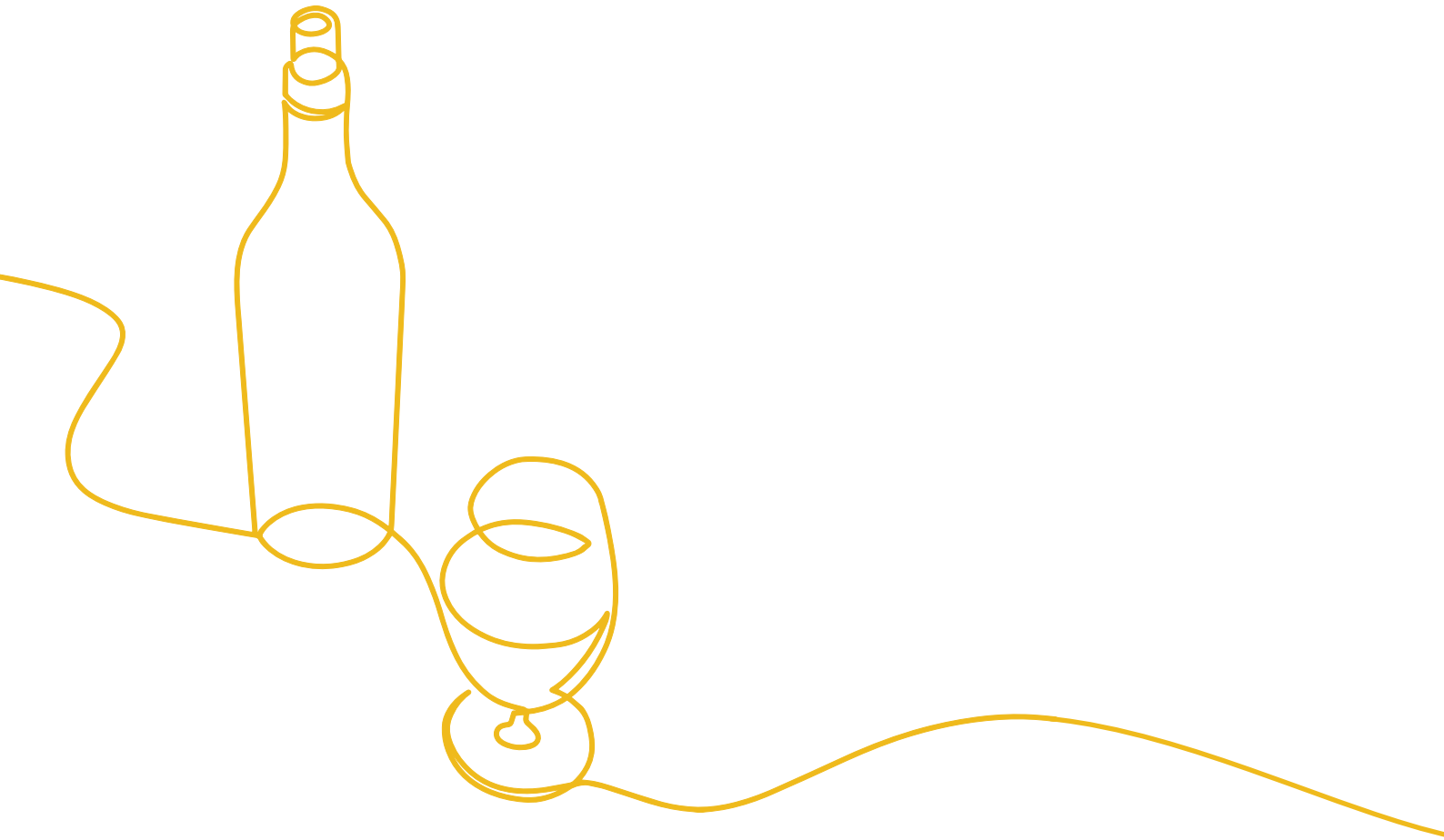
The Alcohol and Drug Foundation estimates that around 50% of people experiencing mental illness have a substance use problem and vice versa (ADF 2021).

It is important to note that many people use alcohol and other drugs (AOD) and this use is not considered problematic or necessarily leading to a substance use disorder. The discussion of AOD use in this report generally refers to where a person's alcohol, tobacco, or other drug use has negatively affected their wellbeing or relationships. This recognises that AOD use is not inherently bad, consistent with a harm minimisation approach.

7 A lifetime mental disorder refers to the number of people who met the diagnostic criteria for having a mental disorder at some time in their life for the NMSHW survey. This does not imply that a person has had a mental disorder throughout their entire life (AIHW 2025b).

The 2022–2023 National Drug Strategy Household Survey findings showed that:

- people with mental health conditions were more likely to drink at risky levels than those without mental health conditions (37% compared with 32%)
- people with high or very high levels of psychological distress were more likely to report drinking at risky levels than those who reported low psychological distress (39% compared with 30%)
- compared to people without mental health conditions, people with a mental health condition were 1.8 times as likely to have recently used any illicit drug (29% compared with 16%) (ABS 2025a).



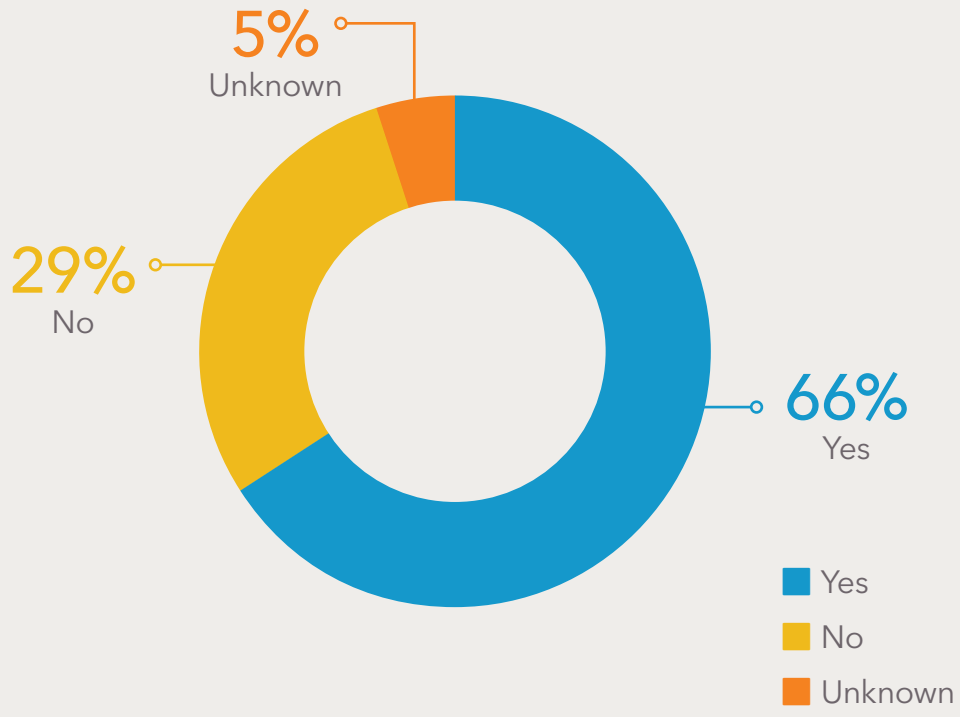
Prevalence of co-occurring mental illness and substance use in Anglicare Tasmania alcohol and drug and mental health programs

Alcohol and drug programs

Between 50% and 76% of people entering alcohol and other drug treatment programs in Australia meet the diagnostic criteria for at least one co-occurring mental illness (AIHW 2025a).

Analysis of a sample of service files from Anglicare's ADATS program statewide demonstrated a high prevalence of co-occurring mental health issues, at 65.85% of clients (see Figure 1 below). This supports research demonstrating that co-occurring needs should be the expectation for treatment systems and not the exception (VAADA 2023).

Figure 1: Prevalence of co-occurring mental health issues among ADATS clients.[8]



8 ADATS service files open at some point during the period 1 December 2025 and 31 December 2026 and remaining open at the end of that period were analysed to determine prevalence. The sample comprised a total of 82 service files.

Importantly, some clients may not have a diagnosed mental illness but are affected by symptoms of a mental health issue and/or underlying trauma.

> **People fit in a few different streams – people being really interested in exploring their mental health, others that feel forced to or not that interested, and others that you would really like to engage in help for mental health but they don't want to or can't**
>
> – Community Services practitioner (ADATS)

Mental health programs

The presence of co-occurring and problematic AOD use should be expected among a considerable proportion of clients of mental health treatment settings and is a significant concern that services must be prepared to address (Marel et al. 2025).

Prevalence estimates of co-occurring alcohol and drug use for people entering mental health treatment programs are less clear and vary based on key factors such as type of mental health disorder, type of treatment setting and method of assessing AOD use (Marel et al. 2025). As the prevalence of mental health disorders alone is higher overall than substance use disorders, the reverse co-occurrence is likely to be slightly lower. However, there is still a high co-occurrence of substance use for people entering mental health treatment programs, with the estimated prevalence of any AOD use in the past 12 months at 53%, and problematic use at 37% (Marel et al. 2025).

In Table 1 below, these prevalence estimates have been applied to participant numbers in UAC and Recovery programs for 2024-25 to give an indication of the number of clients with past 12-month AOD use and problematic AOD use, however the rate is possibly higher.

Table 1: Estimated prevalence of past 12-month AOD use and problematic AOD use among clients of Anglicare mental health programs

Program	Total participants in all service files open within the period 01/07/24-30/06/25	Prevalence estimate – past 12 month any AOD use (53%)	Prevalence estimate – past 12 month problematic AOD use (37%)
Recovery (North and South)	291	154	108
UAC (statewide)	422	224	156
TOTAL	713	378	264

AOD and suicide

> **"It's absolutely frequent that people come through UAC with AOD issues, at least 60 percent, if not more"**
>
> – Community Services practitioner (UAC)

Data to determine the precise rate of co-occurring AOD issues, including where AOD use was a factor in suicidality, could not be gathered from the UAC service for this research, as participants had not given consent for their data to be used for research.

AOD use has a significant relationship with suicide. In 2024, acute alcohol use was recorded as a factor in 15.4% of suicides in Australia and directly contributed to death in a further 2.4%. Acute psychoactive substance use was recorded as a factor in 15.9% of suicides and directly contributed to death in a further 12.2% (ABS 2025b).

Of people in Tasmania between 2012-2020 who died by suicide, the most common 'situational or contextual stressor' they were identified as experiencing was substance use or misuse, recorded for 52% of people (Larasati 2024).

What we heard about the co-occurrence of AOD use and mental health conditions

> **We shouldn't be asking why the addiction, it's why the pain**
>
> – Community Services practitioner (Recovery)

Alcohol and other drug use is often a form of self-medication for trauma, stressors, and mental health concerns. It may be both an adaptive and maladaptive coping mechanism, providing temporary relief but ultimately worsening mental health symptoms. Staff report some clients referring to AOD as their "best friend and worst enemy", highlighting the complex relationship between substance use and emotional distress. For many people, underlying trauma has never been addressed, and when they stop using alcohol or other drugs the pain can surface. In some cases, they may have been diagnosed or misdiagnosed with mental health conditions in the past, without the underlying trauma being treated.

> **When working on relapse prevention with a client, it often stems back to 'I wouldn't use if didn't have mental health concerns / triggers'**
>
> – Community Services practitioner (ADATS)

Barriers to accessing appropriate support for people with co-occurring AOD and mental health issues

Comments from 12 consultations were analysed thematically. Many were similar in nature and grouped accordingly.

Siloed delivery of mental health and alcohol and drug services can result in a non-person-centred model of care

There is a significant gap in integrated care for people experiencing co-occurring mental health and alcohol and other drug issues in Tasmania. The siloed nature of service delivery means individuals can be referred to mental health services or AOD services based on which issue the service providers determine is the 'primary' concern. Separate administration of the mental health and alcohol and drug service systems and siloed government policy over time have contributed to this barrier (Productivity Commission 2025). System fragmentation and lack of continuity of care means people can fall through the cracks with neither issue fully addressed.

Services may expect people to fit into existing service models rather than tailoring support to individual needs, leaving gaps when no suitable service exists. One example involved a person with a long history of mental health and AOD issues, who was known to multiple services, yet received minimal support that met their needs. Despite chronic thoughts of suicide, the person's support largely consisted of crisis intervention, with some services repeatedly opening and closing their file.

> **"There is a focus on whether the person's AOD use or their mental health is the primary issue. For example, you might refer someone who is having concerning thoughts of suicide to the [mental health service], and they might refer them to [AOD service] because they determine the AOD use is causing the suicidality… which might be true, but it is also the mental health concerns that cause the AOD use, and the person might not be able to address their use until their mental health improves"**
>
> – Community Services practitioner (ADATS)

Staff across programs reflected on the high level of clients with complex needs. As well as co-occurring AOD and mental health issues, people may be experiencing trauma, family violence, housing insecurity, homelessness, legal issues and other background factors. This is discussed in further detail below.

> **"The person needs to be ready to address mental health and trauma as well [as AOD use]. We explore these things but are not trauma counsellors. We are there to make appropriate referrals – the person might accept but there are barriers such as long waitlists and costs. This may miss the window of opportunity or engagement may fluctuate"**
>
> – Community Services practitioner (ADATS)

Anglicare staff noted that clients may be turned away from mental health support if they disclose active addiction, reflecting a broader tendency to pass on cases or decline referrals when staff feel unequipped to manage risk. This raises questions about missed opportunities for early, meaningful intervention and the need for services to be willing and supported to engage with risk rather than avoid it. Limited workforce capacity and under-resourcing of services may contribute to this.

Staff explained that securing mental health support for a person with co-occurring issues can be difficult even after obtaining a Mental Health Care Plan through a GP, as some psychologists will not accept clients once they learn of the person's AOD issues, insisting these be addressed first.

> **This is where the gap is, the transfer from [mental health services] to [alcohol and drug services] – mental health services might say there is too much AOD use going on and refer to alcohol and drug services – but they aren't integrated, and that point of interaction for the person with mental health services might be the perfect point of intervention – there might be a delay getting contact from alcohol and drug services, and they might reach out to the person but rely on the person's ability/ willingness to engage at that point**
>
> – Community Services practitioner (UAC)

The way a service engages with a person may reflect its perspective regarding responsibility for managing AOD use and mental health symptoms. At one end of the spectrum, some practitioners and services consider AOD use and mental health concerns primarily a matter of personal responsibility. Others near the other end of the spectrum consider barriers that influence a person's ability to seek and maintain care, such as systemic barriers, the absence of informal supports, and the social determinants of health such as income, housing insecurity and social inclusion and discrimination (AIHW 2024).

These differing perspectives shape service responses. For example, a practitioner or service who considers that help-seeking is mainly the individual's responsibility may take a minimal engagement approach. After receiving a referral, they might schedule an appointment and notify the person by letter or phone. If the person does not attend, the file may be closed without further follow-up. A practitioner or service at the other end of the spectrum may work harder to consider barriers the person is facing and make multiple attempts to engage them in support and address underlying issues.

Jesse's story below briefly highlights how siloed mental health and AOD service delivery results in a client being passed back and forth between multiple services.

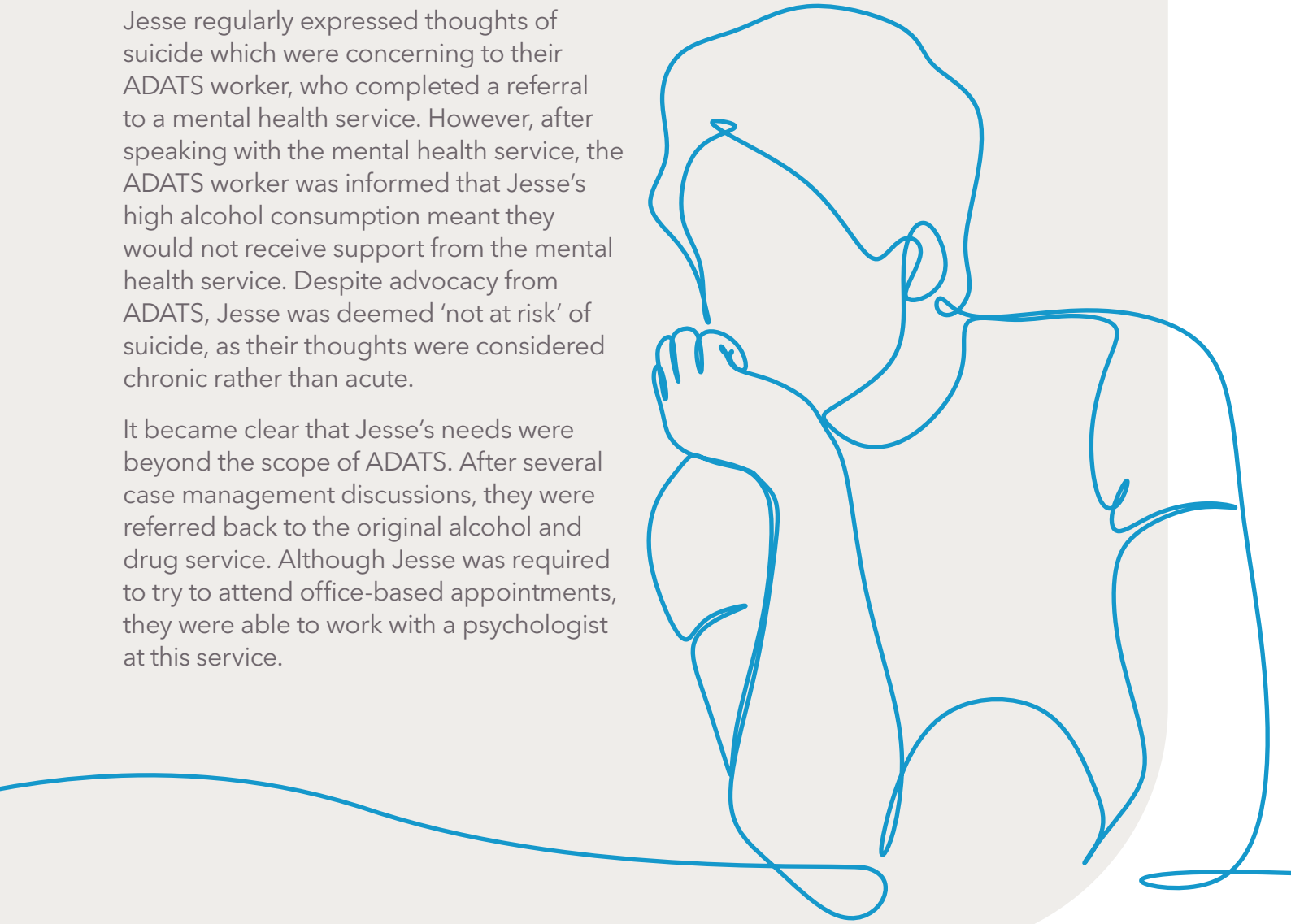
Jesse's experience seeking AOD and mental health support

Jesse was referred to ADATS by an alcohol and drug service because they had difficulty attending office-based appointments, and ADATS could do outreach support where they lived.

Jesse's situation was complex. They had a brain injury that caused severe short-term memory issues. During conversations, they often became confused and struggled to provide accurate information, which created challenges in coordinating their care. Jesse frequently felt overwhelmed by multiple stressors, including legal, financial, and health matters. When these pressures became too much, Jesse used alcohol as a form of self-medication.

Jesse regularly expressed thoughts of suicide which were concerning to their ADATS worker, who completed a referral to a mental health service. However, after speaking with the mental health service, the ADATS worker was informed that Jesse's high alcohol consumption meant they would not receive support from the mental health service. Despite advocacy from ADATS, Jesse was deemed 'not at risk' of suicide, as their thoughts were considered chronic rather than acute.

It became clear that Jesse's needs were beyond the scope of ADATS. After several case management discussions, they were referred back to the original alcohol and drug service. Although Jesse was required to try to attend office-based appointments, they were able to work with a psychologist at this service.



There is a lack of services, and access is impacted by region

Services are commonly delivered divided by region in Tasmania – South, North and North West. There are limited mental health and alcohol and drug services in Tasmania, and service availability and capacity vary by region. In regional and remote areas, services may not do outreach or have very limited outreach capacity.

Staff reflected that the Peacock Centre makes a big difference to mental health service availability for people in the South. The Safe Haven service at the Centre is available over extended hours for people in suicidal distress, where they can talk to a mental health peer worker. The service is peer-led and provides a supportive environment that differs from a hospital Emergency Department (ED).

People in the other regions currently can present to hospital EDs when in distress, but do not yet have the option of the Safe Haven service. If a person presents to an ED in distress, they might not be admitted due to not being assessed as acute enough, or a lack of available beds. The acute care team should then follow up the next day or within the week after the presentation. Once the crisis is 'resolved' the transfer of care would be to the person's GP and/or referral to a mental health support service if the person is eligible and it is appropriate. In this scenario there are many opportunities to fall through the cracks as the person might not have a current GP, may have difficulty finding one they can afford, may not be eligible for an available community service, or could face long waitlists.

The Tasmanian Government has committed to deliver a Mental Health Precinct, including a Safe Haven service, at the Launceston General Hospital (LGH) as part of the LGH Masterplan (Tasmanian Government 2021). The Tasmanian Government indicated construction of the LGH Precinct was intended to be delivered in the first quarter of 2026 (Tasmanian Government 2022). However the latest Tasmanian Government draft update to the LGH Masterplan, dated September 2025, does not yet provide updated delivery timelines for the construction of the Mental Health Precinct (Tasmanian Government 2025). A further Mental Health Precinct at the North West Regional Hospital in Burnie (NWRH) is a priority of the North West Hospitals Masterplan, also previously indicated to be delivered in 2026 (Tasmanian Government 2024a). The Tasmanian Government's draft third implementation plan for the Tasmanian Suicide Prevention Strategy indicates a completion timeframe of July 2027 for expansion of the Safe Haven model to the North and North West regions (Tasmanian Government 2026). Commitments to prioritising the Mental Health Precincts are welcome, and fast-tracked delivery is encouraged.

Regional access to managed withdrawal is a major barrier to accessing AOD treatment

Most residential rehabilitation programs require a person to undergo managed withdrawal or 'detox' before entry, and access to managed withdrawal is a significant barrier to treatment. The only Inpatient Withdrawal Unit is located at St John's Park in southern Tasmania, which means clients from the North, North East and North West need to travel long distances to access the unit. Public transport may be the main available option, which is often unsuitable for people in the circumstances. Other options such as hospital-based withdrawal and community-managed services are very limited. Some individuals may be able to arrange supervised withdrawal through their GP or psychiatrist, if they have access to a treating clinician. Without these options, requiring clients to travel to Hobart remains a significant barrier to care.

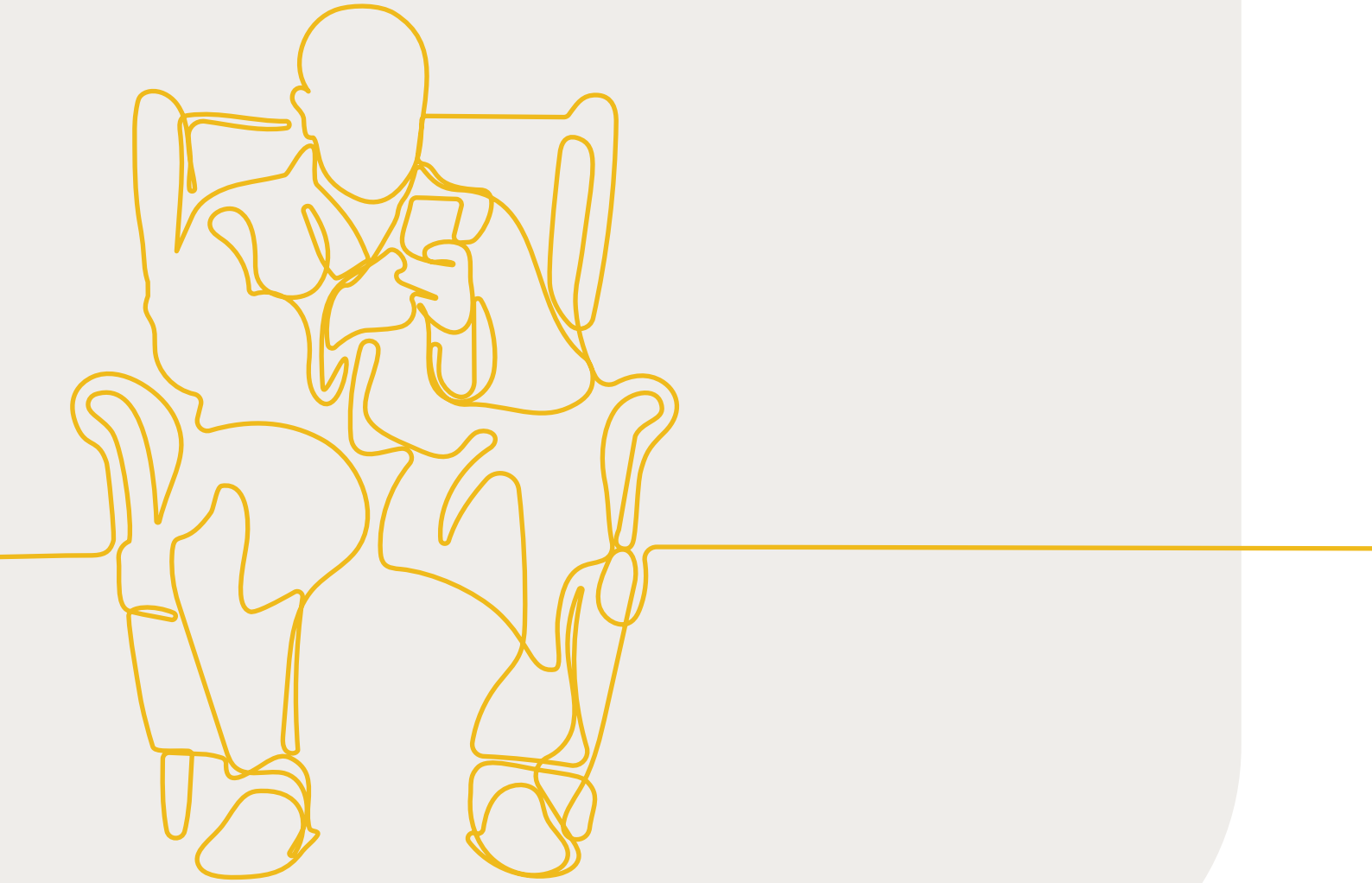
The need to address regional access to withdrawal is urgent, and has been highlighted in advocacy by the Alcohol, Tobacco and Other Drugs Council of Tasmania (ATDC). The ATDC has recommended the Tasmanian Government fund 100 managed withdrawal episodes within existing residential rehabilitation services in the North West to streamline pathways between withdrawal and rehabilitation, reduce wait times, and enable continuity of care. Alternative options must be available to keep people in their communities, which supports recovery, lowers relapse risk, and improves overall outcomes (ATDC 2025).

> **"[In the North West] we don't have detox services for clients to access and for them to commence the local rehabilitation centres/programs they cannot have any drugs in their system. This can be really hard for them to achieve on their own and will quite often trigger mental health issues"**
>
> – Community Services practitioner (NSP)

People with co-occurring issues may also face barriers related to receiving mental health treatment while accessing AOD rehabilitation services. AOD rehabilitation services may not have the capacity to support a person experiencing mental health issues – including thoughts of suicide – in parallel to treating their AOD use.

Douglas's story

In a regional town, Douglas is facing his twelfth withdrawal in just 18 months. He has mental health issues, an acquired brain injury and intellectual disability, which make it more challenging to avoid being influenced by other people. His history of trauma impacts him greatly, and he often returns to drinking with the same group of people. Each time he calls for support to access withdrawal, but the cycle feels difficult to break. A referral was made for him to a psychology clinic, yet long waitlists and out-of-pocket costs create barriers. Telehealth is offered from the mainland, but in places like this regional town, mobile coverage is patchy at best. Every step toward Douglas's recovery is met with obstacles, including geography, systems, and circumstances.



Stigma from service providers, medical professionals and the community

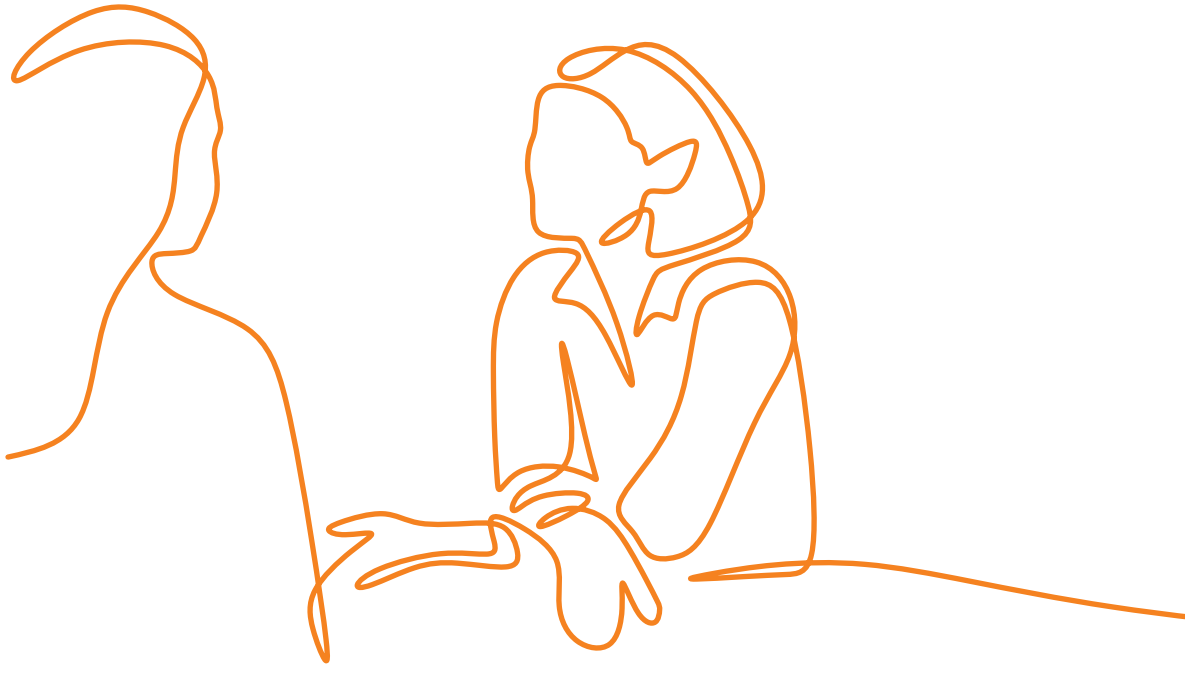
> **A lot of clients don't feel supported in the community and are often met with stigma and discrimination and unfortunately their mental health is either masked by their drug use or placed in the too hard basket and not addressed at all. Clients with co-occurring AOD/mental health issues have experienced stigma from the local pharmacies, the public… it is something that needs to be addressed**
>
> – Community Services practitioner (NSP)

Staff report significant barriers for clients when accessing health and mental health services due to stigma and assumptions about substance use. Some staff shared experiences of clients being denied pain relief while in hospital, where clients report not being heard and treated for pain because they are perceived as drug-seeking. One practitioner shared a story of a client who had used methamphetamine two decades prior and never since, but due to their doctor's inaccurate record-keeping of their substance use, was denied any pain relief during a dental procedure. These examples highlight how stigma and systemic barriers can impact access to appropriate care.

GPs and psychiatrists can be hesitant to prescribe medication due to a patient's AOD use, and patients themselves may avoid disclosing substance use out of fear of judgment or restriction of access to medication. Additionally, some clinicians may lack awareness of AOD treatment and community service options, limiting referrals to appropriate care.

We recognise that trauma is a common element in alcohol and other drug dependence. If a person seeks support for their alcohol and other drug use, it is a health issue. A compassionate and non-judgmental reception in these interactions is essential: it may have taken years, or possibly decades, for someone to schedule and attend an appointment. We know that the disclosure of alcohol and other drug use, particularly illicit drugs, can alter treatment and medication, and we strongly advocate for equal access to healthcare.

– Message from Tasmanians with lived experience in the Tasmanian Drug Strategy (Tasmanian Government 2024b)



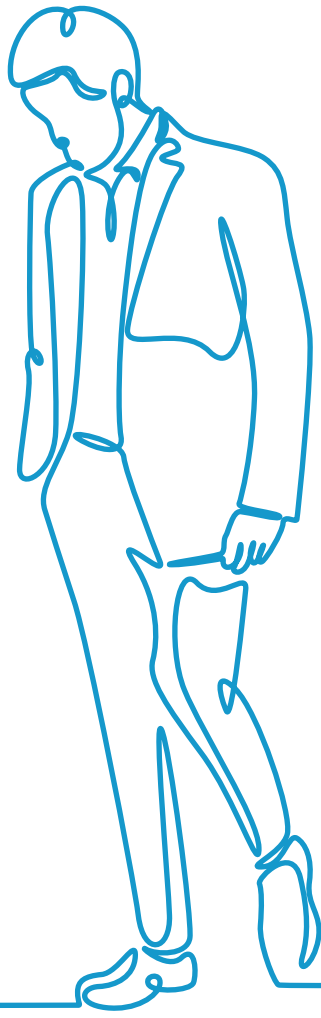
Gap fees and waitlists are a common barrier to accessing GPs, psychologists and psychiatrists

Mind the Gap detailed the lack of affordability and accessibility of GPs and psychologists as a major barrier to seeking support for people with mental health issues. This is also a significant barrier in relation to supporting people with co-occurring mental health and AOD issues.

The barriers include lack of bulk-billing options, unaffordability of out-of-pocket costs, waitlists, and a lack of continuity of care for people without access to a regular GP. Many clients of Anglicare services do not have a regular doctor when they begin working with a service, so workers often assist them to find one. This can be challenging given the limited availability of bulk-billing GPs, especially in the North and South regions. Even when a bulk-billing doctor is located, the first appointment, which may be a double session, can have an out-of-pocket fee.

Some GP practices have introduced triage processes before accepting new patients, requiring full medical histories and then deciding whether to take the person on, which can result in clients being declined if their needs are seen as complex. Recent changes by the Australian Government to Medicare bulk-billing incentives are positive, and have led to an increase in the number of bulk-billing clinics in Tasmania, although the percentage of bulk-billing clinics is still lower than the national average, and the average out-of-pocket fee higher (Cleanbill 2026).

In some regional areas such as the East Coast, GPs are generally locums, so it is not always possible to build rapport with one doctor. People can find it difficult to engage with a locum GP they do not know who might not be staying in the area long-term, especially in relation to stigmatised issues such as AOD use.



The table below provides a breakdown of the number of clients recorded as having income support payments as their main source of income, or with nil income. This breakdown demonstrates that most clients in these four programs are on low or very low incomes which make out-of-pocket fees difficult to afford:

Table 2: Number of clients in Anglicare's mental health and AOD programs receiving income support payments or nil income as main source of income

Program	Total participants in all service files open within the period 01/07/24-30/06/25	Participants with main source of income recorded as government payments	Percentage of participants with source of income recorded as government payments	Participants with nil income recorded	Percentage with nil income recorded
ADATS	511	260	50.9%	44	8.6%
UAC	422	185	43.8%	24	5.7%
Recovery	291	193	66.3%	18	6.2%
Care Coordination	88	73	83.0%	4	4.5%
TOTAL	1312	711	54.2%	90	6.9%

Access to psychologists is even more limited, as there are very few bulk-billing psychologists who offer in-person appointments. Many clients need to apply for the Disability Support Pension (DSP) which requires documentation that cannot be obtained without seeing a clinical psychologist. Others require support to gather documentation for NDIS applications. In these circumstances, having a trusted person or community services worker to support the client's journey is essential.

Some psychology providers offer availability via telehealth, although this does not suit all client needs. Initiatives such as the roll out of the Medicare Mental Health Hubs in each region (providing access to bulk-billed psychology) are positive.

People are often experiencing significant background circumstances in their lives, including unstable housing, homelessness and other life factors which affect recovery

Many clients experience challenging circumstances in their lives such as unstable housing, family pressures, and legal issues which can drive self-medication through AOD use. Managing life administration tasks can be overwhelming, for example returning home after a hospital admission only to discover unpaid bills, rent arrears, or Centrelink issues. In addition, many clients experience food insecurity, rising electricity costs, and broader cost-of-living pressures. Accessing available supports can also be difficult. For example, programs like Aurora bill relief or MyGov services are often only accessible through mobile apps, creating additional obstacles for those without digital literacy or reliable technology.

Services offering primarily AOD counselling may not be able to address these underlying stressors, even though they may be critical to recovery. For example, clients who have been required to attend AOD counselling by legal or social service systems may struggle to work on their AOD use in isolation if they have ongoing family matters such as limited access to their children.

Services that offer case management, such as Care Coordination, can look at broader challenges and support the person with system navigation. Case managers work with the person to identify what the most immediate need is. For many, the most pressing needs are housing and mental health support, which must be stabilised before meaningful progress in AOD recovery can occur.

> **"If people don't have someone on their side such as a regular GP, community services worker, it's really hard – someone to do the complex system navigation for them – all the systems are so complex"**
>
> – Community Services practitioner (Recovery)

Jules's story below illustrates the complex interplay between trauma, addiction, family breakdown, and health deterioration. It highlights the importance of holistic, sustained support that addresses both immediate practical needs and underlying psychosocial factors.

Jules's story

Jules experienced a series of overwhelming and traumatic events, including an armed robbery at his workplace, and his spouse having an affair. He works in the hospitality industry, where alcohol is ever-present. When he entered alcohol and drug treatment, he was consuming up to a litre of spirits per day and struggling to cope with the effects of trauma. His spouse had left, and his relationship with his children was becoming fractured.

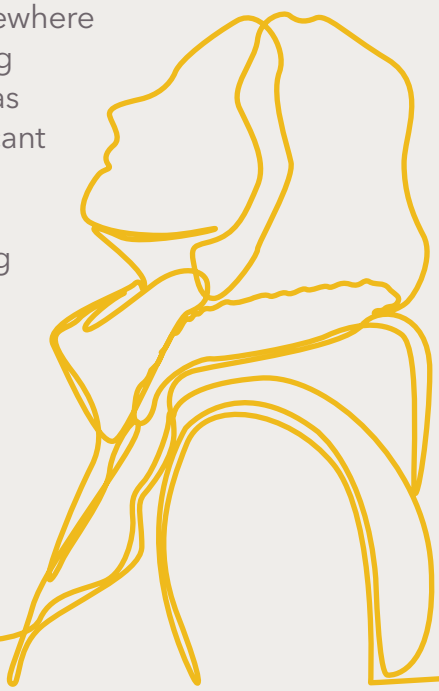
Jules's priority was attempting to keep his home so he did not become homeless as well. Support was provided to stabilise finances and prevent loss of the home. This intervention gave him a sense of security and enabled him to reduce his alcohol intake for a time. He received support to set goals to reduce his alcohol use to a level he was happy with, identify triggers, and develop a relapse prevention plan. However, a recent health scare of a potential cancer diagnosis triggered a relapse in his use of alcohol.

Stable housing is essential to recovery

> **A lot of mental health interventions are built around the assumption that we focus on things we can control, rather than what we can't – and when it comes to housing it's often out of the client's hands**
>
> – Community Services practitioner (Recovery)

Mel's story

When Mel walked into Housing Connect, she was desperate. Her partner had left, and although she had been sober for some time after working with ADATS, she needed somewhere to stay. Frustrated by her circumstances, she was hoping to find a place to stay, but brokered accommodation was unavailable, and long-term housing options had significant waitlists. Mel was not willing to go to Safe Night Space because she knew being around other people who might be using alcohol could trigger a relapse. Avoiding triggers was part of the relapse prevention plan she had worked on, but there was no other emergency accommodation available. For Mel, the system's gaps weren't just frustrating; they put her recovery at risk.



Mel's situation highlights the critical shortage of housing options and the impact on people's AOD recovery. The housing shortage makes it challenging for people to advocate for themselves and their needs to implement their relapse prevention plans.

Maintaining housing while undergoing residential rehabilitation is a challenge. A person in a private tenancy may have to forfeit the accommodation if they cannot afford the fees as well as rent, or if they're unable to pay the rent due to not being able to work during that time. In public housing, a tenant can take up to 3 months away from the house, and a support service may be able to advocate with the housing provider to reduce the rent to the lowest minimum amount. However, when houses are vacant there can be issues with others moving into the house or 'squatting', and 3 months may not be long enough to undergo the program. The possibility of giving up housing presents another barrier to accessing treatment.

Mind the Gap found that Housing Connect Front Door data indicated Tasmanians with mental health conditions who seek housing support are significantly more likely to be experiencing homelessness and they are likely to have been homeless for longer periods, compared to clients without a mental health condition. Mind the Gap also found that increasing housing security is a feasible policy lever to improve mental health.

The Tasmanian Housing Strategy indicates a commitment to a Housing First approach, recognising that Tasmanians should have access to housing regardless of their circumstances (Tasmanian Government 2023b). Work to deliver this must be considered a priority. Housing First provides housing for people who have experienced homelessness without a requirement to address issues such as AOD use prior to being housed, recognising that housing is a human right. Housing First follows the principle that a safe home must be secured before other complex issues can be effectively addressed.

Anglicare Tasmania has previously discussed the body of research providing strong evidence that reducing homelessness and housing insecurity by providing secure, affordable, long-term housing result would result in reduced health care costs in the order of $6,150 per person housed per year (Anglicare Tasmania 2025).

The People's Project was the first Housing First program in Aotearoa New Zealand, providing immediate permanent housing and wraparound support. An evaluation study of the two-year outcomes of 387 people housed through this program found significant reductions in inpatient (-59%) and residential (-50%) mental health bed-nights in the first year, with sustained decreases in the second year (-41% and -51%) (Pierse et al. 2022). This further demonstrates that a Housing First approach is an appropriate policy measure to improve mental health and would lead to significant cost savings associated with health care, including inpatient stays.

Better integration of treatment for co-occurring issues is needed to provide greater continuity of care and a person-centred approach

> **"I don't think it's something that can be siloed, because they are so intertwined… We need clinical support to look at the person's trauma, past history, substance use"**
>
> – Community Services practitioner (Recovery)

A person-centred approach that provides integrated, simultaneous care for both mental health and AOD issues is needed, as well as support to connect with other services such as housing. Services must recognise that problematic AOD use or addiction often stems from coping with trauma, stressors, mental health challenges, and other life factors. Despite how common trauma and PTSD are among clients of AOD services, few services assess trauma history as a matter of routine (Marel et al. 2022).

The need for better integration between mental health and AOD services has been long recognised. Advancing this integration remains a critical priority for government action, reflected in several strategies and reform plans (Tasmanian Government 2023b, 2024b; Tasmanian Government and Primary Health Tasmania 2020; Tasmanian Government 2023a). Implementation of this commitment must occur.

There is an identified connection between mental health and substance use, and a need to build the capacity of the mental health workforce to identify and respond to co-occurring mental ill-health and alcohol and other drug addiction to support the long-term recovery of consumers. There is opportunity to improve service delivery and integration through improving competencies and cross-skilling both the mental health and alcohol and other drugs sector.

– National Mental Health Workforce Strategy 2022-2032 (Commonwealth of Australia 2022b)

The National Mental Health and Suicide Prevention Agreement describes people with co-occurring AOD issues as a priority population (Commonwealth of Australia 2022a). The Productivity Commission's Mental Health and Suicide Prevention Agreement Review Inquiry Report has concluded that an additional schedule on AOD should be included in the next agreement, calling it a major issue requiring a dedicated response that is not appropriately considered in any other policy environment (Productivity Commission 2025). It recommends the schedule be co-designed with people with lived experience, facilitate national planning and coordination across jurisdictions and service systems to increase the availability and accessibility of holistic treatment for people with co-occurring needs, increase funding for evidence-based approaches in treatment, strengthen workforce capacity and contribute to implementing the National Stigma and Discrimination Reduction Strategy (Productivity Commission 2025).

The Productivity Commission recognised that besides AOD, people with lived experience of mental health and suicide may be experiencing other co-occurring problems such as physical health conditions and housing insecurity. They suggested that the process for developing the schedule for co-occurring problematic AOD use could be a blueprint for developing further schedules for other areas in future (Productivity Commission 2025).

Treatment approaches for co-occurring issues

Models to treat co-occurring conditions are explained in the table below: sequential treatment, parallel treatment, integrated treatment, and stepped care.

There is potential for both mental health and substance treatment systems to be more effective in treating their 'target' disorders if they can develop the effectiveness of their response to co-occurring mental health and substance use disorders. For some time, people with lived experience expertise have expressed a preference for the provision of seamless, integrated treatment care and support for both mental health and substance use issues, wherever a person presents for treatment (VAADA 2023).

Table 3: Models of care for co-occurring AOD and mental health conditions, adapted from Marel et al. (2022)

Sequential treatment
The client is treated for one condition first which is followed by treatment for the other condition. With this model, the AOD use is typically addressed first then the mental health condition, but in some cases, it may be whichever disorder is considered to be primary (i.e. which came first). The current service system in Tasmania would be best described as sequential treatment, where clients are generally treated for one condition first due to the separation of service systems. This model is considered outdated in terms of integrated treatment (Foster et al. 2025).
Parallel treatment
The client's AOD use and mental health condition are treated simultaneously, but the treatments are provided independent of each other. Treatment for AOD use is provided by one treatment provider or service, while the mental health condition is treated by another provider or service.
Integrated treatment
The client's AOD use and mental health condition are treated simultaneously by the same treatment provider or service. This approach allows for the exploration of the relationship between the person's AOD use and their mental health condition. 'Integrated treatment' is distinct from the concept of 'integrated services' (combining different services such as mental health and AOD) and 'integrated systems' (combining policies, funding, budgets etc) (Marel et al. 2022).
Stepped care
Stepped care means the flexible matching of treatment intensity with case severity. The least intensive and expensive treatment is initially used, and a more intensive or different form of treatment is offered only when the less intensive form has been insufficient. Of note, stepped care models can include sequential, parallel and/or integrated treatment approaches. The proposed draft service model for Primary Health Tasmania's Continuum of Care is an example of stepped care in the mental health service system (PHT 2025).

Evidence supports integrated treatment approaches providing simultaneous care for mental health and AOD issues by one provider or service. This helps to prevent clients from falling through the gaps, ensures treatment is internally consistent with common objectives, allows the relationship between AOD use and mental health concerns to be explored, and prevents communication problems between providers from impeding treatment (Marel et al. 2022).

Key principles to successful integrated community-based mental health care services include collaborative, multidisciplinary teams, a holistic approach that takes into consideration the social determinants of mental health, the inclusion of peer workers, and improving care pathways. Key outcomes from integrated care may include reductions in service delivery costs, reduced hospital admissions and medication levels, and improved social integration (AIHW 2020).

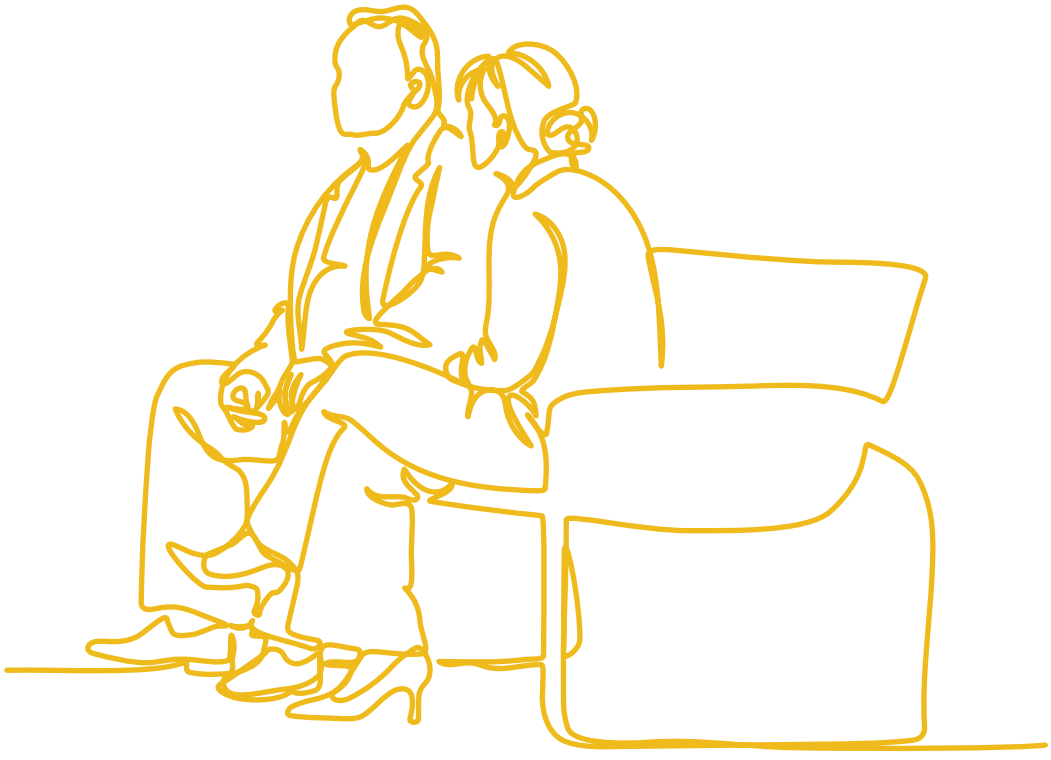
Examples of services for co-occurring issues

Best practice on integrated care calls for working collaboratively between systems and within organisations, including through service design, resourcing and governance to enable success (VAADA 2025).

There are limited dedicated services for co-occurring AOD and mental health issues in Tasmania, although AOD services are likely already providing mental health interventions to clients, and vice versa.

There are examples of services for co-occurring issues in other jurisdictions, and some Victorian examples are discussed below. The Royal Commission into Victoria's Mental Health System heard of issues with siloed service delivery for mental health and alcohol and drug issues and recommended that mental health services provide integrated treatment (State of Victoria 2021).

The Victorian Alcohol and Drug Association (VAADA) has provided guidance on models to integrate AOD support into mental health services, including multidisciplinary teams, service delivery partnerships, and co-location and care coordination partnerships (VAADA 2023).



Multidisciplinary teams

In **multi-disciplinary teams,** workers of different disciplines provide integrated treatment, care and support in a single service setting. There is a high degree of collaboration and co-ordination to deliver person-centred care (VAADA 2023). Common roles in multi-disciplinary teams include GPs, psychologists, psychiatrists, nurses, peer workers, social workers, and nurse practitioners (Ye et al. 2025).

The First Step Service in St Kilda was established in 2000 as a drug rehabilitation program and now operates bulk-billed GPs, addiction and mental health specialist workers and pro bono legal services out of one building as a multi-disciplinary team. It uses a variety of funding sources, including government and philanthropy. A whole program evaluation is currently underway (First Step 2023). A consumer told the Royal Commission into Victoria's Mental Health System that the ability to go to one service for integrated support worked very well for them (State of Victoria 2021).

First Step was the lead agency in the Victorian government's Integrated Care Pilot using the Comprehensive Continuous Integrated System of Care (CCISC) model. The CCISC is an evidence-based AOD and mental health framework which can be implemented in any treatment system, agency and program, designed specifically to optimise the delivery of person-centred care. 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 elected to continue this work despite no ongoing government funding (VAADA 2025).

Service delivery partnerships

Service delivery partnerships are where a mental health service partners with an AOD service to deliver some aspects of a person's treatment, care and support within the mental health and wellbeing service (VAADA 2023). For example, in a bed-based service, the mental health service could partner with a non-government organisation to provide counselling for consumers with substance use issues or addiction (VAADA 2023).

An example of a service delivery partnership is the dual diagnosis program funded by Eastern Melbourne Primary Health Network and delivered by Anglicare Victoria, which provides counselling and case management for individuals impacted by alcohol and other drugs and mental health issues (Eastern Melbourne PHN 2025). This program is underpinned by a welcoming approach to dual diagnosis supported by interagency collaboration (VAADA 2023). It involves a partnership established in 2016 between Anglicare Victoria's AOD service and three adult inpatient psychiatric units operated by Eastern Health. Anglicare Victoria's AOD counsellors provide an 'inreach' service to the inpatient units, and engage with inpatients during their admission, aiming to foster ongoing engagement with AOD treatment following their discharge (Foster et al. 2025). This service is a hybrid approach between integrated treatment and parallel care, as it brings AOD expertise into a mental health service to enable shared care and continuity (Foster et al. 2025).

The Anglicare Victoria 'inreach' service receives funding support from the local Primary Health Network. It involves alcohol and drug counsellors (identified as Dual Diagnosis capable) delivering 'inreach' two sessions a week with capacity to deliver follow up services. Collaboration between the inpatient units and Anglicare Victoria is supported by four mechanisms to embed AOD support in mental health care: regular six-weekly partnership meetings chaired by the Eastern Dual Diagnosis Service Manager to review referrals, address communication and identify staff communication needs; a practice guideline for IPU staff to support consistent identification of substance use, assess readiness to engage and obtain consent for referral; nominated IPU nursing and social work staff to facilitate referrals and cross-team communication; and a memorandum of understanding outlining referral expectations and information-sharing protocols (Foster et al. 2025).

This program has reported positive outcomes, with early work finding the program was associated with increased identification of AOD problems in inpatient units (from 6% to 30% improvement within 12 months), increased engagement in alcohol and drug interventions and a reduction in the rate of readmissions within 28 days. Readmission rates for the period January-June 2022 identified that 84.94% of patients referred from inpatient units to the program were not readmitted at any time during or at the conclusion of an episode of care after referral and engagement with Anglicare services (VAADA 2023).

A peer-reviewed study of the Anglicare Victoria 'inreach' service over the period July 2020 to December 2023 found that 93% of patients referred to the service engaged with AOD counselling following their inpatient stay. The study demonstrated the importance of integrated care in addressing co-occurring needs and found that the high engagement rates following discharge highlight its effectiveness in fostering continuity of care (Foster et al. 2025). The findings support the need for increased investment in integrated care approaches, especially for similar services that bridge gaps between mental health and AOD treatment systems to reduce treatment fragmentation (Foster et al. 2025).

Co-location and care coordination partnerships are where a mental health service physically co-locates with an AOD service to deliver coordinated treatment and support. Through care coordination and single care planning they deliver integrated treatment to meet the person's co-occurring needs. Regular case conferencing and shared records and information enable this, where both providers work towards joint care goals (VAADA 2023). There is some evidence that integrated care including co-located mental health care and AOD specialist treatment is associated with reductions in substance use and related harms and mental health symptom severity, improved quality of life, decreased emergency department presentations/hospital admissions and reduced health system expenditure (Glover-Wright et al. 2023).

Recommendations

Anglicare Tasmania recommends that the Tasmanian Government:

1. urgently expands access to managed withdrawal treatment, particularly for people in the North and North West of Tasmania

2. includes a priority in its next mental health strategy to develop integrated treatment for people with co-occurring mental health and AOD issues

3. provides a progress update on the integration of mental health and AOD treatment under the *Reform Agenda for Alcohol and Drugs in Tasmania*

4. fast tracks the delivery of the Mental Health Precincts at the Launceston General Hospital (LGH) and North West Regional Hospital (NWRH)

5. funds additional investment in transitional and long-term supported accommodation to meet the needs of people living with mental health conditions and works with the Australian Government to scale up investment in long-term social housing.

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