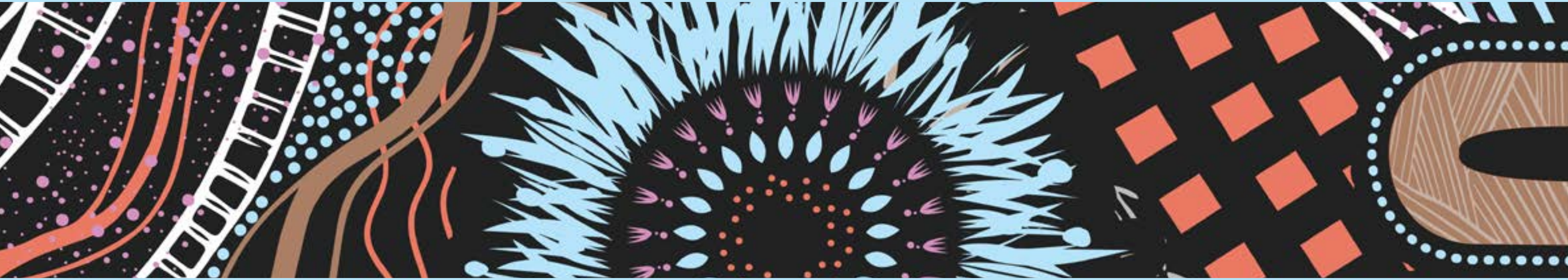

Harmful use of alcohol and other drugs and its relationship with the mental health and wellbeing of First Nations people: a review of the key issues, policy and practice approaches

Julia Butt, Edward Wilkes, Emily Ripley, Jocelyn Jones and Annalee Stearne

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Australian Institute of Health and Welfare
GPO Box 570, Canberra ACT 2601
Tel: (02) 6244 1000
Email: info@aihw.gov.au

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Contents

Summary v

What we know v

What works vi

What doesn't work vii

What we don't know viii

1 Introduction 2

Aims of the review 3

Scope of the review 3

2 Background 5

Locating AOD-related harm within a social and emotional wellbeing (SEWB) framework 5

The inter-relationships between harmful AOD use and mental ill-health 7

3 Method 11

Scoping review. 11

4 Key issues 14

Prevalence and harms of co-occurring harmful AOD and mental ill-health (AOD-MH) 14

AOD-MH among vulnerable groups 18

Policy approaches to co-occurring AOD and mental health 22

5 Programs and initiatives addressing co-occurring AOD-MH 28

The treatment landscape 28

Experiences of First Nations people with AOD-MH in seeking treatment 29

Approaches to AOD-MH treatment and care 29

Barriers and opportunities to providing integrated and holistic care 32

Best practice AOD-MH care for First Nations people 33

Exemplar programs for AOD-MH 34

6 Opportunities to better address co-occurring alcohol and other drug harm and mental ill-health – frameworks for AOD-MH care 41

Overarching principles of AOD-MH care. 42

Principles of quality service delivery 42

Components of quality services 45

7 Summing up. . . . 51
Gaps, limitations and opportunities. . . . 51
Future research priorities 52
Conclusion 52

Appendix A: Background to evidence synthesis 55
Defining key terms and concepts 55
The key contextual factors regarding AOD use and mental ill-health among First Nations people of Australia. . . . 58
Summary of AOD-related harms 64
Approaches to addressing AOD-related harm 65

Appendix B: Summary of reviewed strategies 66

Appendix C: Summary of reviewed programs. . . . 67

Appendix D: Summary of AOD-MH best practice frameworks. . . . 77

Acknowledgements 82

Abbreviations 83

References 85

Caution: Some people may find the content in this report confronting or distressing.

Please carefully consider your needs when reading the following information about Indigenous mental health and suicide prevention. If you are looking for help or crisis support, please contact:

13YARN (13 92 76), Lifeline (13 11 14) or Beyond Blue (1300 22 4636).

The AIHW acknowledges the Aboriginal and Torres Strait Islander individuals, families and communities that are affected by suicide each year. If you or your community has been affected by suicide and need support, please contact the **Indigenous Suicide Postvention Services on 1800 805 801.**

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe suicide and self-harm reporting. Please consider these guidelines when reporting on these topics.

Summary

This review builds on previous work by the AIHW Indigenous Mental Health and Suicide Prevention Clearinghouse, in examining the interconnectedness of alcohol and other drug (AOD)-related harm and mental ill-health, and in its focus on co-occurring conditions. (A companion paper, which addresses the relationship between AOD-related harm and suicide risk, can be found at (https://www.indigenousmhspc.gov.au/publications/aod-suicide).

What we know

- AOD-related harm and mental health disorders are two leading contributors to the burden of disease for First Nations people in Australia, accounting for 23% of the total burden (AIHW 2023a). However, less is known about the co-occurrence of AOD-related harm and mental ill-health, and siloing has led to fragmentation in policy and service delivery. Since Swan and Raphael's 1995 *Ways forward* report, there have been repeated calls for better integration of research, policy and practice for AOD and mental health.
- People with co-occurring AOD and mental ill-health symptoms (AOD-MH) tend to experience greater harms, to have more significant treatment needs, and to have poorer prognoses, compared with those who have either condition alone.
- Research indicates high rates of co-occurring conditions: those diagnosed with mental ill-health have higher rates of AOD-use disorders than those without, and those with harmful AOD use are likely to report poorer mental health and poorer social and emotional wellbeing, compared with those without harmful AOD use.
  - Community-level research, for example, identified that 9.2% of females and 7.7% of males sampled in both urban and regional areas had both mental health and AOD-use disorder diagnoses (Nasir et al. 2018).
  - Among those with AOD-use disorders, 70% of females and 27% males also had an anxiety and/or mood disorder; and just under a quarter of males and of females with anxiety or mood disorders also had AOD disorders (Nasir et al. 2018).
- Co-occurring conditions are noted in high-risk populations – in particular among young people, people experiencing homelessness, and those in contact with the criminal justice system.
- AOD and mental ill-health share common causal pathways, which include the ongoing impacts of colonisation, social disadvantage, and systemic racism. Not surprisingly, trauma is known to play a role in the development and maintenance of co-occurring conditions, and this increases the need for trauma-informed policy, prevention, and intervention.
- Policy approaches to alcohol and drug use in Australia (e.g. the National Alcohol Strategy 2019–2028 and the National Drug Strategy 2017–2026) pay scant attention to co-occurring mental health conditions and to 'wellbeing' more broadly. Meanwhile, policy approaches to mental health acknowledge the interrelatedness of mental ill-health with AOD harms but do not provide clear guidance or support.

- The (now outdated) National Aboriginal and Torres Strait Islander Peoples Drug Strategy (NATSIPDS) 2014–2019 did include aims to address the co-occurrence of mental ill-health with AOD harms. But this aspiration is not featured in the current national strategies, partly due to the disbanding of the National Indigenous Drug and Alcohol Committee (NIDAC) in 2014.
- Responding to AOD-MH requires prevention, early intervention, and treatment responses, yet these are hampered by the separation of MH and AOD services. Among the three general approaches to treating AOD-MH – 'serial', 'parallel', and 'integrated' (the same provider simultaneously treating conditions) – integrated treatment is considered the most effective. It aligns with First Nations conceptions of SEWB and is advocated for by the Australian Comorbidity Guidelines (Marel et al. 2022), however it is underutilised.
- There is a need for services which can address complex co-occurring conditions in an integrated way. Implementation of integrated care is hindered by the structural separation of the AOD and mental health sectors, funding shortfalls, workforce issues, and by a lack of culturally secure services.
- The review noted several promising programs which address AOD-MH for First Nations people. Programs including prevention, treatment and workforce development are highlighted. A commonality among the successful programs is inclusion of cultural strength; First Nations program ownership and design, and client-centred integrated responses to AOD-MH.
- It is clear from the reviewed material that AOD services need better capacity to manage and assist with symptoms of mental ill-health and psychological distress, while mental health services need better capacity to assist those who use AOD in a harmful way.

What works

Community-driven and integrated policy approaches

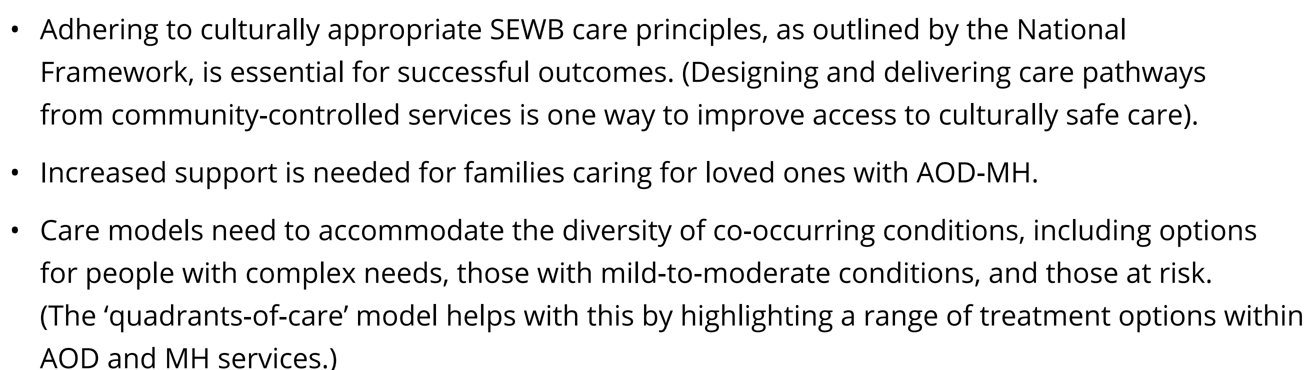
To improve health and wellbeing outcomes for First Nations people, policy needs to be holistic; include cross-governmental strategies that value First Nations' perspectives; emphasise community control; and address systemic inequalities. Policy also needs targeted outcomes, funding, and strategies to address co-occurring conditions, and this will require significant investment, integrated responses, and a national commitment to ending racism.

The re-formation of a national peak body for First Nations AOD-related harm, and better acknowledgement of the interconnectedness of AOD and mental ill-health within existing structures, will also help.

A range of responses to co-occurring conditions

Responses should include prevention (both targeted and population-based); a full suite of treatment options on a stepped-care continuum; and workforce development and support.

- Successful programs include both high-quality service-delivery approaches (emphasising governance and planning) and high-quality services (both treatment and programs).



- Adhering to culturally appropriate SEWB care principles, as outlined by the National Framework, is essential for successful outcomes. (Designing and delivering care pathways from community-controlled services is one way to improve access to culturally safe care).
- Increased support is needed for families caring for loved ones with AOD-MH.
- Care models need to accommodate the diversity of co-occurring conditions, including options for people with complex needs, those with mild-to-moderate conditions, and those at risk. (The 'quadrants-of-care' model helps with this by highlighting a range of treatment options within AOD and MH services.)

Quality service delivery elements

Effective service delivery should involve careful planning and resourcing; community engagement and ownership; accessible and flexible services; integrated care pathways; workforce capacity-building; workforce wellbeing and retention strategies; and support for outcomes evaluation. Services should have the capacity for screening on entry for AOD-MH and should enact a 'no wrong door' approach. This emphasises that any door in which a client enters is the right door – whether AOD, MH or primary health care.

Client-centred approaches

Client-centred approaches should be culturally safe, focus on individual client needs and use best practice in assessment, treatment/intervention, psychosocial and cultural support. Family-inclusive approaches; access to traditional healing where indicated; and strong client/service-provider relationships are critical for effective outcomes.

Comprehensive support for complex needs

There is a need for comprehensive support for those with complex needs, through services that provide holistic support, and address interlinked health and social challenges. These include:

- increased service availability for those who have mild-to-moderate AOD-MH conditions, to enable them to access timely treatment and services
- access to a continuum of care (from detoxification to outpatient counselling)
- practical support for housing, employment, and other social needs. (Housing interventions which can support those with AOD-MH have demonstrated good outcomes)
- access to opportunities within the criminal justice system that address and support those with AOD-MH – and thereby reduce recidivism.

What doesn't work

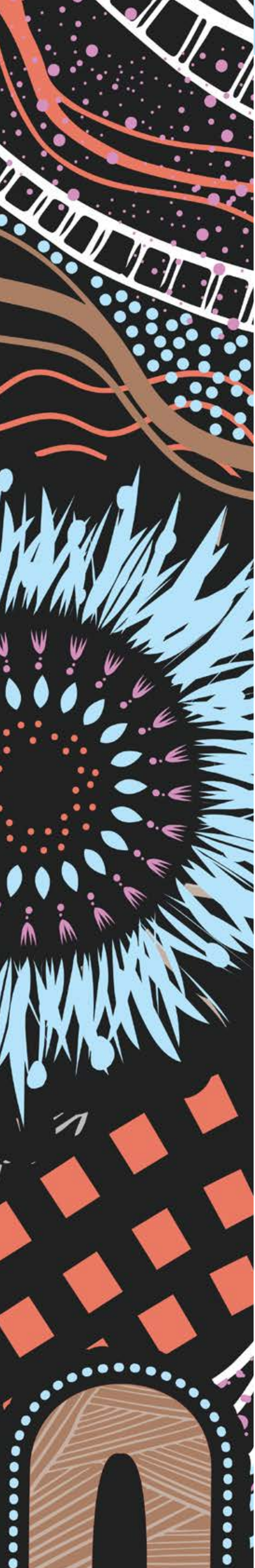
- Fragmented approaches to policy and practice for AOD-MH have not been successful. The fragmentation of AOD and MH services has resulted in a number of barriers to families seeking support for AOD-MH, including:
  - relying on families to navigate complex care pathways, which may prevent treatment engagement and success
  - difficulty in navigating complex service pathways whilst unwell

- a lack of services for mild-to-moderate conditions (as well as for complex conditions) means critical intervention windows are missed.

- The lack of a dedicated body for developing national alcohol and drug strategies for First Nations people is hampering success, as the National Drug Strategy 2017–2026 lacked First Nations representation.
- There is little within policy to encourage the interconnection of AOD and mental health and the prevalence of AOD-MH. (For example, the National Drug Strategy 2017–2026 failed to identify the interrelationship between AOD-related harms, mental health and SEWB, and the implications for policy and practice. The Strategic Framework for Aboriginal and Torres Strait Islander Peoples also lacks advice on how to strategically address AOD-MH, and how to implement and fund the Framework's proposed outcomes.)
- Additional challenges to integrated service provision include:
  - lack of engagement with the practice knowledge of the community-controlled sector
  - a lack of culturally safe care
  - complex referral pathways
  - services which disengage with clients because of a co-occurring condition
  - lack of funding and planning
  - lack of training and support for the workforce
  - the need for an expanded workforce.

What we don't know

- Broadly speaking, there is a lack of community-level and nuanced AOD and mental health data for First Nations people across the life span. For example:
  - there is a need for specific attention to the differing presentations between men and women, and among high-needs groups such as young people, people experiencing homelessness and those in the criminal justice system
  - we need to know the role that different substances, as well as polysubstance use, play on the onset and course of mental ill-health.
- There is also a lack of research specifically about AOD-MH. AOD and mental ill-health are diverse conditions and have different treatment needs, and such data are needed to inform policy and treatment strategies. For example, we need a better understanding of:
  - the AOD-related harms experienced by people in mental-health settings and the mental health of people in AOD treatment settings
  - the role of trauma in the development and course of AOD-MH.
- There is a need to better evaluate policy in terms of meeting AOD-MH outcomes.
- Organisations that treat those with AOD-MH need support and funding, including funding to:
  - support the organisations to innovate
  - further enhance treatment options for those with co-occurring conditions.



1

Introduction

1 Introduction

Harmful alcohol and other drug (AOD) use is a long-standing health and wellbeing priority in Australia and globally (Degenhardt and Hall 2012):

- AOD-related harm is an issue across the population spectrum, accounting for a significant proportion of the total disease burden (10.5% for alcohol use and 3% for illicit drugs) (AIHW 2022a).
- It is also an impediment to the health and wellbeing of First Nations people. In 2018 it was calculated that alcohol contributed 10.5% to the total burden of disease for First Nations people, while illicit drugs contributed 6.9% (AIHW 2023a).

Beyond health, harms associated with AOD use include (but are not limited to) disruption of early childhood development; disruption to education; breakdown in inter-personal relationships; violence; community disruption; and higher levels of incarceration (Gray et al. 2018; Krakouer et al. 2022; Snijder and Kershaw 2019; Wilkes et al. 2014).

As described in several Clearinghouse papers, improving mental health and wellbeing is a significant priority for First Nations people. Harmful AOD use is closely linked to mental health and wellbeing, and it affects (and is affected by) mental health. Furthermore, the co-occurrence and interaction of harmful AOD use and mental ill-health (AOD-MH) is a cause for concern as it affects the quality of life of individuals, their families and communities and is well-documented.

Landmark reports addressing wellbeing, social inequality, colonisation and its consequences for First Nations people have all highlighted the importance of AOD-related harms and their co-occurrence with poor mental health; the need for a greater focus on the impact of AOD on individual and community wellbeing; and the need for responses to AOD to be integrated within a wellbeing framework. These reports have included the *Little children are sacred* report (Wild and Anderson 2007); the *Ways forward* mental health consultancy report (Swan and Raphael 1995); the *Bringing them home* report (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (Australia) 1997); and the recommendations of the Royal Commission into Aboriginal Deaths in Custody (1987–1991) (RCIADIC and Johnston 1991).

The 1995 *Ways forward* report (Swan and Raphael 1995:12) specifically called for an integration of AOD and mental-health service provision:

> *Communities and the consultancy at every level identified the critical importance of the interrelationship between substance abuse and mental health, and that these should not be separated.*

Despite these calls across successive decades, AOD policy, practice and research has been siloed for First Nations people (Hepsibah 2015) and for Australians more broadly (Deady et al. 2015). Lack of integration has resulted in a lack of research that specifically addresses the interaction of harmful AOD with mental ill-health. Understanding the extent of co-occurring conditions (and the impact of AOD on mental health, and vice versa) is necessary for policy that will address overlapping concerns, and to provide the integrated responses which have been called for, for decades.

Aims of the review

This review synthesises research investigating the co-occurrence of harmful AOD use and mental health (including mental ill-health, psychological distress, and wellbeing), and policy and practice responses for First Nations people.

Specifically, the review aims to:

- examine the co-occurrence of harmful AOD use and mental ill-health (AOD-MH), as well as the relationship between harmful AOD use and indicators of mental health – including reviewing the mental health of those using AOD, and AOD use by those experiencing mental ill-health
- examine harmful AOD use among those with elevated or specific mental health risks
- review current policy approaches to co-occurring AOD-MH and identify effective policy responses
- review current programs which integrate responses to AOD-MH
- identify key components to effective integrated care for AOD-MH.

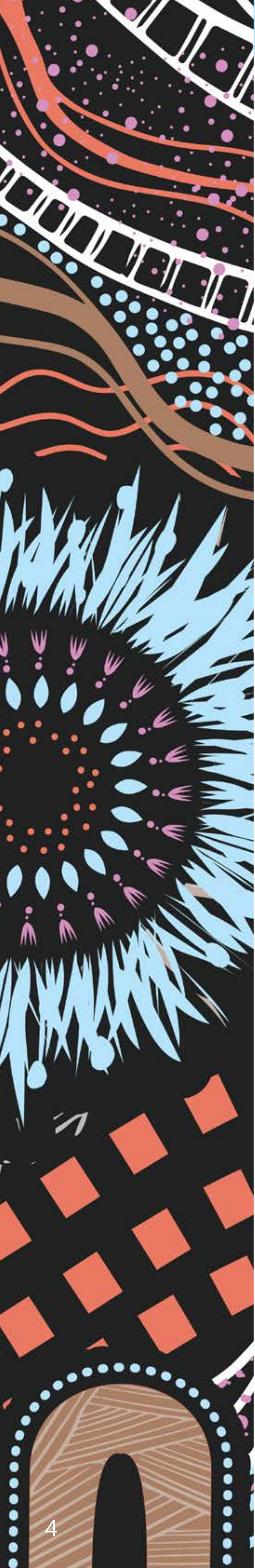
Scope of the review

This review focuses on the relationships between mental health and AOD use. Importantly, suicide risk is elevated among those who have mental health concerns, those who use AOD and those with AOD-MH. (Note: As a related paper covers the interrelationship between AOD use and suicide risk (https://www.indigenousmhspc.gov.au/publications/aod-suicide), its findings are not repeated here.)

The intersection of AOD-related harms and mental health is a complex and wide-ranging field, and it was not feasible for the current review (and its companion paper on suicide) to exhaustively cover all related topics.

The following issues are also beyond the scope of the current review, but are worthy of detailed examination:

- Nicotine's implications for mental health (Colonna et al. 2020) and its association with a significant burden of disease for First Nations people (AIHW 2020a).
- The intersection of AOD, mental health and disability (including foetal alcohol spectrum disorder).
- Neurodiversity (including autism-spectrum disorders (ASD) and attention deficit hyperactivity disorder (ADHD) and their interaction with mental health, AOD and suicide risk. A review of culturally appropriate definitions, assessment and diagnoses of ASD and ADHD is also warranted but is beyond the scope of the current review.
- Supply-reduction approaches to AOD-related harm. (Supply-reduction is an important component of available responses to AOD-related harm; however, the focus of this review is on health and wellbeing and its related policy and practice approaches.)
- Potential merits and harms of drug legalisation or decriminalisation (for example, for cannabis) on harmful AOD use and mental health.



2

Background

2 Background

Locating AOD-related harm within a social and emotional wellbeing (SEWB) framework

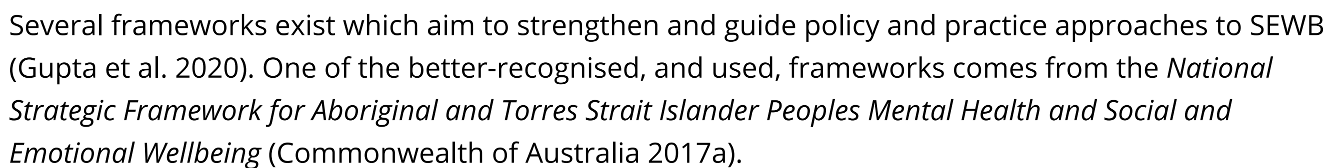
This review considers harmful use of AOD within a broader social and emotional wellbeing (SEWB) framework. SEWB is a nationally accepted, holistic model encompassing seven health and wellbeing domains (Gee et al. 2014; Martin et al. 2023), as follows:

- Connection to country
- Connection to spirit, spirituality, and ancestors
- Connection to body
- Connection to mind and emotion
- Connection to family and kinship
- Connection to community
- Connection to culture.

When researchers and practitioners use a SEWB framework, it helps them to recognise shared causal pathways and risk and protective factors; highlights the interconnection between them; and underscores the need to consider AOD within policy and practices specifically aimed at increasing wellbeing.

As a collectivist model, SEWB views the self as inseparable from the collective: it highlights the interconnectedness of individual and community wellbeing as well as the importance of connection to culture and country to health and wellbeing (Gee et al. 2014; Martin et al. 2023). Accordingly, the importance of cultural identity and cultural expression on positive SEWB are emphasised within the model (Kickett-Tucker et al. 2015). Integral to SEWB is recognition that strengthening the connections between domains results in increased overall wellbeing, whereas disrupting these connections leads to poorer overall SEWB (Gee et al. 2014; Martin et al. 2023). (A note of caution should be given here: whilst SEWB is a valuable overarching model, considerable cultural diversity exists within the First Nations community and it may therefore be experienced and expressed differently by different people and groups (Gee et al. 2014; Martin et al. 2023).

Harmful AOD use can negatively impact all SEWB domains individually and also disrupt connections between domains for individuals, families, and communities. For example, harmful AOD use impacts individual health and chronic health conditions, thereby disrupting ‘connection to body’ (Gray et al. 2018), ‘connection to community’ and ‘connection to spirit’ (Butt et al. 2022; Gendera et al. 2022; Gray et al. 2018; Snijder and Kershaw 2019; Snijder et al. 2021a; Strong Spirit Strong Mind 2021). Consistent with previous Clearinghouse reviews and reports, this review has conceptualised mental ill-health, mental wellbeing and harmful AOD use within a SEWB framework (Martin et al. 2023).



Several frameworks exist which aim to strengthen and guide policy and practice approaches to SEWB (Gupta et al. 2020). One of the better-recognised, and used, frameworks comes from the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing* (Commonwealth of Australia 2017a).

This framework highlights nine guiding principles which – when adhered to – will support SEWB:

1. Health as a holistic concept
2. The right to self determination
3. The need for cultural understanding
4. The impact of history on trauma and loss
5. Recognition of human rights
6. The impact of racism and stigma
7. Recognition of the centrality of kinship
8. Recognition of individual and community cultural diversity
9. Recognition of Aboriginal strengths.

In spite of these principles, the translation of SEWB concepts into practice is complex. Policy, practice, and research tends to consider AOD separately from MH. This goes against First Nations' emphasis on SEWB, because it may obscure the connections between domains and the opportunities for integrated and holistic treatment approaches. This review therefore aims to bring together evidence from the AOD and MH fields and to examine opportunities for AOD–MH research, policy, and practice that is consistent with SEWB guiding principles.

As described in Appendix A, the following background and contextual matters were first reviewed:

- key concepts and terms
- the context to both harmful AOD use and MH within First Nations communities
- the extent of AOD use and related harms for First Nations people
- approaches to addressing AOD-related harm.

The evidence synthesis is best understood by recognising how AOD-related harm and mental health are inter-related (as summarised below):

The inter-relationships between harmful AOD use and mental ill-health

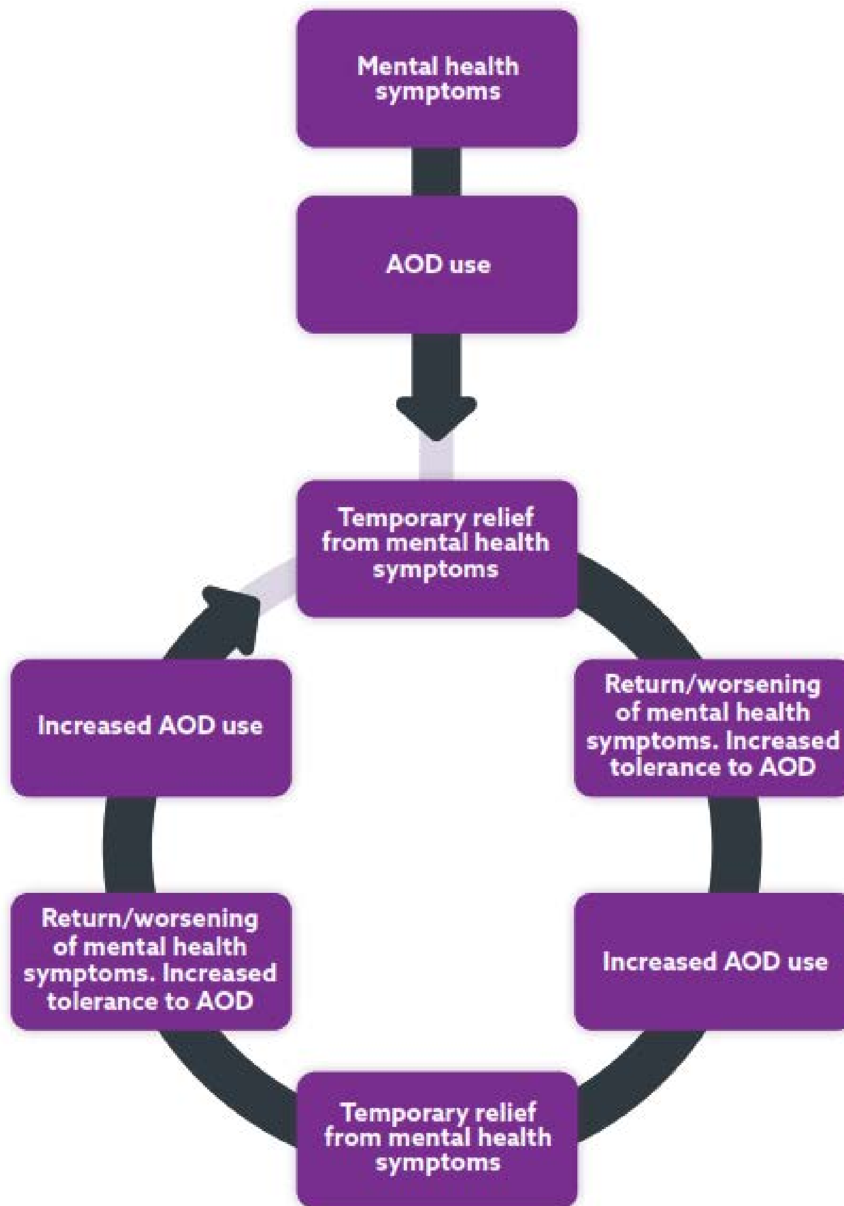
There is considerable cross-over between experiences of harmful AOD use and mental ill-health, yet either can occur independently. (Many individuals who have mental ill-health or experience significant psychological distress do not engage in harmful AOD use; similarly, those with harmful AOD use may not experience mental ill-health.)

However, for those do experience both AOD and mental-health issues, it is important to consider the relationships between the two. Three potential causal pathways explain the AOD-MH relationship (Marel et al. 2022):

- Firstly, there are **shared common pathways** leading both to harmful AOD use and to mental ill-health, including factors we now describe as 'the social determinants of health' (summarised below). There may also be community, family, and individual factors that can predispose a person to developing AOD-MH, including genetic predisposition; personal risk factors including an individual's personality, and their family and personal ways of functioning; a history of personal and intergenerational trauma; and role modelling and normalisation (Marel et al. 2022).
- Secondly, AOD use may **may be a direct cause** of mental ill-health or vice versa:
  - Cannabis use is known to increase the risk of schizophrenia (Bloomfield et al. 2019; Campeny et al. 2020; Degenhardt et al. 2001; Hall 2014; Hall and Degenhardt 2006) and can worsen episodes of depression and anxiety (Campeny et al. 2020). Similarly, alcohol use (and withdrawal) can induce symptoms of anxiety, depression, and psychotic symptoms.
  - Conversely, the harmful use of AOD may arise from a desire to manage symptoms of mental ill-health (a 'self-medication hypothesis', whereby the effects of alcohol or drugs may be sought as a way of alleviating mental health symptoms) (Turner et al. 2018; Wycoff et al. 2021).
- Thirdly, there are **indirect causal relationships** between harmful AOD use and mental ill-health. For example, early-onset regular cannabis use predicts early school withdrawal and difficulty in finding employment (Stiby et al. 2014). Failure to find employment may lead to symptoms of depression (Hudson and Hudson 2021; Marel et al. 2022) – thus creating an indirect link between harmful cannabis use and depression.

The first two of these pathways are described by First Nations participants exploring mental behaviours (Barry and Guerin 2024) and are well understood across many First Nations communities. While recognition of these causal pathways can inform intervention, it is potentially more important to consider how AOD use and mental ill-health influence each other (Hepsibah 2015; Lee et al. 2014). As summarised in the Australian Comorbidity Guidelines and represented in Figure 1 below, AOD use can provide temporary relief from mental health symptoms, but ultimately worsen an individual's overall mental (and physical) health. This concept is supported by qualitative research among First Nations people (Hepsibah 2015) and non-Indigenous Australians (Barrett et al. 2019) and underscores the need for both AOD and MH to be considered side-by-side in treatment and policy.

Figure 1: Example of mutual relationship between AOD use and MH (Marel et al. 2022)

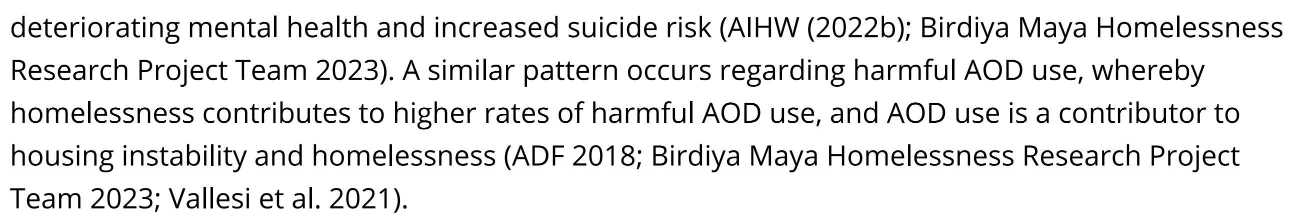


Interrelationships between AOD, MH and the social determinants of health

Discussion of harmful use of AOD and mental ill-health cannot be considered in isolation as they are both intimately related to the ongoing effects of colonisation and to the broader social determinants of health (Wilkinson and Marmot 1998). First Nations people have experienced the effects of structural inequality from colonisation onwards, effects that have persisted due to systemic racism and greater exposure to social disadvantage. Inequalities in the 'social determinants' of health arise from increased experiences of insecure housing, interpersonal violence, and incarceration.

These factors are themselves interrelated and have a 'bi-directional' relationship with mental health and harmful AOD use, both as determinants and as impacts (Gall et al. 2021), as follows:

- Experiences of insecure housing and homelessness are associated with mental ill-health and harmful AOD use in a bi-directional way. That is, mental ill-health contributes to housing instability or homelessness and housing instability or homelessness makes a significant contribution to

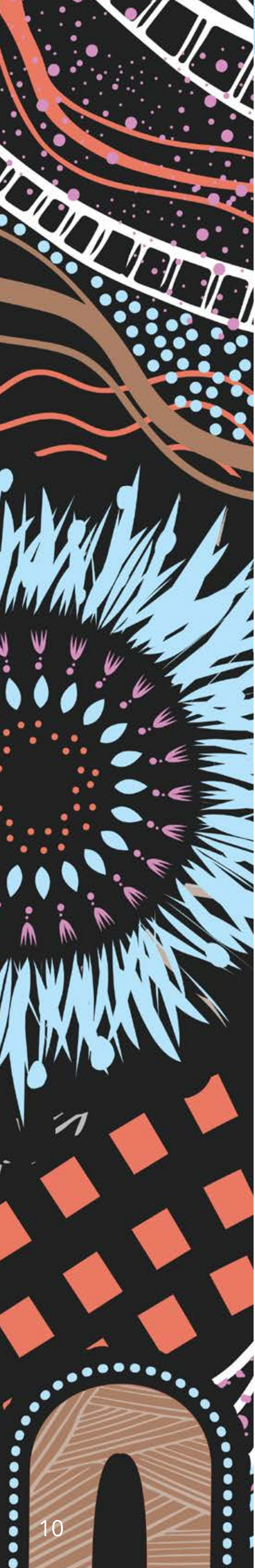


deteriorating mental health and increased suicide risk (AIHW (2022b); Birdiya Maya Homelessness Research Project Team 2023). A similar pattern occurs regarding harmful AOD use, whereby homelessness contributes to higher rates of harmful AOD use, and AOD use is a contributor to housing instability and homelessness (ADF 2018; Birdiya Maya Homelessness Research Project Team 2023; Vallesi et al. 2021).

- Experiences of incarceration are also associated with poorer mental health and have a bi-directional relationship with harmful AOD use (AIDA 2022). Harmful AOD use is associated with initial contact with the criminal justice system and ongoing criminal justice system contact. Conversely, incarceration is associated with onset and increased severity of harmful AOD use (Doyle et al. 2022; Bista et al. 2021).
- The relationship between AOD use and violence has been noted by several research and review papers with particular reference to alcohol, methamphetamine, and cannabis (Cripps 2023; Lee et al. 2015; Wilson and Butt 2019; Wilson et al. 2013). Research findings emphasise the role of AOD use in perpetuating exposure to unsafe environments (Snijder and Kershaw 2019) and increasing the risk of being a perpetrator and/or victim of violence. Domestic violence (DV) is a topic of particular concern: experiences of DV contribute directly to poorer mental wellbeing, including post-traumatic stress disorder (PTSD) and depression (Humphreys et al. 2021). Furthermore, women experiencing DV are more likely to use AOD harmfully, as a coping strategy (Tuber and Cox 2020, Humphreys et al. 2021). Compounding this, vulnerability to experience of DV increases with harmful AOD use, creating a difficult-to-interrupt cycle (Humphreys et al. 2021). Experiences of DV are also closely linked to mental ill-health, and a recent publication by the AIHW Clearinghouse (Cripps 2023) offers a comprehensive review of mental health and violence.
- Engagement in education and employment also influences, and is influenced by, MH and AOD. Detailed reviews are available on the Clearinghouse website regarding the relationship between MH and employment (https://www.indigenousmhspc.gov.au/publications/employment) and MH and education (https://www.indigenousmhspc.gov.au/publications/education).

This summary briefly demonstrates the complexity of interactions between determinants of health and harmful AOD use and MH. While the focus of this review is on harmful AOD and mental ill-health, the recognition of these determinants and how they co-occur and intersect is critical to engaging in effective discussion which moves away from the existing silos.

Policy and intervention approaches tend to separate these intersecting and complex issues into discrete areas despite recognition that – to have lasting and impactful change – approaches to addressing AOD-MH need to consider the social determinants of health (Butt et al. 2022; Cripps 2023; Dudgeon et al. 2010; Gray and Wilkes 2010; Krakouer et al. 2022; Wilkes et al. 2014). As an example, research indicates that when people have access to safe and secure housing, rates of harmful AOD use decrease; overall mental health improves; and offending rates and interaction with the criminal justice system decrease (AIHW 2022b; Vallesi et al. 2021). These outcomes have subsequent beneficial effects for both harmful AOD use and mental health, as well as for suicide risk (Vallesi et al. 2021).



3

Method

3 Method

Scoping review

A scoping review was undertaken to identify relevant literature and to synthesise the evidence in the key issues, policy, and intervention sections. As defined by Munn et al. (2022):

> … s*coping reviews are a type of evidence synthesis that aims to systematically identify and map the breadth of evidence available on a particular topic, field, concept, or issue, often irrespective of source (i.e., primary research, reviews, non-empirical evidence) within or across particular contexts.*

Importantly for this topic, scoping reviews are expansive: they seek a broad range of literature and can be used to both identify the types of available evidence in a given field as well as to identify and analyse knowledge gaps (Munn et al. 2018). Based on their existing knowledge, and this preliminary scoping, the review authors knew that there is a lack of specific literature on First Nations AOD-MH. An expansive search was therefore undertaken, which was able identify research which addressed AOD-MH in indirect ways.

This review has synthesised research into the context of co-occurring AOD-MH; its prevalence; policy approaches; and treatment and prevention approaches. The search drew on the researchers' own databases; traditional literature search; and searches of grey literature. The search was iterative, and additional searches were conducted as the review and synthesis proceeded, using key-author searches and reviews of reference lists, to identify sources of primary material.

In the initial stages, electronic databases were searched to identify academic and grey literature about AOD and mental health as well as relevant policy, treatment, and programs. Due to the siloing of mental health and AOD research, literature was searched using both AOD-related terms and mental health-related terms. 'Search strings' were developed from the example terms summarised in Table 1 (below), combined with key policy and intervention search-terms.

Table 1: Search terms for literature search

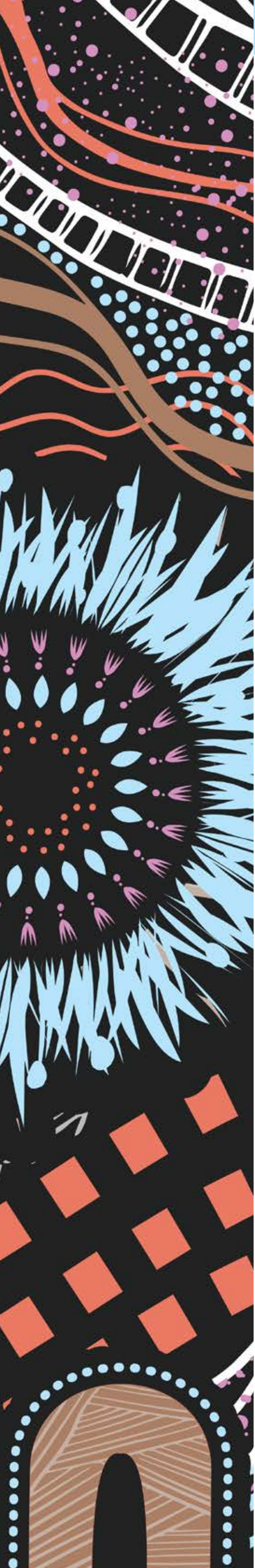
Population terms	AOD terms	Mental health terms	Comorbidity terms
Aboriginal, Torres Strait Islander, Indigenous, First Nations AND Youth, children adolescents, at risk, LGBTQI, women, female, men, male	Drugs, substances, AOD, alcohol, methamphetamine, cannabis, marijuana, cannabis prescription drugs, illicit drugs, polydrug use	Mental health, mental disorders, wellbeing, SEWB, diagnosis, psychological distress, depression, anxiety, self-harm, psychosis, schizophrenia, BPAD, PTSD, trauma	Comorbidity, co-occurring, dual diagnosis

These strings of terms were entered into the following databases:

- ATSIHEALTH
- Healthinfonet
- PychINFO
- PubMed
- ProQuest
- Google Scholar
- Scopus.

Following the initial literature search, grey literature was searched using the Google search engine, the Clearinghouse, and the AOD Knowledge Centre. Terms were also sourced from key organisations such as the Healing Foundation and the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, and from key government agencies including the AIHW. Additional literature was then sought using an iterative process.

Due to the complexity of the area, the overlap across several research domains and the changing policy landscape around AOD the review limited searches to the previous 10 years (from 2013). Six exceptions were made for critical works on co-occurring conditions among First Nations people (AMSANT 2011; Hunter 2003; Nadew 2012; Nagel et al. 2009; Nagel et al. 2011; Schlesinger et al. 2007). Papers on the search topics were not indiscriminately included; unless indicated the review did not include research regarding other First Nations people (for example Canada, USA, and New Zealand). Finally, First Nations voices and research were privileged within the report; papers without clear links to community oversight and authorship were not included.



4

Key issues

4 Key issues

Prevalence and harms of co-occurring harmful AOD and mental ill-health (AOD-MH)

A detailed summary of the extent of AOD use and related harms for First Nations people and communities is summarised in Appendix A. Population-level data has also been summarised in detail by AIHW (AIHW 2023a; 2023b) and is updated regularly.

In considering the extent and harms related to AOD-MH the following points are important to hold in mind:

- While the proportion of First Nations people who consume alcohol is lower than for Australians in general, First Nations people experience a disproportionate amount of harm from AOD (AIHW 2023a).
- The most commonly used drugs are alcohol, cannabis, and methamphetamine, which are also the three drugs most commonly cited by communities as causing harm, and are the most common drugs of concern for treatment recipients (AIHW 2023a). These substances have both direct and indirect mental health impacts. In general, patterns of AOD use vary across different demographics, with younger people and males showing higher rates of usage.
- Whilst national data sets likely underestimate use, 2018–19 NATSIHS data suggests that 50% of First Nations people over 15 drank alcohol above safe limits, and 28% used drugs in the previous year (AIHW 2023a).
- For those aged over 15, 25% in the NATSIHS reported using cannabis in the past year; however, community-level studies suggest higher rates, with cannabis use considered 'normal' (AIHW 2023a). This normalisation and high levels of use are of particular concern, considering that cannabis can have a direct, negative impact on mental health, including on the course and severity of mental illness (Butt et al. 2022).
- Methamphetamine use significantly impacts mental health, family functioning and community wellbeing, with injection use posing additional risks. Prevalence of methamphetamine use is hard to determine: in the NATSIHS, 3% of the over-15s reported past-year usage (AIHW 2023a, Snijder and Kershaw 2019).
- 'Polysubstance' use is common and poses the risk of greater harm – although there is a lack of data accurately describing it. Further research is necessary to inform prevention and treatment.
- The prevalence of AOD-use disorders among First Nations people is challenging to ascertain due to methodological issues, but existing research highlights significant concern.
- The existing data does not adequately describe the differing patterns of use by individuals over time. Patterns of use (such as binge use and periods of abstinence) are important because they have an impact on harm experienced, and can inform treatment approaches (see, for example, Weatherall et al. 2022).

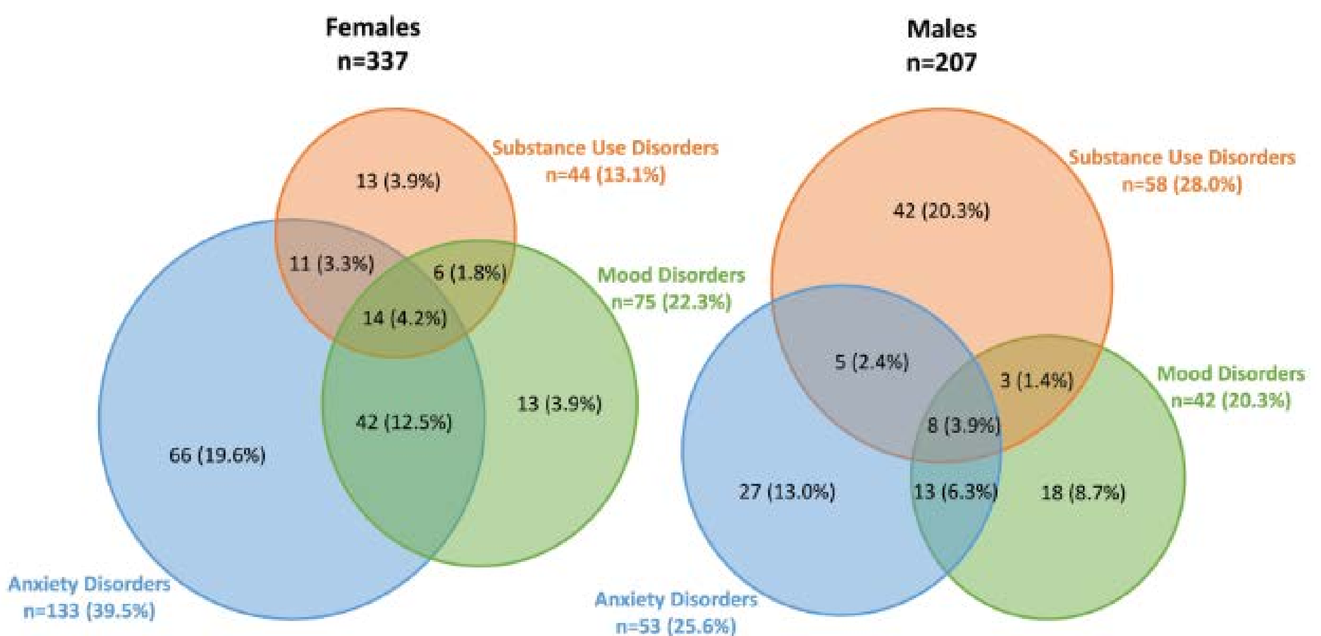
- The broader harms of AOD use occur at the individual, familial, and community levels, exacerbated by systemic issues like racism and socio-economic disadvantage, emphasising the urgent need for comprehensive, culturally sensitive interventions.

Prevalence of AOD-MH

Mental health and AOD-use disorders are estimated as the highest contributor to burden of disease for First Nations people, accounting for 23% of the total burden in 2018 (AIHW 2022a). Comparatively, cancer and cardiovascular disease contribute 9.9% and 10%, respectively (AIHW 2022a). Despite this, and the known interrelationship between AOD and MH, there is a lack of detailed information on the co-occurrence of mental health and AOD-use disorders – a problem which has been noted for at least the last two decades (for example, by Hunter 2003). Obtaining this information is complicated by a lack of appropriate mental health diagnostic tools for First Nations people, and limited use of those tools which are available (Brinckley et al. 2021; Westerman and Dear 2023). At a population level, data from the 2018–19 NATSIHS suggest that First Nations people who reported a mental health condition were more likely to have used substances in the last 12 months, compared with those without a mental health condition (AIHW 2023b), which highlights the overlap between mental ill-health and AOD use (irrespective of any harm which may have occurred).

The literature search identified one First Nations longitudinal birth-cohort study, and one community-based study, which highlighted rates of AOD-MH. Within the longitudinal study (which was conducted in Queensland), 25% of those with a hospital admission for a psychiatric illness also had a co-occurring AOD-related diagnosis (Ogilvie et al. 2021b). The community-based study sought to identify prevalence of common mental-health disorders among First Nations people in regional and urban Queensland and New South Wales. It found that 9.2% of females, and 7.7% of males, had co-occurring mental health and AOD-use disorder diagnoses (Nasir et al. 2018). The findings of this research project are reproduced in Figure 2, below.

Figure 2: Prevalence of anxiety, mood and substance use disorders for females and males (Nasir et al. 2018)



Closer examination of the data from this community-based study show that:

- women were more likely than men to have an anxiety and/or mood disorder (61% compared to 46%) and men were more likely to have substance-use disorders (28% compared to 13%)
- 70% of females with an AOD disorder also had an anxiety and/or mood disorder
- 27% of males with an AOD disorder also had an anxiety and/or mood disorder
- 20% of females with an anxiety and/or mood disorder also had an AOD disorder
- 22% of males with an anxiety and/or mood disorder also had an AOD disorder.

The study did not investigate severe mental health conditions such schizophrenia, bipolar affective disorder, or other complex conditions such as trauma-related disorders and personality disorders; neither did it detail specifics of AOD use. However, the data represented (below) in Figure 3 provide useful insights into the prevalence of common mental health conditions co-occurring with AOD-use disorders, and highlights the differing presentations between women and men.

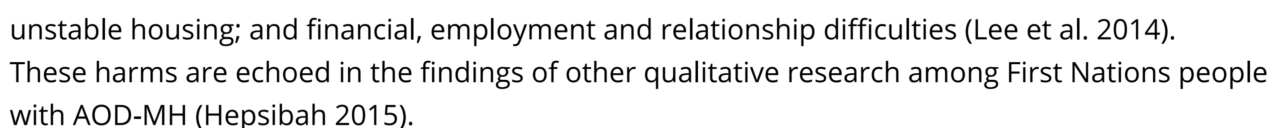
There is a clear lack of detail in the population and community level research. In a more specific sample, Lee and colleagues (2014) conducted a qualitive study of the needs of First Nations women with AOD-MH in a treatment setting. The women reported mental health conditions ranging from mild anxiety to severe depression and psychosis. The women also reported harmful use of a range of substances, including alcohol, cannabis, heroin, prescription medications, amphetamines, and polysubstance use (Lee et al. 2014) – which exemplifies the diversity of experiences of AOD-MH even within one setting. The women described experiences with early childhood trauma as impacting on their wellbeing and life courses, and the compounding effects of chronic stress as critical components of becoming unwell (Lee et al. 2014). (This is consistent with this paper's earlier discussion of the role of the social determinants of health and of the ongoing legacy of colonisation.)

The role of trauma in the development of AOD disorders is well established (Nadew 2012) and, given the experience of trauma among First Nations people, the co-occurrence of AOD and trauma-related mental health conditions is not unexpected. It underscores the need for early intervention in early childhood adversity, together with adequate resourcing of prevention initiatives.

Although it is outside the frame for this review, a study by Nadew (2012) is worthy of note. Research conducted with a community sample identified a strong relationship between PTSD diagnosis, exposure to traumatic events, and alcohol use. The overwhelming majority (97.3%) of participants had been exposed to traumatic events, while 55.2% met the criteria for PTSD, 20% for major depression and 73.8% for alcohol-use disorder. This clearly demonstrates the role of trauma in AOD-MH and the importance of using a trauma-informed lens when considering relevant policy and practice.

Harms associated with AOD-MH

There is a lack of research summarising the harms associated with co-occurring conditions for First Nations people. Internationally, it is surmised that those who experience AOD-MH typically experience more harms, have poorer prognoses, and have greater treatment needs, compared with those who experience either condition alone (Marel et al. 2022). Furthermore, people with comorbid conditions report greater difficulty in accessing treatment (Hunter 2003; Marel et al. 2022). In a study with women in a treatment setting, participants identified that having a co-occurring condition could have a range of negative consequences, including involvement with child protection services;



unstable housing; and financial, employment and relationship difficulties (Lee et al. 2014). These harms are echoed in the findings of other qualitative research among First Nations people with AOD-MH (Hepsibah 2015).

The experience of extended family

Significantly, several pieces of qualitative research have highlighted the experiences of extended family in managing co-occurring conditions (Birdiya Maya Homelessness Research Project Team 2023; Gendera et al. 2022; Hepsibah 2015). For example, patient advocates in a study investigating the service needs of First Nations people with AOD-MH in South Australia highlighted experiences of violence within families and its impacts on child rearing, as well as the stresses and time involved in sourcing and accessing care for their family members (Hepsibah 2015).

Mental health in AOD research

Considering the overall lack of research specifically addressing co-occurring disorders, it is useful to consider how mental health is addressed withing the AOD literature and vice versa. The review below summarises information regarding co-occurring disorders from both bodies of literature.

The relationships between MH and AOD, and the presence of co-occurring disorders, have been highlighted in a range of AOD research projects. From a strengths-based perspective, analysis of the ASSAD data shows that First Nations secondary students who had never used cannabis were also more likely to have never had anxiety and/or depression (Graham et al. 2021).

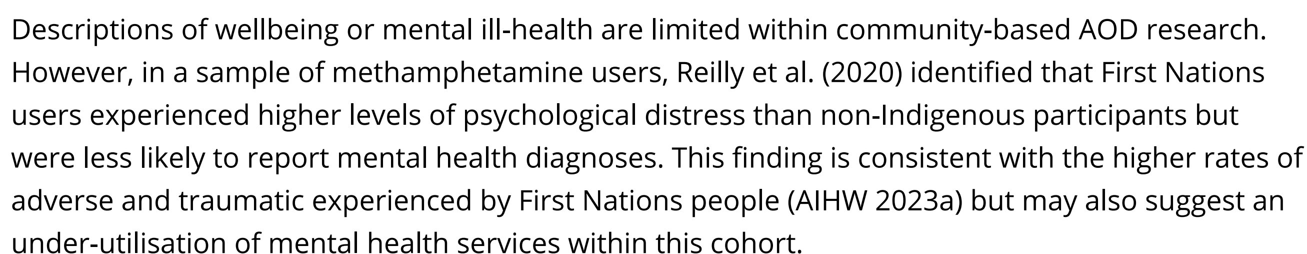
Several studies have looked at the rates of mental health conditions in AOD treatment settings with variable results. A national systematic review of mental-health diagnoses among Australian people presenting for AOD treatment found that prevalence ranged widely, between 47% and 100%. For example, the prevalence of depression ranged from 27% to 85%, and anxiety from 1% to 75%. The review recommended improved assessment of mental health across AOD settings (Kingston et al. 2017).

In relation to the experiences of First Nations people, three case-review studies highlight the high rates of co-occurring conditions.

To investigate the impact of psychiatric comorbidity on treatment outcomes, Davis et al. (2023) reviewed the files of voluntary patients receiving AOD detoxification services, including 17% who identified as First Nations. The following prevalences were identified for the First Nations patients: any mental health condition (61%), depression (53%), self-reported anxiety (31%), PTSD (9%), Bipolar Affective Disorder (7%), psychosis (11%), and anxiety disorder diagnosis (5%) – demonstrating the high rate of co-occurring mental health disorders among all AOD treatment seekers.

The second study – a file review in a remote Aboriginal community AOD service that included 85% First Nations patients – found a high rate of AOD-MH (Munro et al. 2018). The review identified that 51% of client admissions had reported a mental illness, with 'depression' being the most commonly reported (24%).

The third study – a file review by James et al. (2020) in Aboriginal residential rehabilitation services in NSW – reported that 78% of residents experienced co-occurring AOD-MH, with one service identifying that 88% of participants were at risk of mental health problems (James et al. 2020).



Descriptions of wellbeing or mental ill-health are limited within community-based AOD research. However, in a sample of methamphetamine users, Reilly et al. (2020) identified that First Nations users experienced higher levels of psychological distress than non-Indigenous participants but were less likely to report mental health diagnoses. This finding is consistent with the higher rates of adverse and traumatic experienced by First Nations people (AIHW 2023a) but may also suggest an under-utilisation of mental health services within this cohort.

The 'missing middle'

These studies highlight the challenges First Nations people experience in accessing mental health care and receiving culturally appropriate assessment and diagnosis. Taken together, this research shows that comorbidity is high among people who are seeking treatment for AOD, but that we know a lot less about those who experience AOD-related harm but are not seeking AOD treatment.

This is consistent with national and international research, which raises concern that there is a 'missing middle' in AOD-MH in which people with mild-to-moderate MH or AOD harms have difficulty accessing appropriate services (State of Victoria 2021).

AOD use in mental health research

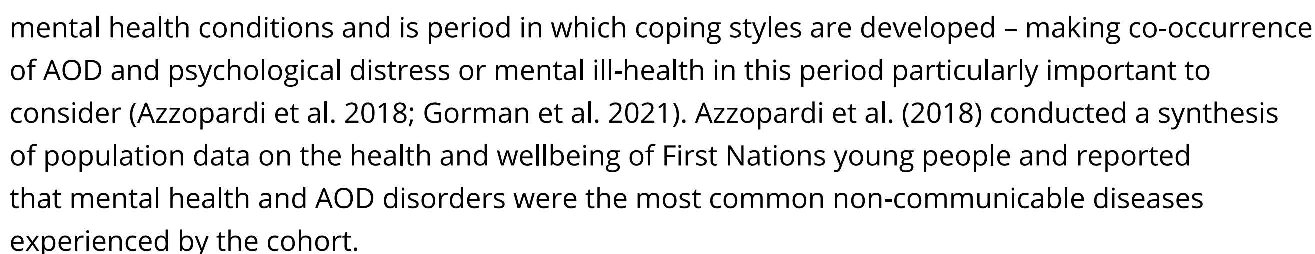
Understanding AOD use and related harm among those with mental health diagnoses or experiencing psychological distress is another avenue to examine AOD-MH, however AOD tends to be poorly assessed in mental health research. That said, research among First Nations people with psychosis has noted high rates of AOD use (Gynther et al. 2019, Carlin et al. 2022). A data-linkage study examining treated cases of psychosis in Cape York found cannabis use was associated with 60% to 70% of psychosis cases in the Aboriginal population from 2003 to 2015 (Gynther et al. 2019). Similarly, a file audit of mental health presentations in remote a WA primary health clinic reported that AOD was highly prevalent and noted in 21 out of the 30 files (Carlin et al. 2022).

The same study noted that mental health diagnoses in the files tended to be for severe conditions (for example, schizophrenia), leading authors to consider if adequate screening for more common mental health disorders was occurring (Carlin et al. 2022) – a concern raised by other authors (Brinckley et al. 2021). Although there is a lack of data, the available evidence highlights the importance of understanding AOD use among people with mental ill-health and/or psychological distress. As described above, the relationships between trauma and adverse experiences, mental ill-health and psychological distress, and AOD-related harms, are becoming more evident and warrant significant further attention.

AOD-MH among vulnerable groups

Young people

Improving the wellbeing of First Nations young people is national priority, yet there is a lack research specifically addressing AOD-MH in young people to inform interventions. AOD use affects developing brains, so early commencement of AOD use has more serious mental and physical health consequences (Bista et al. 2021). Thus, young people are particularly vulnerable, and worthy of specific attention for AOD-related harms. Similarly, adolescence is a time of vulnerability for



mental health conditions and is period in which coping styles are developed – making co-occurrence of AOD and psychological distress or mental ill-health in this period particularly important to consider (Azzopardi et al. 2018; Gorman et al. 2021). Azzopardi et al. (2018) conducted a synthesis of population data on the health and wellbeing of First Nations young people and reported that mental health and AOD disorders were the most common non-communicable diseases experienced by the cohort.

Research that is available has noted a high level of co-occurrence of AOD and MH: of a sample of First Nations young people seeking mental health support from an outpatient facility in Western Australia, 50% reported a co-occurring AOD-use disorder (Sabbioni et al. 2018). In addition, Westerman and Dear (2024) analysed data from the WASC-Y assessment tool used in mental health settings to develop clinical norms for the scale. The scale contains two AOD-related items and, although these items were not described in detail, Westerman and Dear (2024) reported that males from clinical settings had higher scores on the AOD items than males from a previously collected community sample. This is a finding suggestive of the importance co-occurring AOD-MH for young First Nations males in mental health settings. (This finding was not replicated among females.)

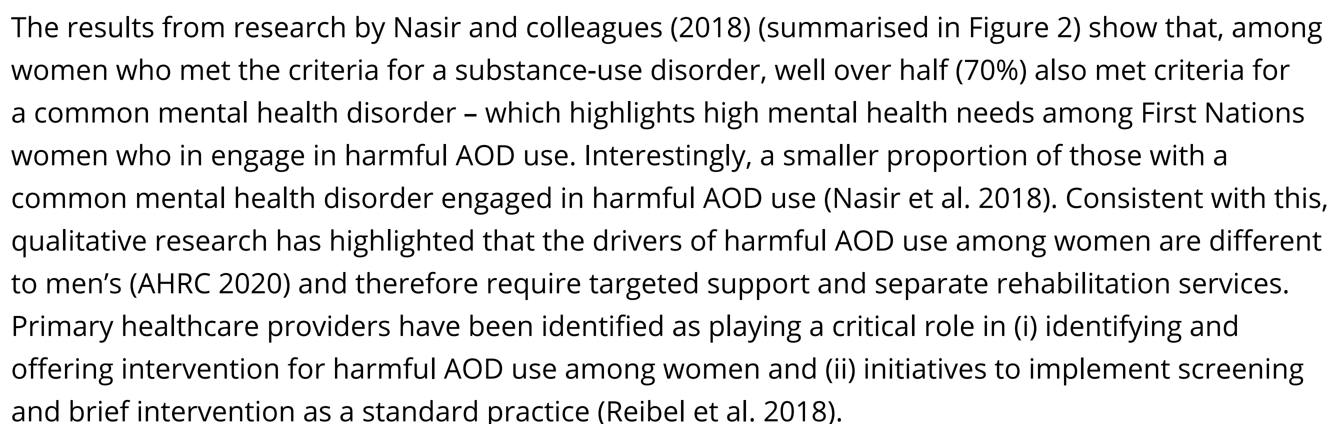
Azzopardi and colleagues (2020) noted higher rates of psychosis for First Nations young people than non-Indigenous young people and hypothesised the role of cannabis use as risk factor (Azzopardi et al. 2020). This suggests an ongoing need to investigate the role of AOD in the development and progression of MH concerns.

Men

There is a gap in understanding the health needs of men outside of acute hospital presentations (Haregu et al. 2022) and correctional settings. As shown in Figure 2, First Nations males use AOD at higher rates and are more likely than females to have a use disorder. The data underpinning Figure 2 (Nasir et al. 2018) indicate that 27.5% of the sample who had an AOD diagnosis also had a common mental health disorder. Beyond this, there is a lack of research looking specifically at the experiences of men in relation to AOD-MH. Of note, First Nations men access primary healthcare services at lower rates than matched population groups – at among the lowest rates across the population (Farnbach et al. 2020). This suggests a gap not only in prevention and early intervention opportunities, but in understanding the community-level prevalence of co-occurring AOD-MH.

Women

There is a growing body of research regarding AOD use (with a focus on alcohol and, to a lesser extent, cannabis) and pregnancy among First Nations women. However, there is much less research relating to AOD harms and AOD-MH among First Nations women outside the perinatal period. Pregnant First Nations women are less likely to drink alcohol during pregnancy than non-Indigenous Australians, but those who do drink are more likely to do so at harmful levels (Gibson et al. 2020), which echoes broader patterns of alcohol use by First Nations people. With respect to cannabis, a study of pregnant mothers of First Nations babies found that 21% had used cannabis (Brown et al. 2019; Brown et al. 2016) and a cross-sectional sample of pregnant Aboriginal women showed that 15% of participants smoked cannabis (Passey et al. 2014). The study also noted that almost half of the participants did not smoke cannabis, drink alcohol nor smoke tobacco during pregnancy, but that the co-occurrence of alcohol, tobacco and cannabis use did occur among a high-risk cohort (Passey et al. 2014).



The results from research by Nasir and colleagues (2018) (summarised in Figure 2) show that, among women who met the criteria for a substance-use disorder, well over half (70%) also met criteria for a common mental health disorder – which highlights high mental health needs among First Nations women who in engage in harmful AOD use. Interestingly, a smaller proportion of those with a common mental health disorder engaged in harmful AOD use (Nasir et al. 2018). Consistent with this, qualitative research has highlighted that the drivers of harmful AOD use among women are different to men's (AHRC 2020) and therefore require targeted support and separate rehabilitation services. Primary healthcare providers have been identified as playing a critical role in (i) identifying and offering intervention for harmful AOD use among women and (ii) initiatives to implement screening and brief intervention as a standard practice (Reibel et al. 2018).

LGBTQIASB+ people

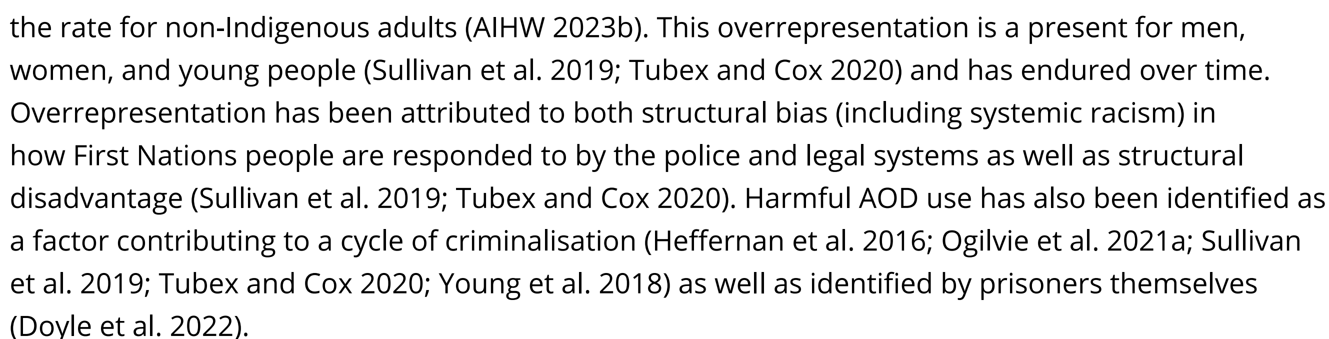
There is very little published research describing AOD-MH among First Nations LGBTQIA+ people. This is despite (i) rates of both AOD and MH being higher among general samples of the LGBTQIA+ population and (ii) the population being a priority in the National Drug Strategy 2017–2026 (Lea et al. 2021). This gap is highlighted and discussed in a recent Clearinghouse review alongside risk and protective factors specific to suicide among First Nations LGBTQIASB+ people (Day et al. 2023) – and the current review builds on this with a specific focus on harmful AOD use.

Walkern Katatdjin (Liddelow-Hunt et al. 2023) is a research project currently exploring SEWB among First Nations LGBTQIASB+ young people. Given its sample size of 619, this project should make a significant contribution to understanding SEWB for this cohort. The majority of participants in the study either did not use AOD, or used it in ways they did not associate with harm, while 12.4% reported that AOD use was associated with harms in their lives and 6.8% had been diagnosed with a substance use disorder (Liddelow-Hunt et al. 2023). The study also reported that 78% of respondents reported AOD use in their family and that, of this group, 38.2% reported this use to be harmful (Liddelow-Hunt et al. 2023). While rates of harmful AOD use in the sample were relatively low, both 'high' or 'very high' psychological distress were reported by a large proportion (91.9%) of the sample (Liddelow-Hunt et al. 2023). The findings suggest that AOD-MH is not a significant concern for this cohort. Similarly, research has suggested that identifying as LGBTQIASB+ is a protective factor for cannabis use among young people (Graham et al. 2021).

However, there is complexity within these findings, the second GOANNA study reported transgender and gender diverse people were less likely to drink alcohol at harmful levels than males or females but more likely to use illicit drugs (in particular cannabis and methamphetamine; Ward et al. 2020). Taken together, the results present an unclear picture and suggest that AOD-related harms are not a foremost SEWB priority for First Nations LGBTQIASB+ people. This said, AOD-MH is present, and the design of treatment and prevention requires close consideration within this population given efficacy is closely related to services tailoring their approach to be culturally safe across the intersecting identities lived by First Nations LGBTQIASB+ people (Lea et al. 2021).

Criminal justice involved people

First Nations people in Australia are criminalised and incarcerated at significantly higher rates than the broader Australian population and are among the most incarcerated peoples globally (AIDA 2022). Recent data indicates that the imprisonment rate for First Nations adults is 14 times



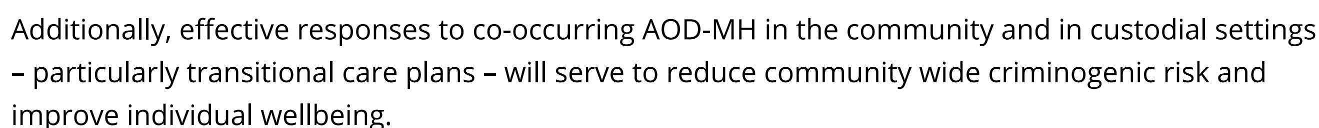
the rate for non-Indigenous adults (AIHW 2023b). This overrepresentation is a present for men, women, and young people (Sullivan et al. 2019; Tubex and Cox 2020) and has endured over time. Overrepresentation has been attributed to both structural bias (including systemic racism) in how First Nations people are responded to by the police and legal systems as well as structural disadvantage (Sullivan et al. 2019; Tubex and Cox 2020). Harmful AOD use has also been identified as a factor contributing to a cycle of criminalisation (Heffernan et al. 2016; Ogilvie et al. 2021a; Sullivan et al. 2019; Tubex and Cox 2020; Young et al. 2018) as well as identified by prisoners themselves (Doyle et al. 2022).

AOD use is higher among First Nations people in prison and police detainees than non-Indigenous people in prison and detainees (Doyle et al. 2015; Doyle et al. 2022; Doyle et al. 2023; Walker et al. 2018). For example, data from Drug Use Monitoring in Australia (DUMA), which involves the routine collection of survey and urinalysis data from police detainees across Australia, found that 84% of First Nations detainees tested positive to a drug, and 54% of First Nations detainees tested positive to multiple drugs. Similarly, Heffernan and colleagues (2016) reported that among a predominately male sample of First Nations people in prison, AOD-use disorders were highly prevalent (66%), with alcohol dependence, followed by cannabis dependence the most common types of use disorder. Co-occurring conditions have also been clearly identified within research. In a Queensland study of incarcerated male and female adults Young and colleagues (2018) reported that 24% of prisoners reported AOD-MH, 35% AOD-use disorder only and 16% mental health disorder only. In a study of Aboriginal mothers in prison, Sullivan and colleagues (2019) identified high rates of mental health diagnoses among women in prison for alcohol or drug related offences (70% in NSW and 40% in WA).

Research outside the custodial setting highlights the interaction between mental ill-health, offending and AOD; using data linkage across mental health separations and court records Ogilvie and colleagues (2021a) demonstrated an overlap between offending and psychiatric diagnoses (including AOD disorders) which were more pronounced for First Nations people compared with non-Indigenous Australians (14.8% and 2.7% respectively; Ogilvie et al. 2021a). These findings emphasise the importance of culturally appropriate mental health responses being embedded into the criminal justice system (Ogilvie et al. 2021a) and highlight the potential role for mental health support, including AOD intervention, as a pathway to prevent offending. Despite this opportunity Heffernan and colleagues (2016) noted that the majority of participants (87%) in their study did not have any treatment contact in the 12 months prior to custody.

Leaving prison is a high-risk time for mortality, and AOD and mental health concerns are a significant impediment to quality-of-life post release and are predictors of harms post release (including overdose, recidivism, homelessness and mortality) (Abbott et al. 2017; Keen et al. 2020; Young et al. 2018). As described by incarcerated First Nations men with injecting drug use histories in a qualitative study: limited social support and housing instability contributes directly to resumption of drug use, re-offending and returning to prison (Walker et al. 2018), with men identifying a lack of control over this cycle despite their awareness of it (Walker et al. 2018). Over many years, multiple authors and advocates have highlighted the importance of custodial settings to provide AOD and mental health programs to reduce recidivism and improve post release morbidity and mortality. However, many individuals report not accessing quality care within custodial environments (Heffernan et al. 2016).

Taken together, this discussion further evidences what has previously been identified; culturally capable alcohol and other drug treatment services in custody and in the community are critical.



Additionally, effective responses to co-occurring AOD-MH in the community and in custodial settings – particularly transitional care plans – will serve to reduce community wide criminogenic risk and improve individual wellbeing.

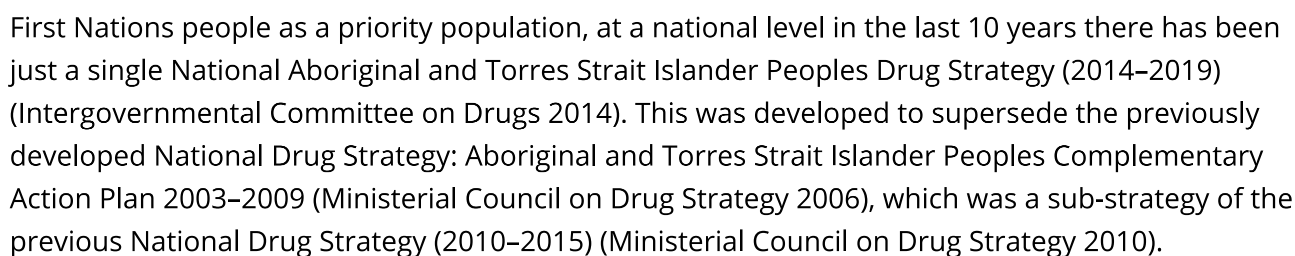
People experiencing homelessness

As previously highlighted, occurring together or separately, AOD harms and mental ill-health compound homelessness. In a recent report describing First Nations people's experiences of homelessness in Western Australia, the relationship between AOD, mental health and housing was identified as complex and significant, with AOD use and mental ill-health both contributing to loss of stable housing as well as to barriers to accessing housing supports (Birdiya Maya Homelessness Research Project Team 2023). AOD use was described as a way of coping with the experience of being homeless and to cope with both psychological distress and mental health concerns by participants and was highlighted as significant by Elders overseeing the research project. Additional research has identified high rates of co-occurring disorders among people experiencing homelessness; for example, a large study with people engaged with specialist homelessness services in Western Australia including a relatively large sample of First Nations people found that 37.4% of Frist Nations people self-reported AOD-MH (Vallesi et al. 2021), lower than the non-Indigenous population in the same sample (51.8%). That said, it is important to acknowledge that AOD-related harms and mental health conditions, as well as co-occurring conditions, are largely undiagnosed and are undertreated among people experiencing homelessness (AIHW 2022b; Vallesi et al. 2021); with the under diagnosis and treatment of trauma related conditions particularly noteworthy (AIHW 2022b).

Stable housing coupled with access to mental health support has been shown to reduce AOD use and improve mental health outcomes among people experiencing long-term homelessness. In recent research among adults experiencing chronic homelessness (8% identified as First Nations) it was observed that people who were provided with stable housing who did not also access mental health support reported an increase in alcohol use severity 12 months after being housed, whereas those who also accessed mental health care reported significantly reduced AOD use alongside improved mental health (Taylor et al. 2023). People who are experiencing homelessness are particularly vulnerable to harm and to falling through gaps in treatment services; this research highlights the need for holistic provision of care to address the intersecting and complex social and emotional wellbeing of this population.

Policy approaches to co-occurring AOD and mental health

A review of national level AOD and Mental Health strategies and frameworks, and how these policies consider AOD-MH and the interconnection of AOD and MH is presented in Table B in Appendix B. At a national level there are two key policies and strategies informing the harm minimisation approach to alcohol and other drug harms – National Alcohol Strategy 2019–2028 and National Drug Strategy 2017–2026 (Department of Health 2017; Department of Health 2019). These are also supported by specific strategies including tobacco, methamphetamine, foetal alcohol spectrum disorder and workforce (DHAC 2023; Commonwealth of Australia 2015; Commonwealth of Australia 2017a). All these strategies are underpinned by the principle of minimising harms from use of alcohol, tobacco, and other drugs through the reduction of harms, demand, and supply (Department of Health 2017, 2018; Moore 1993; Zinberg 1984). While each strategy specifically identifies

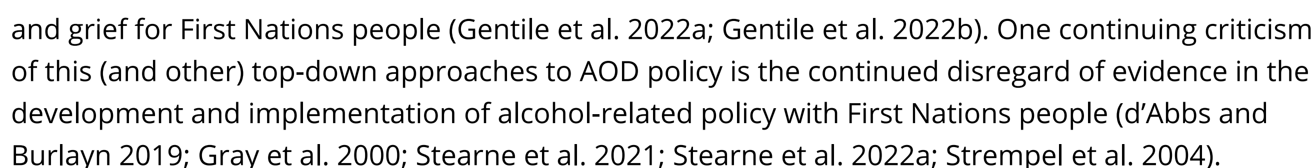


First Nations people as a priority population, at a national level in the last 10 years there has been just a single National Aboriginal and Torres Strait Islander Peoples Drug Strategy (2014–2019) (Intergovernmental Committee on Drugs 2014). This was developed to supersede the previously developed National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009 (Ministerial Council on Drug Strategy 2006), which was a sub-strategy of the previous National Drug Strategy (2010–2015) (Ministerial Council on Drug Strategy 2010).

The National Aboriginal and Torres Strait Islander Peoples Drug Strategy (NATSIPDS) 2014–2019 makes mention of the co-existing relationship of alcohol and other drug use with mental health and wellbeing (Intergovernmental Committee on Drugs 2014). The NATSIPDS does not specifically identify mental health as priority area for consideration; however, it is mentioned as examples of actions within priority areas one and two (Intergovernmental Committee on Drugs 2014). The NATSIPDS is now out of date, and not aligned with the current National Drug Strategy; one key factor contributing to this is that the Strategy was the remit of the now disbanded National Indigenous Drug and Alcohol Committee (NIDAC) (Lee et al. 2017). The National Indigenous Drug and Alcohol Committee, a sub-committee of the Australian National Council on Drugs (ANCD), provided an informed First Nations perspective through individual members with diverse experience and connections. Both ANCD and NIDAC were disbanded in 2014 and replaced with the smaller and narrower focused Australian National Advisory Council on Alcohol and Other Drugs (ANACAD). At the time of writing, ANACAD's terms of reference do not require First Nations representation. This has also resulted in no body or group having the responsibility for developing national alcohol and other drug strategies with First Nations people. This absence of responsibility has had a cascading effect, with no state or territory-level First Nations-specific alcohol and other drug strategies. Further to this, alcohol and other drug responsibilities are "sprinkled" throughout many state departments, providing a piece-meal approach to related policy rather than a systematic approach to addressing harms.

Gaps in policy and policy making practice for AOD

There are a number of factors that need to be considered specifically regarding the development of AOD-related policies in Australia, with First Nations people. The language and approach of the policies should not be ignored. The history of First Nations people and alcohol policy is long and complex (Allen 2019, 2020; Blyton 2013; Brady 1990, 2008; Flood 2019; Freeland 1966; Gray et al. 2018; Swensen 2017). Since the repealing of the prohibition of alcohol for First Nations people in the 1970s, it was decades before the Australian Government again introduced 'race-based' or targeted restrictions for Aboriginal people to access alcohol (Brady 2000; Saggers and Gray 1998). In 2007, the Australian Government introduced a suite of legislative changes (Northern Territory National Emergency Response Act (NTNER) 2007; Vivian and Schokman 2009), including restrictions on possession of alcohol that affected 70% of Northern Territorian Aboriginal people. This legislation was strongly criticised for its semblance to the previous protectionist policies, as well as for its paternalism (Altman and Hinkson 2007; Baehr and Schmidt-Haberkamp 2017; Central Land Council 2008; Combined Aboriginal Organisations of the Northern Territory 2007). Despite assertions that the NTNER restrictions were not racially focused, the *Racial Discrimination Act 1975* (Cth) was suspended in the Northern Territory to implement it – effectively undermining any such arguments (McQuire 2012; Nicholson et al. 2012; Vivian and Schokman 2009). The underlying prejudice and racism towards First Nations people within such policies continues to contribute to the on-going trauma



and grief for First Nations people (Gentile et al. 2022a; Gentile et al. 2022b). One continuing criticism of this (and other) top-down approaches to AOD policy is the continued disregard of evidence in the development and implementation of alcohol-related policy with First Nations people (d'Abbs and Burlayn 2019; Gray et al. 2000; Stearne et al. 2021; Stearne et al. 2022a; Strempel et al. 2004).

Such policies ignored both the importance of First Nations people's leadership and self-determination in reducing alcohol-related harms (Stearne et al. 2021; Stearne et al. 2022b). Much can be learnt from the approach of First Nations communities in how they have addressed alcohol-related harms in their communities (Barazani 2014; d'Abbs and Burlayn 2019; d'Abbs et al. 2013; Fitzpatrick et al. 2017; Gray et al. 2000; Lee et al. 2008; Shanthosh et al. 2018; Shaw et al. 2004; Stearne 2007; Stearne et al. 2022b; Strempel et al. 2004). Self-determination and leadership by Aboriginal people and their communities is key to not causing additional harms in the development and implementation of policy (Blagg and Valuri 2003; Brady 2017; Chenhall 2007; d'Abbs and Burlayn 2019; d'Abbs and Togni 2000; James et al. 2020; Kavanagh 1999; Mckillop 1993). Self-determination has been recognised as a right under the United Nations Declaration on the Rights of Indigenous Peoples, and a key determinant of health (The Lancet 2020; United Nations 2007). In the Australian context, the term self-determination is often used to reflect a consultation process, or simply including a First Nations representative in the policy process (Behrendt 2002). Self-determination as a right is greater than this (Stearne et al. 2021). Self-determination is not something that can be given by non-Indigenous people nor the Australian Government, but there must be a pathway and support (some would argue a requirement) for First Nations people to be able to exercise their right to self-determination (Stearne et al. 2021). In Australia, some states and territories have implemented some models (or systems) that require this to be done, however these are terms that remain defined by the government and policy makers (Dreise et al. 2021; Northern Territory Government 2021).

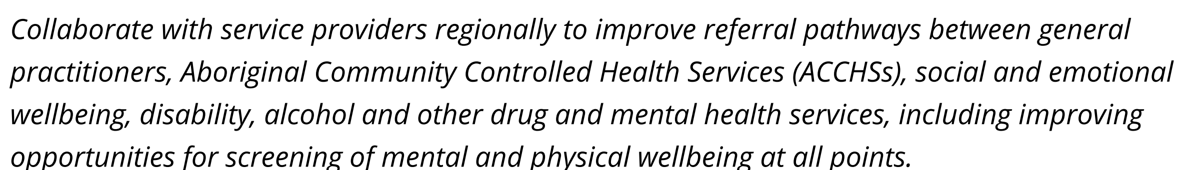
Mental health

Nationally, the mental health direction is set by *The Fifth National Mental Health and Suicide Prevention Plan* ('the Fifth Plan') and its *Implementation Plan* (Commonwealth of Australia 2017b). As with the AOD strategies, Priority Area 4 of the Fifth Plan identifies mental health and suicide prevention for First Nations people as a specific priority (Commonwealth of Australia 2017b). One of the key indicators for this priority area identifies the importance of alcohol and other drug services in providing care:

> *Culturally competent care is provided through integrating social and emotional wellbeing services with a range of mental health, drug and alcohol and suicide prevention services. (Commonwealth of Australia 2017b:35)*

The Fifth Plan is complemented by the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (Commonwealth of Australia 2017a). This strategic framework has evolved since its first iteration in 2004 (Social Health Reference Group 2004).

The 2017 framework includes five key action areas, with four of the key action areas having AOD-related outcomes and some related strategies. The importance given to AOD can also be seen, for example, in 'Action area 1: Strengthen the foundations – Outcome 1.3 Effective partnerships between Primary Health Networks and Aboriginal Community Controlled Health Services', which includes the recommendation to:



Collaborate with service providers regionally to improve referral pathways between general practitioners, Aboriginal Community Controlled Health Services (ACCHSs), social and emotional wellbeing, disability, alcohol and other drug and mental health services, including improving opportunities for screening of mental and physical wellbeing at all points.

In general, the role of alcohol and other drug use is recognised as a risk factor in this strategic framework, but approaches to strategically address AOD-MH are absent, as are steps to implement and fund the proposed outcomes in relation to AOD.

In March 2022 the National Mental Health and Suicide Prevention Agreement (the Agreement) came into effect (Commonwealth of Australia 2022). This Agreement identifies a commitment to investment in both mental health and suicide prevention services, by the Australian Government and all jurisdictions. Though not First Nations-specific, there is recognition that implementation will require support of ACCHSs, the Closing the Gap agreement, and the Gayaa Dhuwi Declaration. The Agreement identifies First Nations people as one of number of vulnerable and priority groups. Under the Agreement the responsibilities of the Australian Government (amongst other commitments) are to provide funding to ACCHSs for mental health services. State and territory governments are responsible for funding ACCHSs for programs and services. While there is recognition that AOD and mental ill-health are co-occurring conditions, the Agreement focuses on the need for supporting the health care workforce to understand this, rather than addressing the structural barriers this creates. However, the Agreement specifically states that these agreements are not legally enforceable.

What is needed for AOD-MH

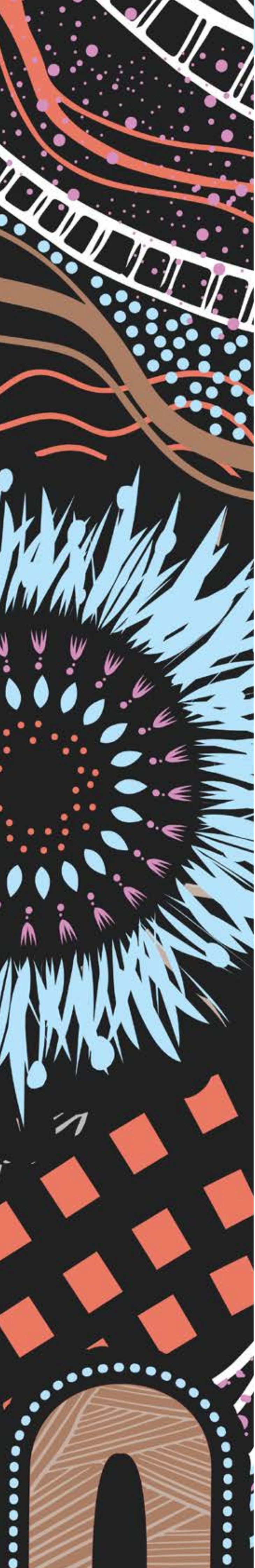
The inclusion of First Nations people in policy development is vital to improving their health and wellbeing (Green et al. 2012). As described previously, First Nations peoples' understanding of health and wellbeing is much broader than non-Indigenous definitions (Gee et al. 2014). This understanding needs to underpin approaches to both alcohol and other drug, and mental health and wellbeing strategies. Presently the First Nations-specific strategies are complementary to the wider Australian strategies, the parameters are pre-determined and exclude a First Nations view of health and wellbeing. Facilitation of First Nations perspectives and views in the development of these strategies needs to be directed and led by First Nations people.

This was identified and expressed in the *Uluru Statement from the Heart* (Appleby and Davis 2018; First Nations National Constitutional Convention 2017). The *Uluru Statement from the Heart* called for Voice, Treaty, Truth: a First Nations voice to Parliament, then Treaties, and truth-telling (Appleby and Davis 2018; Davis et al. 2018). In October 2023, the Albanese Labor government responded to the call for the 'Voice' by holding a referendum on a proposed change to the Australian Constitution that would create a First Nations peoples' 'Voice to Parliament' (Biddle et al. 2023). The referendum was unsuccessful. Localised efforts remain to develop pathways for First Nations people to contribute to policy development (Dreise et al. 2021; Northern Territory Government 2021); however, these are not universal.

In the context of health and wellbeing related policy – such as alcohol and other drug, mental health, and suicide prevention – the valuing of the First Nations worldview and understanding of health would improve outcomes. At a national level, these strategies only briefly recognise the inter-relatedness of alcohol and other drug use and mental health and wellbeing. Further to this there is

even less guidance or consideration of how to specifically support the First Nations communities to adequately address these issues. The mental health-specific strategies acknowledge the contribution of harmful alcohol and other drug use; but this is not reciprocated in the AOD-related strategies. The co-occurrence of AOD use, mental health, and AOD-MH conditions for First Nations people and their communities, have been skimmed over in the development of strategies and policies. First Nations people are priority groups in all of these strategies; however, no guidance has been provided in how best to support these priority groups. The absence of such guidance at a strategic policy level is significant at the operational level. Further to this, the intersectionality and relationship between all these issues, have wider consequences than the health and wellbeing of the individual.

Thus, to adequately and sustainably address AOD-MH among First Nations people, a broad cross-government approach to reduce inequalities and build on existing cultural strengths is needed. The pathways to healthy lives and positive SEWB have been long identified and would require significant investment from the perinatal period. This would ensure quality of life, not simply the treatment of ill-health. As described above, to effectively address AOD-MH, a decolonising approach to service planning and funding is required from the policy level. Pathways out of poverty can only be achieved through community control, up-front investment (humped funding models), integrated responses and genuine political commitment. Furthermore, a national commitment to end the racism experienced by First Nations people is needed and requires policy support, funding, and strategies.



5

Programs and initiatives addressing co-occurring AOD-MH

5 Programs and initiatives addressing co-occurring AOD-MH

In reviewing programs and initiatives targeting AOD-MH specifically, clear gaps in service provision can be seen (Deady et al. 2015; Fisher et al. 2022; Lee and Allsop 2020). And much like the policy landscape, there is no national approach to treating or responding to AOD-MH. The following review will discuss current best practice approaches and exemplar programs which address AOD-MH. Prevention, treatment, and workforce development are considered the key components of AOD-MH care in the present review and initiatives are reviewed below. Prior to reviewing these, the following are summarised:

- the 'landscape' in which services are delivered (because they impact the capacity of organisations to deliver care)
- the lived experience of First Nations people with AOD-MH and their treatment experiences (because we cannot understand treatment success and struggles without the voices of consumers)
- the differing approaches to AOD-MH care
- barriers and opportunities to delivering integrated care.

The treatment landscape

Historically, AOD and MH services have been delivered separately – a separation based on historic views that harmful AOD use was a 'self-inflicted' moral failing, as opposed to the 'medical model' approach taken toward mental health conditions (Lee and Allsop 2020). This separation has resulted in significant differences between the AOD and MH treatment sectors, including: the governance of services; the makeup of the workforce; and approaches to funding.

Funding of AOD and MH services in Australia is complex – they are both funded and administered by the state and federal governments and serviced by state, federal, non-government and private sectors. Whilst AOD and MH are now better understood as biopsychosocial conditions with similar antecedents, differences in service structures persist, leaving the AOD and MH sectors largely independent of each other.

It is beyond the scope of the current review to examine the structural separation in detail, or to review structures and funding models state by state – yet it is a pattern across jurisdictions and important to note. Future reviews into structural components of the health system are required and will need oversight from First Nations experts, advocates, and consumers. Such a review would identify whether a complete re-structure and re-alignment of AOD and MH is necessary or whether high-quality interventions could be provided within the existing structures.

Experiences of First Nations people with AOD-MH in seeking treatment

Understanding the experiences of people with AOD-MH in accessing care is vital to evaluating existing care and in adapting existing models and innovating new models. There are significant gaps in service provision for AOD-MH for First Nations people. This is not surprising, considering that First Nations people experience higher rates of mental ill-health across the lifespan, but are less likely to receive treatment (Wright et al. 2019). Similarly, they are more likely to experience AOD-related harm but less likely to receive treatment. Furthermore, First Nations leadership and lived-experience leadership is needed to increase the likelihood of more effective and sustained outcomes (Queensland Mental Health Commission 2022) and to uphold self-determination.

Qualitative research has highlighted the following significant challenges for people who experience AOD-MH, and their families and advocates in accessing support (Barrett et al. 2019; Butt 2020; Dawson et al. 2023; Heath et al. 2022; Hepsibah 2015; Kalucy et al. 2019; Kilian and Williamson 2018; Lee et al. 2014):

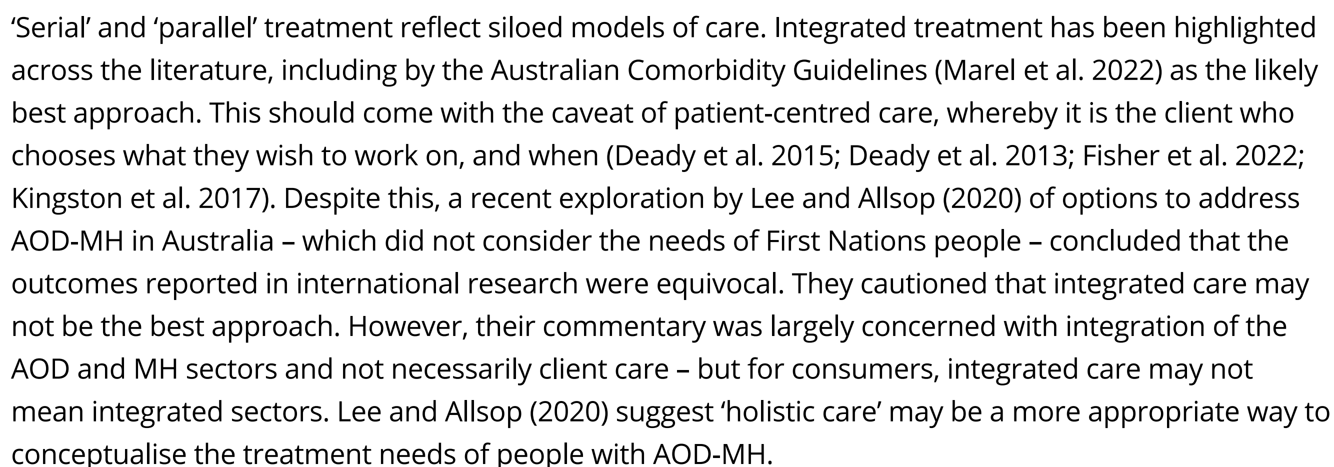
- a lack of services
- a lack of integration of services (siloing as an impediment to receiving care)
- difficulty finding information about service pathways
- long and/or confusing referral between services or to access services
- inflexible service delivery approaches which impact client engagement and success (due to both AOD and MH symptoms but also due to practical challenges such as transport to services)
- (in some services) a lack of screening and awareness of the co-occurring condition – with inadequate screening leading to inadequate care
- being excluded from MH services due to AOD use and vice versa.

These factors place the onus on the unwell person and their family/advocates to navigate and integrate care. This can lead to disengagement or termination from services – which itself leads to greater distress and ill-health. These factors also result in a great reliance on families to provide all care needs and accept an overall greater risk of harm (Gendera et al. 2022; Hepsibah 2015; Lee et al. 2014).

Approaches to AOD-MH treatment and care

Across the international literature there are three identified approaches to AOD-MH treatment, being: serial treatment, parallel treatment, and integrated treatment.

- Serial treatment refers to the treating of one condition followed by treatment of another.
- Parallel treatment refers to treating two conditions at the same time but with different service providers.
- Integrated treatment refers to the treatment of both conditions at the same time by the same service provider.



'Serial' and 'parallel' treatment reflect siloed models of care. Integrated treatment has been highlighted across the literature, including by the Australian Comorbidity Guidelines (Marel et al. 2022) as the likely best approach. This should come with the caveat of patient-centred care, whereby it is the client who chooses what they wish to work on, and when (Deady et al. 2015; Deady et al. 2013; Fisher et al. 2022; Kingston et al. 2017). Despite this, a recent exploration by Lee and Allsop (2020) of options to address AOD-MH in Australia – which did not consider the needs of First Nations people – concluded that the outcomes reported in international research were equivocal. They cautioned that integrated care may not be the best approach. However, their commentary was largely concerned with integration of the AOD and MH sectors and not necessarily client care – but for consumers, integrated care may not mean integrated sectors. Lee and Allsop (2020) suggest 'holistic care' may be a more appropriate way to conceptualise the treatment needs of people with AOD-MH.

However, regardless of the language used, integrated AOD-MH treatment is more consistent with First Nations models of SEWB; is strongly advocated for in homelessness and corrections literature; and is consistently preferred by people experiencing AOD-MH. Indeed, qualitative research highlights that those receiving care with AOD-MH recognise that their mental health and AOD challenges are intertwined (Barrett et al. 2019; Liu et al. 2016; MHC WA 2020; Queensland Mental Health Commission 2022; Croton 2019).

Using 'levels of care' quadrants to conceptualise treatment options

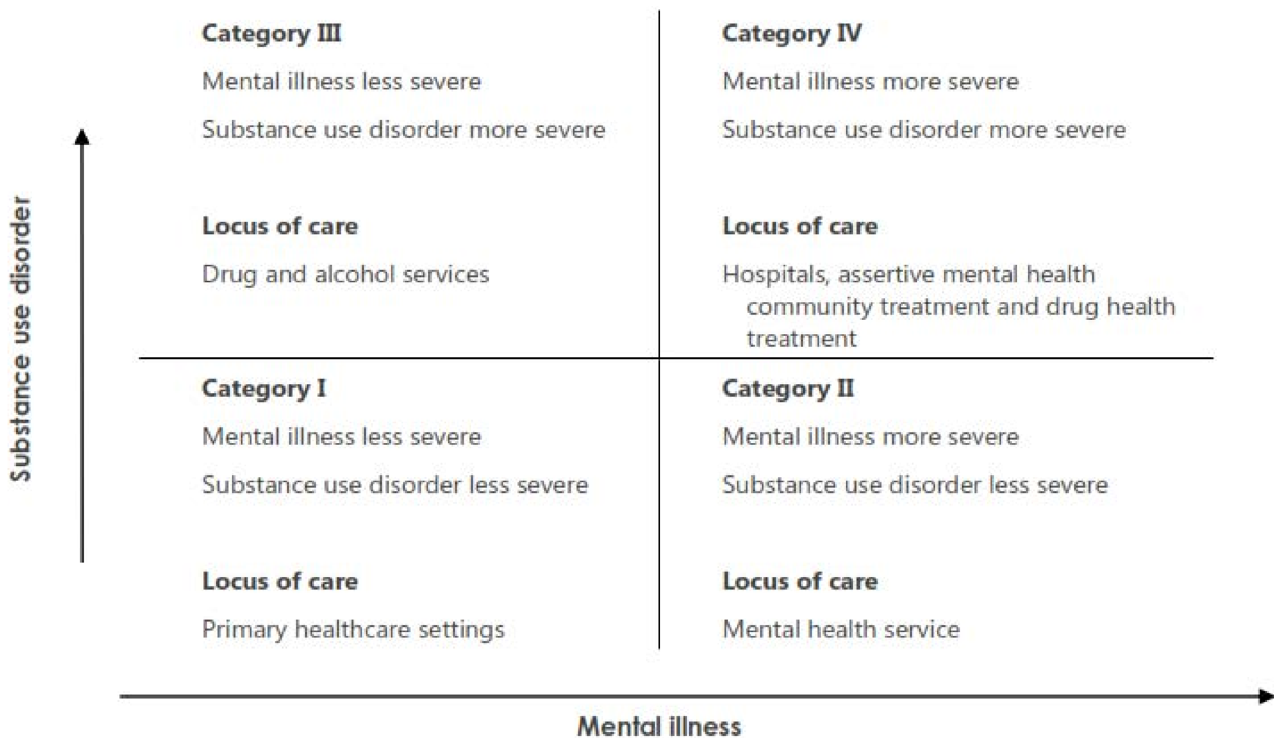
Effective integrated care requires system-wide approaches to delivery of evidence-based AOD-MH care to a heterogenous group of clients, many with multiple needs. Given the diversity of AOD-MH conditions and the separation of sectors, an Australian review by Deady et al. (2015) has used 'levels-of-care' quadrants to conceptualise the treatment options. Summarised below in Figure 3, this model is consistent with stepped-care approaches, whereby 'service intensity' is matched to 'client need'.

The model suggests that integrated treatment may require intensive specialist services for individuals with severe MH and AOD conditions (Category IV) – and there are strong arguments for comorbidity-specific teams to address people in this quadrant (Croton 2019). However, this matrix of 'category of need' and 'locus of care' would suggest that people with AOD-MH could be supported within AOD, MH and primary health care settings. (That is, a 'no wrong door' approach.)

The model was originally developed in the United States and, as noted by Deady et al. (2015), there is a lack of research which tests the application of the model with any rigour, but it is a useful way to conceptualise possible service delivery options and to identify which services may be best placed to provide care.

The Levels of Care model implies that comorbidity is core business for all AOD and MH services. All settings require some capacity to address AOD-MH, and adequate screening of AOD and MH is necessary in all settings to identify appropriate care – a sentiment supported by a number of researchers (for example, Liu et al. 2016). Of note in Figure 3 is the positioning of primary health care. Existing primary health infrastructure is one of the few settings able to deliver integrated care for First Nations people (AMSANT 2011), and these settings – in particular Community Controlled Primary Care Services (ACCHS) – also allow for management of other health conditions.

Figure 3: Level of care quadrants



Barriers to delivering integrated or holistic care are summarised below; however, it is important to acknowledge that there is an increasing concern that service models overlook the 'middle' of the quadrants. For example, recent reviews in Queensland (Queensland Mental Health Commission 2022) and Victoria (Croton 2019; Liu et al. 2016) highlight the 'missing middle'. That is, a large and growing group of people whose needs are considered too complex or severe to be supported by primary health services alone, but not severe enough to meet the criteria for entry into public mental health services. As a result, people receive inadequate treatment, care, and support, or none at all (Croton 2019).

Azzopardi and colleagues (2018) note that First Nations young people aged 18 to 24 had twice as much psychological distress as their non-Indigenous counterparts yet were less likely to be admitted to hospital for anxiety or stress. In contrast, hospital admissions related to psychoses and AOD use occurred at three times the rate of non-Indigenous young people (Azzopardi et al. 2018). While exercising caution with these comparative statistics, the results indicate that First Nations young people are at risk of hospitalisation for severe MH and AOD concerns but appear to have difficulty accessing the same support at an earlier stage of severity, or for a less acute presentation. This picture reinforces that described above whereby there appears to be a lack of equitable access to care for mild to moderate mental illnesses, and for presentations (such as distress and trauma) associated with negative life experiences. Consistent with this, most of the funding and resourcing is aimed at individuals at the two ends of the severity continuum, that is, the mild (through prevention, screening and brief intervention) and the severe/crisis. Therefore, the model in Figure 4 whilst a valuable starting point may need further refinement to support those in the 'missing middle' which may include as described by Dawson and colleagues (2023) services which provide pre-crisis support.

Barriers and opportunities to providing integrated and holistic care

It is important to note four interrelated barriers to providing integrated care in Australia which result in First Nations AOD-MH service consumers falling through gaps. These are: the siloing of AOD and MH, a lack of funding and resourcing in both sectors, workforce factors and a lack of cultural security. These four areas also provide opportunities for integration.

Siloing of AOD and MH

Siloing of AOD and MH occurs at all levels – including policy, service delivery and research. The siloing of AOD and MH in research has meant that data on co-occurring conditions is often not collected or discussed and treatment research actively excludes participants with co-occurring conditions. While participant exclusion can be important to establish best practice for treating individual conditions (for example, depression), if additional research does not build on these findings to include co-occurring conditions, then the evidence base becomes skewed away from people with AOD-MH – which is troubling when considering that research clearly demonstrates high rates of co-occurrence.

At the policy and service delivery level siloing has resulted in service fragmentation, pathways for clients are unclear and First Nations clients describe a 'run around' (Dawson et al. 2023; Cairney et al. 2015; Liu et al. 2016). As described above, in the lived experience literature this can result in clients having one of their conditions minimised, or conversely being excluded from services because of their co-occurring condition (Croton 2019; MHC WA 2020). Lee and Allsop (2020) note that even when there is good intent, the lack of structures to support integration result in a barrier to collaboration. This separation of service delivery has resulted in criticism that mental health services often overlook AOD (including use disorders), and that AOD services do not have the capacity to manage MH; particularly consumers with severe, low prevalence mental illness presentations (Groenkjaer et al. 2017; Searby et al. 2022 Lee and Allsop 2020). A final consequence of the historic siloing of AOD and MH is the stigma many people who experience AOD-related harm experience, this stigma results in a significant barrier to receiving MH care.

Funding shortfalls

Funding shortfalls across the AOD and MH sectors contribute to insufficient treatment options for people with co-occurring conditions. An increase in service availability is needed and this is particularly the case for regional and remote areas (Croton 2019; Queensland Mental Health Commission 2022) and requires an increase in funding. Furthermore, the structure of funding to date has been rooted in a colonising approach, which can result in negative impacts for First Nations people. For example, competitive short-term funding for service providers prevents service development and improvement and creates competition rather than collaboration between agencies (Gray et al. 2014). Non-government organisations (NGOs), in particular community-controlled NGOs, require longer funding cycles to promote stability and retain skilled workers (Hepsibah 2015; Liu et al. 2016).

Workforce factors

Workforce factors are oft cited barriers to providing integrated care for people with AOD-MH. Of note, this includes lack of training and skills (Liu et al. 2016) within the workforce, frequent staff turnover (Barrett et al. 2019; Liu et al. 2016), and a potential reluctance to engage in integrated models of care (Searby et al. 2022). A recent study investigated the attitudes and experiences to integrated care among nurses working in AOD settings in Australia (Searby et al. 2022) and identified reluctance to the integration of AOD-MH care. The study clarified that some reluctance was related to concerns that system wide integration would result in job losses and a reduction in service capacity (Searby et al. 2022) and there was less reluctance to providing integrated care to individuals. In general, there is agreement across stakeholders that MH and AOD should be integrated in some way and staff should have skills in both areas even if they have more expertise in one than the other. Furthermore, a lack of First Nations staff has been highlighted as a significant workforce issue (Dawson et al. 2023).

Accessibility of culturally safe care

Easy access to appropriate services is critically important to addressing complex AOD-MH and research across the MH and AOD sectors highlights a lack of services and fear associated with attending non-Indigenous services as barriers to care (Garay et al. 2023; Culbong et al. 2023; Krakouer et al. 2022; Milroy et al. 2023; Westerman 2021). Research clearly identifies that culturally centred care is preferred by First Nations consumers and critical to positive outcomes (Culbong et al. 2023; Munro et al. 2017). Detailed reviews of culturally centred care are provided elsewhere (Dudgeon et al. 2014); but improving the cultural safety of existing services, supporting (i.e. adequately resourcing) community-controlled services and the expansion of the First Nations workforce (Dawson et al. 2023) all provide clear opportunities.

Best practice AOD-MH care for First Nations people

An evidence base for AOD-MH care for First Nations people (including prevention, treatment, and workforce development) is lacking. This persists across the academic and grey literature. There have been so few papers published in the past decade (for example, Deady et al. 2015; Lee et al. 2014; Nasir et al. 2018; Leske et al. 2016) that reviews risk overgeneralising those few studies available. In addition, structural reviews looking at AOD-MH opportunities in the Australian system have paid scant attention (Deady et al. 2015) or no attention (Lee and Allsop 2020) to how First Nations clients may be supported or reference community insight and knowledge, in developing appropriate AOD-MH care structures. Consequently, the experience and wisdom of First Nations people with AOD-MH, their families, service providers and communities is missing in the general discourse of this field. These voices are critical to identifying quality responses, program development and design, and ensuring self- determination (which is itself associated with enhanced outcomes). Despite the lack of evidence there are a range of services and programs who do aim to provide quality, integrated care for First Nations people with AOD-MH.

Exemplar programs for AOD-MH

This review aimed to identify programs – including prevention, treatment, and workforce development – which specifically address co-occurring AOD-MH for First Nations people. Only four academic sources were identified. There were two published papers – one by Lee et al. (2014) who reviewed the needs of women with AOD-MH and one by Nagel et al. (2011) who piloted a brief comorbidity intervention in primary health care. Both are significant pieces of research however were conducted with small sample sizes. An additional source of academic research was that by Hepsibah (2015) whose unpublished PhD focused on First Nations participants of a broader comorbidity project (Comorbidity Action in the North (CAN); Cairney et al. 2015; Liu et al. 2016.). One final academic paper was identified which noted AOD-MH presentations and outcomes in a paper reviewing mental health treatment for First Nations young people, without specifically targeting AOD-MH (Sabbioni et al. 2018). Of note, no research to date has considered economic factors in outcome research.

The search also included grey literature and, as noted by others (for example, Geia et al. 2018; Smith et al. 2019) even within this literature programs are described but there is a lack of outcome data published – limiting what can be presented. In the absence of evidence and to promote ongoing development of AOD-MH responses we describe below a range of exemplar programs and 'promising practice' which together constitute best known practice. The term 'promising practice' is used consistent with Smith et al. (2019) who undertook a scoping review into First Nations youth SEWB programs. The term 'promising practice' is consistent with strengths-based approaches and was identified by the Australian Psychological Society and Australian Indigenous Psychologists Association (Smith et al. 2019) to recognise advancements in the absence of practice-based evidence.

Reviews can only summarise what is publicly available therefore the list compiled does not suggest that there are no other successful programs and organisations. For those services innovating in the AOD-MH space there is also often a lack of resources for the conduct and dissemination of evaluations; a problem compounded by short term funding cycles. Indeed, a number of programs have been identified during this review as addressing both AOD and MH in an integrated and holistic way, but specific program details and outcomes are not available. Examples include the Aboriginal Drug and Alcohol Council *AOD Youth and Wellbeing Program* (https://www.adac.org.au/) and South West Aboriginal Medical Service Counselling team Kaat Darabiny https://www.swams.com.au/service/mental-health/.

Furthermore, many organisations providing services in health, mental health, social and emotional wellbeing and AOD deliver services which likely address many of the determinants of health and support people with, or at risk of, AOD-MH. For example, a recent document analysis of 67 Aboriginal Community Controlled Health Organisation (ACCHO) annual reports found that all services were working to improve clients' intermediary social determinants of health, specifically material circumstances, biological, behavioural, and psychosocial factors (Pearson et al. 2020). There is doubtless a range of successful AOD and MH interventions which address co-occurring conditions or their shared determinants but do not specifically address AOD-MH or assess AOD-MH outcomes in their program descriptions and outcomes.

The section below summarises seven AOD-MH initiatives including prevention, treatment (exemplars from three of the four quadrants of care have been identified), and workforce development. These exemplars below include services that are both community controlled and those embedded in mainstream services. No services were included which did not have clear First Nations consultation and oversight.

Prevention

Health promotion and prevention programs aim to address risk and protective factors holistically at the community level, and also to provide information and skills to individuals. These programs are likely to support people with, or at risk of, AOD-MH through targeting social determinants, many of which have been described in previous Clearinghouse studies and in other reviews, including English et al. 2022). We identified a range of prevention programs which mention (or allude to) AOD-MH, but do not provide outcomes specific to AOD-MH.[1]

School based prevention programs aim to support the capacity of young people to make informed choices and are a critical component of the prevention mix; they include universal programs (aimed at all children) and targeted interventions (aimed at high-risk individuals and groups). Strong and Deadly futures is one school-based prevention program that aims to address SEWB, including some of the risk factors that can lead to AOD-MH, and has an emerging evidence base – it is described below as an exemplar program.

Strong and Deadly Futures

The Strong and Deadly Futures Program (Snijder et al. 2021b) is a six-lesson, curriculum-aligned wellbeing and risk prevention program utilising a story-based structure that was designed for, and with, First Nations young people.

Strong and Deadly Futures includes three core approaches:

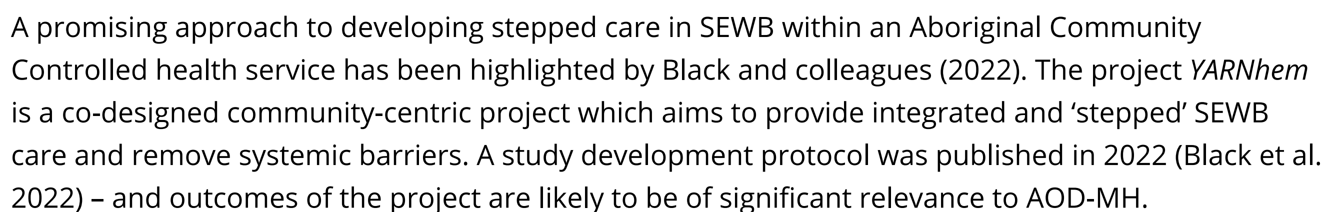
1. Combining effective components of mainstream prevention with cultural elements, highlighting First Nations cultural strengths
2. Avoiding stigma and focusing on the strengths of cultural diversity by including both First Nations and non-Indigenous students
3. Using digital technology to enhance engagement.

The program used a clear co-design process that ensured cultural factors were emphasised throughout the program. Criticisms of some prevention programs is that they do not adequately target known risk factors (Westerman and Sheridan 2020), however, Strong and Deadly Futures is based on a theoretically sound ecological model. A randomised controlled trial of Strong and Deadly Futures has commenced, with results anticipated in 2024. However, an early pilot study identified good feasibility and acceptability for both students and staff (Routledge et al. 2022) and furthermore that it increased AOD knowledge and reduced psychological distress signalling promising outcomes for AOD-MH.

Treatment

As described previously, treatment for AOD-MH requires a large range of services to address the diversity in AOD-MH conditions. Six treatment and recovery approaches were identified in the literature and are described below; these represent services from all four categories in the quadrants of care described in Figure 3 and describe outcomes that are related to AOD-MH.

1 These programs are summarised in Table C1 in Appendix C. (Note: Table C1 does not review either specific AOD or specific MH programs, as they are beyond the scope of the current review.)



A promising approach to developing stepped care in SEWB within an Aboriginal Community Controlled health service has been highlighted by Black and colleagues (2022). The project *YARNhem* is a co-designed community-centric project which aims to provide integrated and 'stepped' SEWB care and remove systemic barriers. A study development protocol was published in 2022 (Black et al. 2022) – and outcomes of the project are likely to be of significant relevance to AOD-MH.

Bunjilwarra – AOD residential rehabilitation (Category III)

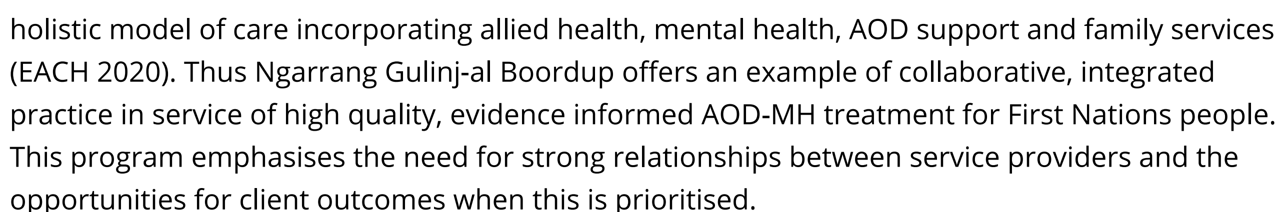
Bunjilwarra is a 12-bed residential rehabilitation and healing program for First Nations young people experiencing AOD-related harms and supports associated mental health needs. Based in Melbourne, it is developed and delivered by the Victorian Aboriginal Health Service and Youth Support and Advocacy Service (YSAS n.d.). Bunjilwarra describes a model of care embedded in a SEWB framework to address cultural, physical, and mental health through connections to land, culture, kinship, and community (Farrant and Weiss 2022). The program is staffed by people with AOD and MH experience and is described in integrated terms. The program is structured with therapeutic activities including individual and group therapy, as well as regular recreational, educational, and training opportunities. The program facilitates engagement with juvenile justice as well as leadership and violence prevention programs. The components help young people develop living skills, strengthen cultural identity, increase physical, emotional, and spiritual wellbeing, and improve connections to family and community.

Bunjilwarra reviewed their service model in 2021 and reported that past and current clients had positive SEWB outcomes across domains of body, mind, emotions and culture (Farrant and Weiss 2022). Bunjilwarra use the Aboriginal Resilience and Recovery Questionnaire to effectively measure domains of SEWB pre- and post- engagement (Farrant and Weiss 2022). The evaluation report has not been published in full and further details are therefore not available; however, the program has clear cultural oversight and an integrated approach to SEWB.

Ngarrang Gulinj-al Boordup – community-based treatment program (Category III)

The Ngarrang Gulinj-al Boordup program is an adult outpatient service which began in 2017 as an informal collaboration between a mainstream AOD service (EACH 2020) and an Aboriginal Health and Wellbeing Team (AHWT) (both auspiced by the same lead agency), based in outer Melbourne. EACH includes two programs which specifically includes people with mental and physical health comorbidities: 'HOPE' and 'THRIVE'. 'HOPE' provides peer support and counselling and 'THRIVE' is a family-inclusive, trauma-informed integrated and multidisciplinary outpatient counselling service (https://www.each.com.au/service/project-hope-and-thrive-alcohol-tobacco-and-other-drug-counselling/).

The programs, supported by the AHWT, work conventionally that is, through booked, in-clinic appointments) as well responsively (through outreach; informal appointments; yarning; and non-clinical check-ins) using a flexible engagement model that is not time-limited. This targets a number of barriers in traditional service delivery. The flexible model allows relationships to develop, with clients' timing and needs respected during treatment. The work of the AHWT is framed by SEWB principles, anti-oppressive theory, and trauma-informed care (EACH 2020) and is delivered within an



holistic model of care incorporating allied health, mental health, AOD support and family services (EACH 2020). Thus Ngarrang Gulinj-al Boordup offers an example of collaborative, integrated practice in service of high quality, evidence informed AOD-MH treatment for First Nations people. This program emphasises the need for strong relationships between service providers and the opportunities for client outcomes when this is prioritised.

Brief motivational intervention (motivational care planning) – primary health care intervention (Category I)

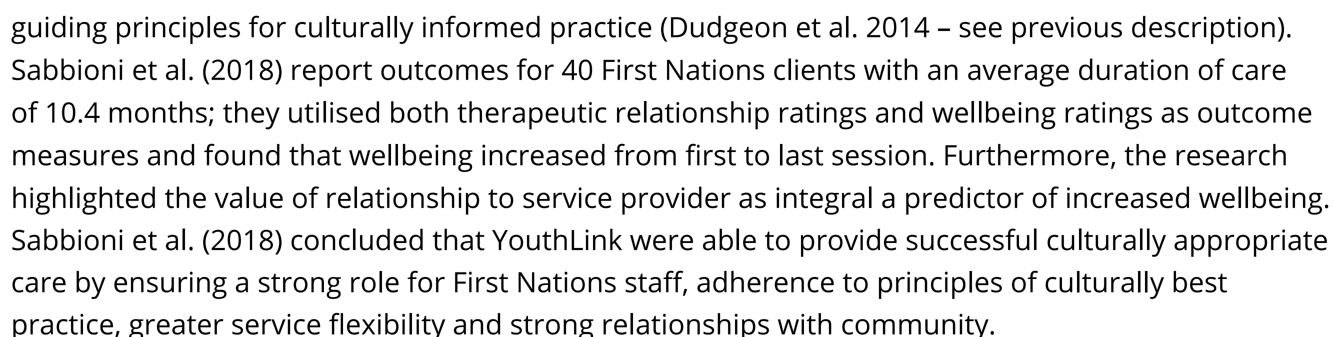
Nagel et al. (2009) conducted a randomised trial comparing a brief intervention with treatment as usual for clients with AOD-MH conditions in a primary health care setting. The brief intervention included two one-hour sessions which ranged from between two and six weeks apart. The sessions included psychoeducation, motivational care planning and supported family engagement. Those receiving the brief intervention demonstrated greater and more sustained improvements in both mental health and alcohol dependence with a trend to reduced cannabis dependence. Although this study was conducted outside our review window, it is included as the only identified intervention to date with published efficacy. The results highlight the importance and value of brief interventions in the primary health care setting to address AOD-MH. Of note previous reviews have highlighted not only the motivational and psychoeducational components of the intervention but the focus on building family ties as integral to the outcomes (MacLean et al. 2017).

Homeless Health Care Team – outreach service embedded in primary health care (Category IV)

Homeless Healthcare (HHC) is a primary health service in metropolitan Perth providing specialised, multi-site healthcare for people experiencing homelessness (Wood et al. 2022). They auspice the Homeless Outreach Dual Diagnosis Service (HODDS) to work alongside the primary health care team to provide specialised AOD and mental health care to people experiencing homelessness. HODDS identify 24% of their clients as First Nations people (Wood et al. 2022). They use a collaborative approach to assist people to access supports to manage their psychological, AOD-related and medical concerns in the community and in accessible locations. This accessible care model reduces or removes the barriers people experience through service siloing, allowing the complexities they experience to be addressed in service of improved overall health and wellbeing. The service works with clients with complex needs in an integrated structure, limited outcomes beyond service utilisation are provided.

YouthLink – Culturally informed youth mental health services (Category II)

YouthLink are part of the North Metropolitan Health Service in Perth, Western Australia; they provide recovery oriented and evidence-based treatment for young people with complex mental health and psycho-social-cultural needs) using psychosocial and psychotherapeutic approaches in a flexible approach (including outreach and assertive follow-up) delivered by a multidisciplinary team (Sabbioni et al. 2018). YouthLink's team includes dedicated Aboriginal mental health practitioners who provide direct clinical services, cultural consultation, and community triage. Whilst a mental health-oriented service, they employ a 'non wrong door approach' and 50% of their First Nations clients report AOD comorbidity (Sabbioni et al. 2018). The service describes its structure as aligned with the nine



guiding principles for culturally informed practice (Dudgeon et al. 2014 – see previous description). Sabbioni et al. (2018) report outcomes for 40 First Nations clients with an average duration of care of 10.4 months; they utilised both therapeutic relationship ratings and wellbeing ratings as outcome measures and found that wellbeing increased from first to last session. Furthermore, the research highlighted the value of relationship to service provider as integral a predictor of increased wellbeing. Sabbioni et al. (2018) concluded that YouthLink were able to provide successful culturally appropriate care by ensuring a strong role for First Nations staff, adherence to principles of culturally best practice, greater service flexibility and strong relationships with community.

Workforce initiatives

Workforce initiatives are integral to supporting the AOD and MH sectors in responding to AOD-MH as well as ensuring high quality AOD-MH workforce. Three types of workforce education initiatives are worthy of note. These include training (upskilling of workers), the development of quality practical and clinical resources to support workers, and the dissemination of general education about AOD, MH and AOD-MH.

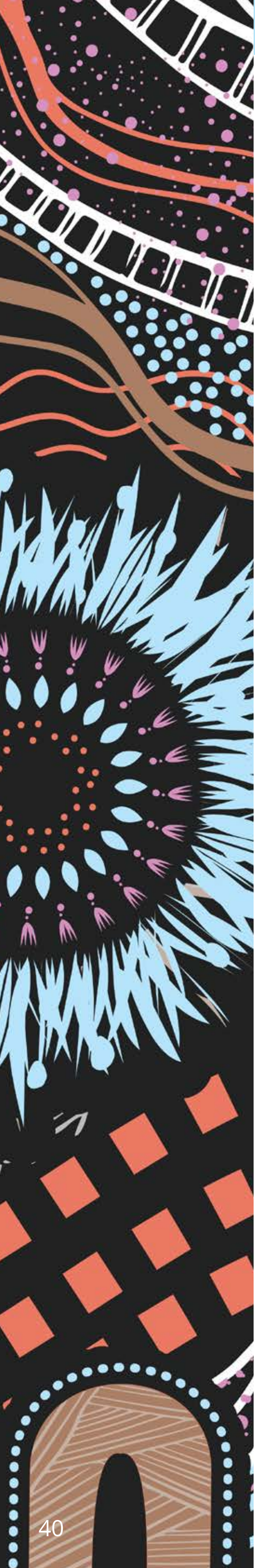
- A number of First Nations mental health training programs exist which are suitable for the AOD workforce, for example, Indigenous Psychological Services Mental Health Assessment and Suicide Risk Prevention training (https://indigenouspsychservices.com.au/workshops/mental-health-assessment-suicide-workshop-prevention/) which reports good outcomes in cultural competence around mental health (Westerman and Sheridan 2020), however does not report outcomes specific to AOD. Further details of this program and outcomes are described in the companion paper which addresses AOD and suicide risk.
- Several practical resources and materials were identified in the current review. These include the First Nations component of the *Comorbidity Guidelines* (Marel et al. 2022), the *Strong Spirit Strong Mind Resources* for example (Strong Spirit Strong Mind 2021) produced by the West Australian Government, and the *Our Healing Ways* practice manual (2012) to guide the provision of mental health and drug and alcohol support for First Nations people. The former two resources are developed using collaborative approaches and oversight from First Nations expertise and the available literature. Although outside the review window *Our Healing Ways* is worthy of note – it was developed using accumulated wisdom of the First Nations AOD and MH workforces and was the result of a collaboration between the Victorian Dual Diagnosis Initiative, VACCHO, VAHS and the Statewide Aboriginal Alcohol and Drug Service.
- Similarly, a range of sources also exist which promote the dissemination of general information about AOD and about MH. This includes for example the AOD Knowledge Centre (https://aodknowledgecentre.ecu.edu.au/), an arm of the Indigenous HealthInfoNet which promotes evidence-based information with the aim of reducing AOD-related harm for First Nations people in Australia. Whilst the website promotes high quality AOD-related content to all interested –its reach within the MH workforce is not clear.

In general, our search suggested that there were more MH resources for the AOD workforce than vice versa, consistent with previous commentary that the MH workforce may not have access to sufficient AOD training and capacity (Lee and Allsop 2020). All the resources described above present good face value – yet there is a lack of data as to how they are implemented and utilised by the workforces, nor how they impact outcomes for clients.

One specific AOD-MH workforce initiative is described below:

Yarning about mental health

Although it sits outside our review window this program is included due to its value and potential to be replicated. Hinton and Nagel (2012) reported the outcomes of *Yarning About Mental Health,* a First Nations-specific training package for the AOD workforce. The training included culturally adapted strategies and tools for understanding mental health, promoting wellbeing, and delivering brief interventions in the AOD setting. Pre and post workshop questionnaires were used to examine the efficacy of the training. The training was perceived to be highly appropriate and helpful in participants' work with First Nations AOD clients. Hinton and Nagel (2012) reported significant improvement in confidence and knowledge related to First Nations mental health and wellbeing and qualitative data supported these positive outcomes. This said, there was no long-term follow-up of the training participants or examination as to whether changes in confidence and skills translated into improved outcomes for clients. Nevertheless, the results are important and highlight that workforce training may be an effective component of reducing siloed AOD and MH care.



6

Opportunities to better address co-occurring alcohol and other drug harm and mental ill-health – frameworks for AOD-MH care

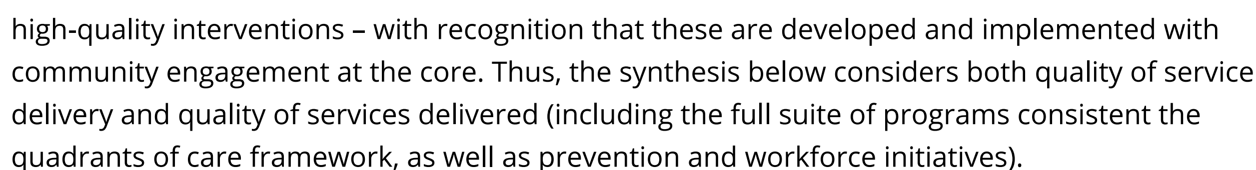
6 Opportunities to better address co-occurring alcohol and other drug harm and mental ill-health – frameworks for AOD-MH care

As described in the preceding sections, AOD-MH conditions are a significant impediment to quality of life for many First Nations people and their families. For several decades, reviews of national data and reviews of AOD and MH with First Nations people have highlighted the importance of effective prevention and treatment of co-occurring conditions, yet there is scant research or evaluated programs which address AOD-MH specifically. Thus, developing frameworks of best practice which bring together the elements noted in the current review and previous AOD and MH literature provides an opportunity from which to develop stronger initiatives for AOD-MH. Several organisations, advocates, secondary review papers and primary research papers have previously proposed recommendations, practice principles, and frameworks for approaching AOD-MH care for First Nations people (AMSANT 2011; Hepsibah 2015; Lee et al. 2014; Marel et al. 2022). A summary of these is provided in Table D in Appendix D and shows considerable overlap. Also included in Table D are the recommendations from two non-First Nations specific papers – one national review (Deady et al. 2015) and one international review (Fisher et al. 2022). In addition, there are several recommendations, practice principles and frameworks for approaching both AOD (Gray and Wilkes 2010) and MH (Snodgrass et al. 2020). These recommend similar principles around cultural security of service provision, ease of access and workforce stability. It is clear from the consistency across these frameworks that options are available – it is imperative that initiatives consistent with these frameworks are fully funded to enable ongoing and adequate service responses to AOD-MH.

Although not summarised in Table D, it is also useful to highlight that a recent royal commission into the Victorian mental health system (Croton 2019) outlined a series of steps to ensuring an increase in availability of AOD care. There is no current update as to the implementation of these recommendations, but they include more broadly the development of a comorbidity service to support the needs of people living with AOD-MH who need a high level of care. In addition, regarding the provision of services for First Nations people (Croton 2019) they proposed to:

- resource the establishment of two co-designed SEWB 'healing centres'.
- resource mainstream area mental health services to collaborate more effectively with Aboriginal Community Controlled Organisations (ACCOs) in support of culturally safe service options.
- resource ACCOs to deliver culturally appropriate, family oriented SEWB services for children and young people.
- resource VACCHO and mainstream area mental health services to collaboratively design and deliver a family oriented, culturally appropriate intensive SEWB program for children and young people.

A synthesis of the frameworks in Table D and the outcomes of the Victorian Royal Commission are described below and highlight the key components for the development of appropriate AOD-MH care. In synthesising these findings these we used a health services framework (Sibthorpe and Gardner 2007) which recognises that effective programs are influenced by stewardship (policy settings), organisational factors (including both workforce and organisational structure) as well



high-quality interventions – with recognition that these are developed and implemented with community engagement at the core. Thus, the synthesis below considers both quality of service delivery and quality of services delivered (including the full suite of programs consistent the quadrants of care framework, as well as prevention and workforce initiatives).

Overarching principles of AOD-MH care

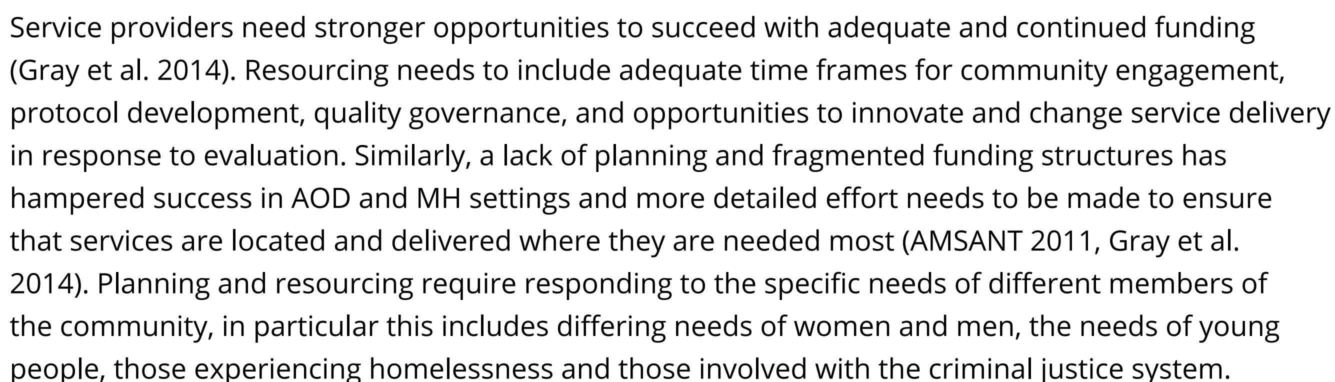
To ensure high-quality service delivery, overarching principles of care in the commissioning, planning, delivery, and evaluation of services are required. In relation to commissioning, this requires sufficient resourcing to ensure these principles of care can be achieved; they represent a baseline from which services must begin. Overarching principles of AOD-MH care include adherence to the nine guiding principles of culturally appropriate SEWB care. These are described by the National Framework and informed by the *Ways forward* national consultancy (Commonwealth of Australia 2017b; Swan and Raphael 1995) (and listed in the introduction), and recommendations of the Gayaa Dhuwi (Proud Spirit) Declaration (National Aboriginal and Torres Strait Islander Leadership in Mental Health 2015). More specifically in relation to AOD-MH there are several additional considerations:

- Connection to, and oversight from, national First Nations peak bodies for health, mental health and alcohol and other drugs is critical, (for example, NACCHO), with recognition that expertise required to address complex comorbidity exists within communities (Gentile et al. 2022b). There is a need to re-form a national peak body for First Nations AOD-related harm.
- Engagement with local community in the development and delivery of services and where possible undertaken under community control.
- Recognition of the diversity of AOD-MH conditions, with the full suite of services funded and available from prevention to high intensity and in-patient. This will prevent illness, limit the progression of illness, and treat those who are unwell. This recognises that community level prevention and targeted screening and brief intervention programs are valued but should not come at the expense of treatment (Bainbridge et al. 2018). Furthermore, it recognises the treatment needs for those with conditions that are not at the highest level of severity but still require support.
- Recognition that AOD-MH can be a chronic condition – continuity of care (including after care and through care) is critical to recovery. Maintenance and relapse prevention needs to be embedded in service planning and resourcing.
- Recognition that working in the AOD-MH field can be highly emotive and stressful, and given relationships between clients and workers are critical to positive outcome – staff wellbeing, recruitment, development, and retention needs ongoing focus and significant innovation.

Principles of quality service delivery

Planning and resourcing

Numerous reports have highlighted the need for appropriate planning and resourcing of First Nations AOD and MH interventions and have recognised the harm of underfunding, non-recurrent funding, and fragmented services (AMSANT 2011; Gray et al. 2014), this is similarly true for AOD-MH.



Service providers need stronger opportunities to succeed with adequate and continued funding (Gray et al. 2014). Resourcing needs to include adequate time frames for community engagement, protocol development, quality governance, and opportunities to innovate and change service delivery in response to evaluation. Similarly, a lack of planning and fragmented funding structures has hampered success in AOD and MH settings and more detailed effort needs to be made to ensure that services are located and delivered where they are needed most (AMSANT 2011, Gray et al. 2014). Planning and resourcing require responding to the specific needs of different members of the community, in particular this includes differing needs of women and men, the needs of young people, those experiencing homelessness and those involved with the criminal justice system.

Community engagement and partnership

The prioritisation of community engagement and partnership in the delivery of programs is necessary and requires an investment of time and resources (Blignault et al. 2015). Successful programs are developed alongside community and should include components of community development (Blignault et al. 2015). Importantly this includes the need to steer away from 'one size fits all' approaches to SEWB (Blignault et al. 2015; Calma et al. 2017; Crowe et al. 2017) and to ensure self-determination at the local level.

'No wrong door' to service entry

It is well established across the AOD and the AOD-MH literature that a 'no wrong door' approach is critical to delivering quality care (Deady et al. 2013; Lee and Allsop 2020; Marel et al. 2022). This emphasises that any door in which a client enters is the right door – whether AOD, MH or primary health care. A number of conditions are necessary for this to occur, and the literature suggests that it has not been the experience for many consumers (Hepsibah 2015) the effect of which is compounded by stigma and shame at seeking help (Price and Dalgleish 2013). The key components to supporting a 'no wrong door' are summarised below, and also require workforce development.

Effective screening at all entry points

Effective AOD and mental health screening at all services is required and yet must be delivered in such a way that it does not result in service exclusion.

Service linkages

As highlighted in the preceding review and in particular qualitative research – consumers and families note difficulties in understanding and navigating available services. Firstly, there is a need for services to be appropriately linked and have stable relationships with each other and effective communication channels. Secondly, there is a need to make information regarding services easily available and accessible to consumers and their families. AMSANT (2011) highlights the central role that ACCHOs can play in coordinating services and ensuring continuity of care between service providers. Given the heterogeneity of AOD-MH and in particular the needs of the 'missing middle' and of high needs clients following leaving hospital or corrections facilities, ACCHOs can provide linkages for clients between different levels of care depending on the severity of their condition (AMSANT 2011). However, as described above it is critical the full suite of services is available.

Clinical pathways

In addition to service linkages, AMSANT (2011) advocate for potential clinical pathways to assist with planning, service delivery and case management. Clear client pathways for common co-occurring conditions can help clients and the workforce navigate the multiple systems that can be involved in care. Furthermore, pathways assist workforce uptake of screening as staff have clear options to provide to clients. Previous research has identified a lack of potential referral pathways as a barrier to screening for AOD in primary health care (Butt et al. 2014).

Accessibility and flexibility of service delivery

Given the range of needs of people with AOD-MH there is a need to provide flexible service delivery that is easy and psychologically safe to engage with. This may include the following considerations: flexible appointment times, planned and on-demand appointment availability, non-punitive approaches to non-attendance, outreach, in-community service delivery, the provision of childcare or welcoming of children into services, easy accessibility (in terms of location) and choice of service provider within a service.

Accessible care may include telehealth and mobile technology (Reilly et al. 2019; Queensland Mental Health Commission 2022), with further research required to establish the value of this approach.

Capacity for integrated service delivery

The desire for holistic and integrated care is highlighted in the lived experience literature (Birdiya Maya Homelessness Research Project Team 2023; Hepsibah 2015; Wilson and Butt 2019) and advocated for by other sectors. As previously described, re-consideration of the system wide siloing of AOD-MH is required and the need for a national review and cohesive approach is clear.

Within the current siloed context and in considering the quadrant model in Figure 3, integrated care will look different for different AOD-MH presentations. Integrated care ensures the minimising or exclusion of other conditions does not occur, that any door is the right door, and that there is case co-ordination and continuity of care. As highlighted by the Victorian Royal Commission this may include specific services to address complex AOD-MH presentations.

Further to this there is a need for better opportunities for integrated care beyond AOD-MH needs and may include: wrap around services, one-stop shop/co-located services (for example access to health, housing, employment services), and better communication between sectors. The general approach proposed by AMSANT in which care for AOD-MH commences and is held in primary health care is an important approach – however it is also important that the whole system needs to be better equipped. In line with self-determination and its association with treatment outcomes, First Nations people with AOD-MH deserve the option to have their care coordinated outside an ACCHO if they so choose and thus whole of system increased capacity is required.

Workforce capacity

A stable and skilled workforce is the most critical element to delivering services to First Nations AOD-MH consumers. A number of contributory elements are highlighted across the literature:

- Overall workforce expansion: there needs to be a growth in the number of First Nations workers in the AOD-MH area, at all levels of specialisation. Strategies to develop the workforce need to go beyond recruitment and look at the pathways into specialisation to grow the pool of First Nations

workforce (for example, Hill et al. 2022). This is critical across the board but most clearly in regional and remote areas.

- A multidisciplinary workforce which values the skills and input of a range of relevant professions.
- Investment in workforce retention: innovative strategies are needed which will require adequate funding and evaluation to support implementation.
- Upskilling workforce: easily accessible training for both the AOD and MH sectors on AOD-MH is critical. Upskilling is clearly needed for much of the workforce, but capacity requires more than knowledge and skills. The workforce also needs to have role validity (seeing AOD-MH as core business) and comfort in addressing AOD-MH to be able to provide services.
- Prioritising supervision: clinical supervision is a requirement for some professions (for example, psychologists) but not others – this said it will benefit much of the AOD-MH workforce. Supervision can support retention and skill development and should be supported at all levels for the AOD and MH workforces, and particularly the First Nations workforce (Brodie et al. 2021).
- Valuing the peer workforce, the value of peer workforce is clearly articulated by clients, and ongoing investment and support of the peer workforce is critical.

Ongoing, funded, and meaningful evaluation

There is an evidence gap in AOD-MH service delivery and treatment. To address this gap, and to support innovation, an increase in investment in the evaluation of existing programs is required. Evaluation which measures community valued outcomes and is iterative is indicated.

Effective implementation of policy and programs

Currently a number of frameworks exist to address SEWB more broadly, and we have identified several promising programs for AOD-MH, but widespread and well executed implementation is missing. Over the years considerable investment has been made in programs with the goal of improving First Nations health (Percival et al. 2016) yet there has been limited commitment to the implementation of well-designed resources and programs into practice (Butt 2014; Percival et al. 2016). Investment in effective implementation will reduce a range of barriers to effective care and ensure the needs of all stakeholders are considered in the introduction and roll out of any model of care, service, or intervention approach.

Components of quality services

Components of quality AOD-MH care across organisational structures and policy settings are described below, and if applied effectively, the delivery of high-quality interventions is possible. These services need to be available for all First Nations people with AOD-MH and their families along the continuum of stepped care; with access to both therapeutic and pharmacological intervention where appropriate and be delivered by both the community-controlled service sector and culturally safe non-Indigenous specific services. This continuum includes detoxification services, residential rehabilitation, outpatient counselling (for those with severe, moderate, and mild conditions), pharmacotherapy, screening, and brief intervention. The involvement of the peer workforce at all levels of care is also strongly indicated as described above, as is the need for community input in the design of care.

Culturally centred care

The central role of cultural safety must not be overlooked at any phase of service design or delivery. Cultural safety requires recognition of, and effective responses to, power dynamics between healthcare providers and First Nations people, which can only be decided by the service user (Milroy et al. 2023). That is, consumer perspective is definitive regarding whether a service or interpersonal experience can be considered culturally safe. Culturally centred care requires not only adherence to the nine guiding principles (Dudgeon et al. 2014) but also recognises the need for culturally developed treatment approaches (Murrup-Stewart et al. 2021a; 2021b) and the inclusion of culture within treatment (Berry et al. 2022; Hill et al. 2022; Murrup-Stewart et al. 2021a; 2021b). Accordingly, culturally developed treatment approaches need to be valued and resourced.

To ensure the cultural competence of clinical services:

- the whole organisation (in particular its leadership) needs to engage with Elders and community in developing culturally safe practice (Hill et al. 2022; Wright et al. 2019; Wright 2021a; Wright et al. 2021b)
- the organisation's workforce must all receive training to achieve cultural competence in their practice (Westerman and Sheridan 2020).

Trauma-informed care

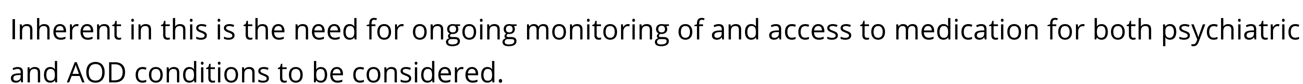
Given the high rates of trauma among First Nations people with AOD-MH, it is critical for service structures and the workforce to be 'trauma informed' and to be skilled in identifying and responding to trauma-related symptoms of AOD-MH.

Screening and brief intervention

Effective screening of AOD and MH at the entry point into a service or program is critical (Hinton et al. 2015), this includes adequate screening of AOD in MH services, of MH in AOD services and of both in primary health care, justice, and homelessness settings. Several resources exist to support screening for First Nations consumers particularly in relation alcohol use (Weatherall et al. 2020; Zheng et al. 2022) and to psychological distress and mental health risk (Brinckley et al. 2021), however there are a lack of screening tools which include both AOD and MH. Importantly, the Indigenous Risk Impact Screen (IRIS; Schlesinger et al. 2007) is a validated 13 item questionnaire that assesses mental health and AOD harms and is a useful and well-regarded option for screening of AOD-MH across a range of settings. Importantly, any implementation of screening and brief intervention requires the workforce to also have options for the provision of appropriate support in response to any identified harms – such as clear clinical pathways as described above.

Client centred treatment

The primary components for treating AOD-MH include pharmacotherapy, psycho-therapeutic interventions, and psychosocial support. Detailed discussion of the potential pharmacological options for AOD-MH conditions are beyond the scope of the current review. However, it is important that best practice for pharmacological approaches be regularly monitored and be administered alongside culturally appropriate psycho-therapeutic interventions and psychosocial support (Marel et al. 2022).



Inherent in this is the need for ongoing monitoring of and access to medication for both psychiatric and AOD conditions to be considered.

Efforts in determining best practice approaches to AOD, MH and AOD-MH have focused on determining the evidence-based components of psycho-therapeutic approaches (such as cognitive behaviour therapy and narrative therapy). However, it is important to recognise that these approaches are not one size fits all and that factors related to treatment success go beyond the specific therapy type used. These factors are referred to as the common factors of therapy (Wampold 2015) and include the relationship between the client and the practitioner, a shared understanding of what is happening (which includes assessment of the concern and the case formulation specific to each client), as well as components of treatment itself. It is important to note that there has been no research related to the common factors among First Nations people, however, themes in the qualitative literature highlight their potential importance. We consider them below in turn:

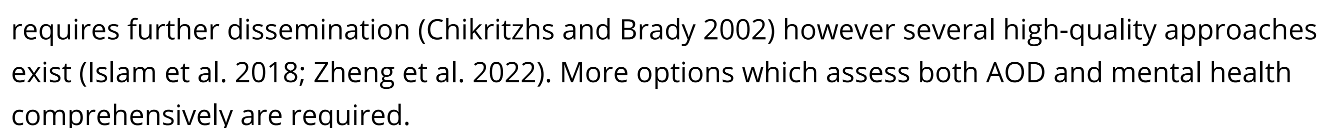
Relationship between client and service provider

In the AOD context Project Match, the largest alcohol treatment study conducted to date in the USA, found that therapy type did not predict outcome whereas therapeutic relationship did (Project MATCH Group 1997), yet there is far less literature on therapeutic relationship than there is treatment modality. A number of First Nations studies have highlighted the importance of a good relationship with service providers (both organisations and clinicians) as a significant component of client outcomes (Heath et al. 2022; Lee et al. 2014; Munro et al. 2017 Wright et al. 2019; Wright et al. 2021b). Thus, a focus on engagement and relationship building with First Nations clients should be regarded with as much significance as the treatment approach in planning effective services.

Characteristics of healing relationships for First Nations people have been discussed by Wright et al. (2016) for Noongar people in Western Australia and include the attributes of humility, inquisitiveness, and openness as key for service providers, in addition to trustworthiness, inclusivity, adaptability and reciprocity. Whilst broader research is indicated, research by Wright and colleagues (Wright et al. 2016) highlights the importance of how people engage with services. Factors which negatively influence engagement and relationship have been highlighted throughout the qualitative literature and include a lack of cultural appropriateness of service delivery; language barriers; concerns about confidentiality; shame; fear of being judged; discrimination; fear of child removal; difficulties with accessibility; power imbalances; and high staff turnover. These elements will need to be considered to facilitate the relationships between AOD-MH consumers and practitioners, and ultimately treatment success.

Assessment, diagnosis and case formulation

Assessment, diagnosis, and case formulation (case conceptualisation) are critical components of providing client centred care – that is, providing treatment that is tailored to the unique goals, needs, maintaining and predisposing factors of clients and their families (Brodie et al. 2021). As discussed elsewhere, the culturally appropriate assessment and diagnosis of mental health conditions is an ongoing challenge and continued investment in building the evidence base and accessibility of high-quality established measures is required (Westerman 2021; Gorman et al. 2021; Kickett-Tucker et al. 2015; Westerman and Dear 2023, 2024). Quality assessment of AOD-related harm similarly



requires further dissemination (Chikritzhs and Brady 2002) however several high-quality approaches exist (Islam et al. 2018; Zheng et al. 2022). More options which assess both AOD and mental health comprehensively are required.

Case formulation models which incorporate First Nations worldview and cultural strengths have been identified and described in the literature (Kilcullen and Day 2018) and within the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (APA 2022). The systematic use of these approaches will ensure appropriately tailored care to clients as it is from an individual's case formulation that the most appropriate treatment approaches can be identified. Brodie and colleagues (2021) further emphasise the need for screening to include social factors (such as finances and food security) and be strength based to ensure that social determinants of health are considered alongside wellbeing and resilience.

Psycho-therapeutic interventions and treatment approaches

There are several psycho-therapeutic interventions which have demonstrated efficacy in treating either/or both AOD and MH conditions for First Nations people. These include cognitive behaviour therapy (CBT) (Bennett-Levy et al. 2014), motivational enhancement therapy/motivational interviewing (Nagel et al. 2011), Community Reinforcement Approach (CRA) (Calabria et al. 2013) incorporates CBT and motivational enhancement strategies); CRA Family Training (CRAFT) (Calabria et al. 2013); narrative therapy and, more recently, acceptance and commitment therapy and mindfulness-based therapies (Reilly et al. 2019). Application of these therapeutic interventions requires careful cultural consideration and case-by-case decision-making using culture-based formulation as described above.

Psychosocial interventions and wrap around services

In addition to treatment for AOD-MH conditions, people often require support for health and social challenges that are interlinked with AOD-MH. Easy access to these supports is critical and includes external services (which may be co-located) to help with housing, employment, finances and entitlements, health, and justice. Furthermore, some people will need assistance to engage with these services, as well as practical support and life skills. Case management models which can work with clients to access support for all their needs is critical (Brodie et al. 2021) and can be implemented alongside therapeutic interventions.

Peer support groups

Whilst there is a lack of empirical knowledge regarding the efficacy of peer support groups for First Nations people in Australia, reviews suggest they are an important component of the treatment mix (Dale et al. 2019).

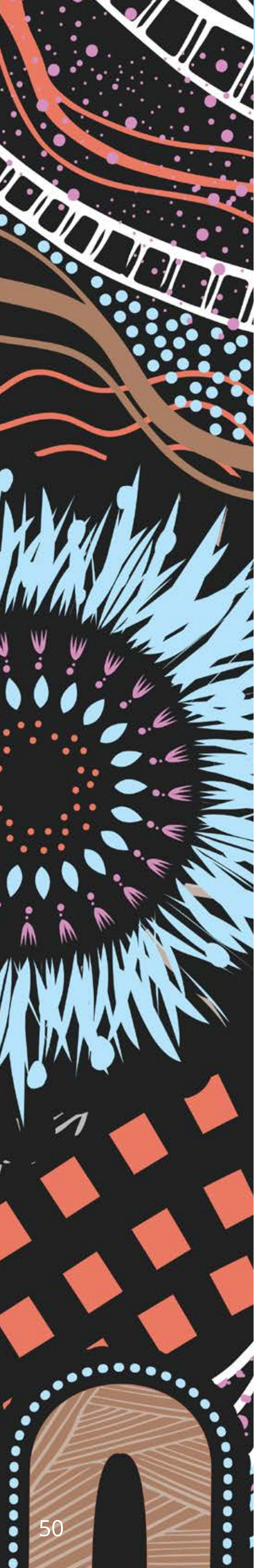
Cultural, spiritual, and traditional healing and support

The opportunity for First Nations people to access cultural, spiritual and/or traditional healing requires consideration and investment to become a bigger part of the treatment mix available to people and as a complement to other therapeutic approaches.

In summary, treatment for AOD-MH which focuses on relationship and utilises culturally valid assessment, case formulation and treatment coupled, where appropriate with pharmacology, make up the core requirements for quality services.

Family inclusive treatment

The impacts of AOD-MH are not felt only by individuals, but also by their social and family system. As described in several papers (Gendera et al. 2022; Hepsibah et al. 2015) family members provide significant care for those with AOD-MH. This care giving can result in psychological distress for family, in addition to other economic and practical challenges. Given this, there is a need to support families more explicitly in service of their ongoing contribution to positive outcome for their loved one(s). This may include the development of new models of care and therapeutic approaches which both received guidance from but also provide emotional and practical support to the SEWB of family members.



7

Summing up

7 Summing up

Gaps, limitations and opportunities

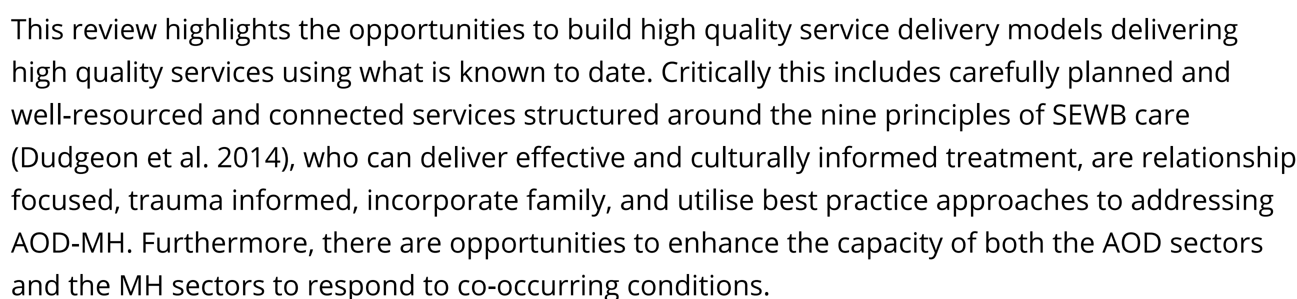
The gaps and limitations in research, policy and practice have been highlighted throughout preceding sections. There are a number of these gaps worthy highlighting again here – the majority of which stem from the historic siloing of AOD from MH and underfunding of both sectors. Firstly, in terms of research there is a lack of nuanced data that accurately describes the diversity within and across AOD-MH conditions, including: the lack of MH data and screening with AOD research and vice versa, sufficient research on AOD-MH conditions, lack of data on positive indicators of wellbeing, and a lack of evaluation and implementation data on existing and proposed treatments and programs. There is great opportunity in building on existing qualitative research to further understand the lived experience of people with AOD-MH and use their experience to guide the development of high-quality policy and service delivery.

Secondly, in terms of policy AOD and mental health strategies only briefly recognise the inter-relatedness of alcohol and other drug use and mental health and wellbeing. Furthermore, there is a lack of guidance on how to specifically support the First Nations communities to adequately address these issues. The mental health-specific strategies acknowledge the contribution harmful alcohol and other drug use; but this is not reciprocated in the AOD-related strategies. The co-occurrence of AOD use, mental health, and AOD-MH conditions for First Nations people and their communities, have been skimmed over in the development of strategies and policies. In addition, there is a legacy of non-involvement of First Nations communities in the development of policy; thus, an opportunity presents itself to update develop genuine community driven policy in this space which not only recognises AOD-MH and the interrelatedness of AOD and MH but provides specific guidance to better integration.

Finally, within practice there is a lack of evidence base – largely due to lack of investment of evaluation and capacity building, and a lack of specific AOD-MH services. There are several existing reviews pointing to potential avenues for more integrated and holistic approaches to AOD-MH. There is need for these to be refined by First Nations communities to suit the needs of specific areas and groups. Subsequently, these refinements need to be funded, implemented, and evaluated – then further developed in line with evaluation results. There needs to be an ongoing and consistent effort to improve integrated service delivery through sustained funding, and recognition of the centrality of Aboriginal Community Controlled health care.

Additional gaps in service delivery are summarised below:

- Lack of cultural safe services available.
- Lack of overall services – of note this includes services for specific groups (for example, men), crisis response as well as a lack of services for those in the 'missing middle' (or pre-crisis).
- Siloed service delivery, including inconsistent screening and complex or fragmented referral pathways.
- Lack of continuity of care.
- Workforce challenges.
- Limited modes of service delivery with a lack of focus on extended family.



This review highlights the opportunities to build high quality service delivery models delivering high quality services using what is known to date. Critically this includes carefully planned and well-resourced and connected services structured around the nine principles of SEWB care (Dudgeon et al. 2014), who can deliver effective and culturally informed treatment, are relationship focused, trauma informed, incorporate family, and utilise best practice approaches to addressing AOD-MH. Furthermore, there are opportunities to enhance the capacity of both the AOD sectors and the MH sectors to respond to co-occurring conditions.

Future research priorities

Further development in understanding and addressing AOD-MH is hampered by a lack of evidence. There are numerous avenues for potential research, however the priorities include: nuanced research into the patterns and prevalence of AOD-MH in the community in order to better understand the range of AOD-MH conditions and the needs of people affected, improved data quality at a service level, more qualitative research documenting the lived experiences of people with AOD-MH through care pathways, and program evaluation research. Program evaluation research needs to include both outcomes and implementation as well as be iterative to ensure the ongoing development of sustainable programs rather than pilot programs. Within both AOD and MH research there is also a need to better assess for the other. The area is also challenged by a lack of community driven research; further research needs to be conducted in lead by and in partnership with community control and with equitable community partnerships in order to develop meaningful research with practicable outcomes. Finally better metrics of wellbeing and more widespread adoption of appropriate measurement is needed. Furthermore, there is a need to prioritise research into the implementation of programs and policy.

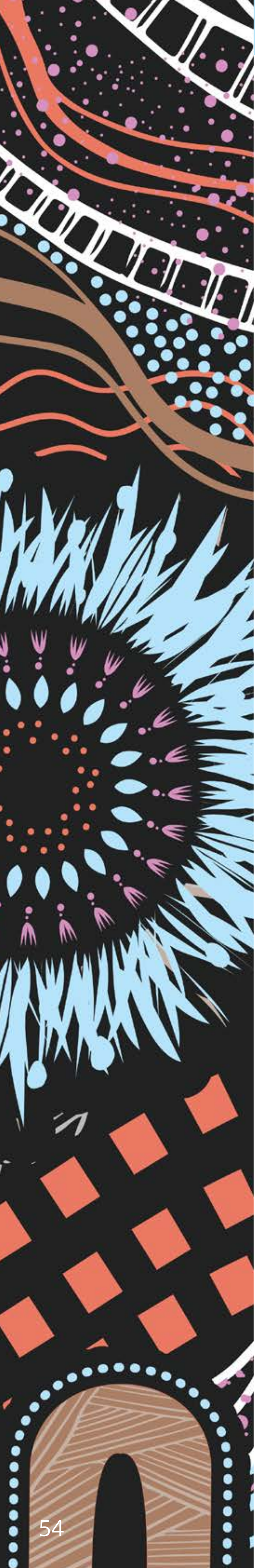
Conclusion

The harmful use of AOD and mental ill-health are interconnected and can be a significant impediment to the SEWB of First Nations people, families, and communities. AOD and mental ill-health arise as a consequence of ongoing health inequalities, systemic disadvantage as a result of colonisation, and racism; the two negatively impact each other. Both AOD and mental ill-health are best considered as part of SEWB. The review highlighted high rates of co-occurring AOD-related harm and mental ill-health; with particular concerns for young people, men, justice-involved people and those experiencing homelessness. Despite high rates of co-occurring conditions, there is a lack of services available which address AOD-MH in an integrated way and system wide siloing negatively impacts those seeking care. The review highlighted the range of available intervention options, exemplars of promising practice and a detailed framework for improved AOD-MH care.

This review started, and will end, with these recommendations from the *Ways forward* report (Swan and Raphael 1995:12). This call for integrated care is now almost 30 years old and continues to go unheard:

> *Communities and the consultancy at every level identified the critical importance of the interrelationship between substance abuse and mental health, and that these should not be separated. Program collaboration should be established through mental health and substance abuse agencies at national and regional levels. Combined initiatives should address education; interventions for the affected and those at risk; special programs for young people; clinical programs; programs for alcohol-related brain damage; prevention programs including prevention of foetal alcohol syndrome; and prevention programs related to injecting drug use and other substances …*

AOD and mental ill-health are interconnected and integrated approaches to understanding, responding, treating, and preventing harms at the affected individual, family and community level are clearly needed and are consistent First Nations definitions of SEWB. To ensure success, future developments in research policy and practice must be community-led, have culture at the centre, and be adequately funded.



Appendixes

Appendix A: Background to evidence synthesis

Prior to synthesising the literature from MH and AOD fields and examining the key issues, the following background and contextual issues were reviewed:

- Defining key concepts and terms.
- Understanding the contextual background to both harmful AOD use and MH within First Nations communities.
- Understanding the inter-relationships between AOD and MH.
- Understanding approaches to addressing AOD-related harm.

Defining key terms and concepts

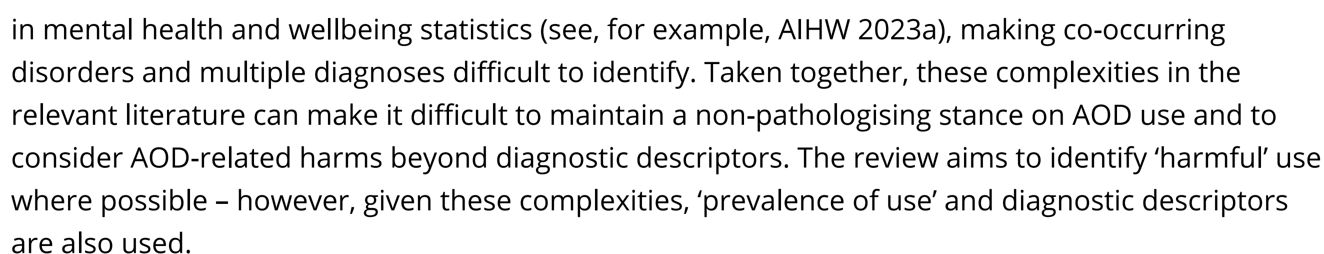
AOD use and related harm

This review notes that not all AOD use is harmful and considers AOD use on a spectrum from non-harmful to harmful use, with dependence at the far end of the spectrum. In line with the approach of others (Snijder and Kershaw 2019; Wilkes et al. 2014) this review considers 'harm' from a public health lens – whereby 'harm' is considered at the level of the individual user, their family, and their community. As a non-exhaustive list, harms from AOD use can include short- and long-term psychoactive and physical effects of the substance; psychosocial impacts of accessing, being under the influence of, and recovering from use; economic impacts of use; and legal implications of use. Harmful use is not then restricted to the meeting of diagnostic criteria for a substance use disorder and the associated concepts of dependence, addiction or 'use disorder' (American Psychiatric Association 2022).

In reviewing the AOD research this review is mindful of three factors which complicate research and its findings:

1. The illegality of some AOD use and its practices creates complexities in research participation.
2. Much AOD use does not conform to standard measurement units and therefore it is difficult to quantify patterns of use.
3. For many drugs (for example, cannabis) there is a lack of clarity around what can be considered 'safe' and 'unsafe' levels of use – which makes it difficult to identify non-harmful use.

As consequence of these challenges, AOD use and related harm tends to be described across the literature through the lens of diagnostic criteria (for example, having a use disorder) or prevalence data (lifetime or past year use of a substance). This lack of specificity creates limitations in the data and its interpretation. This is further limited by the likely underdiagnosis of AOD use disorders and the availability of appropriate interventions. AOD-related data is also categorised and understood in differing ways across the literature; for example, within the Indigenous Health Performance Framework (IHPF) (AIHW 2023a) AOD use (identified by prevalence) is categorised in Tier 2 as a determinant of health whereas AOD-use disorders are categorised as Tier 1 for health status and outcomes. Consistent with this, AOD-use disorders are classified as mental-health diagnoses



in mental health and wellbeing statistics (see, for example, AIHW 2023a), making co-occurring disorders and multiple diagnoses difficult to identify. Taken together, these complexities in the relevant literature can make it difficult to maintain a non-pathologising stance on AOD use and to consider AOD-related harms beyond diagnostic descriptors. The review aims to identify ‘harmful’ use where possible – however, given these complexities, ‘prevalence of use’ and diagnostic descriptors are also used.

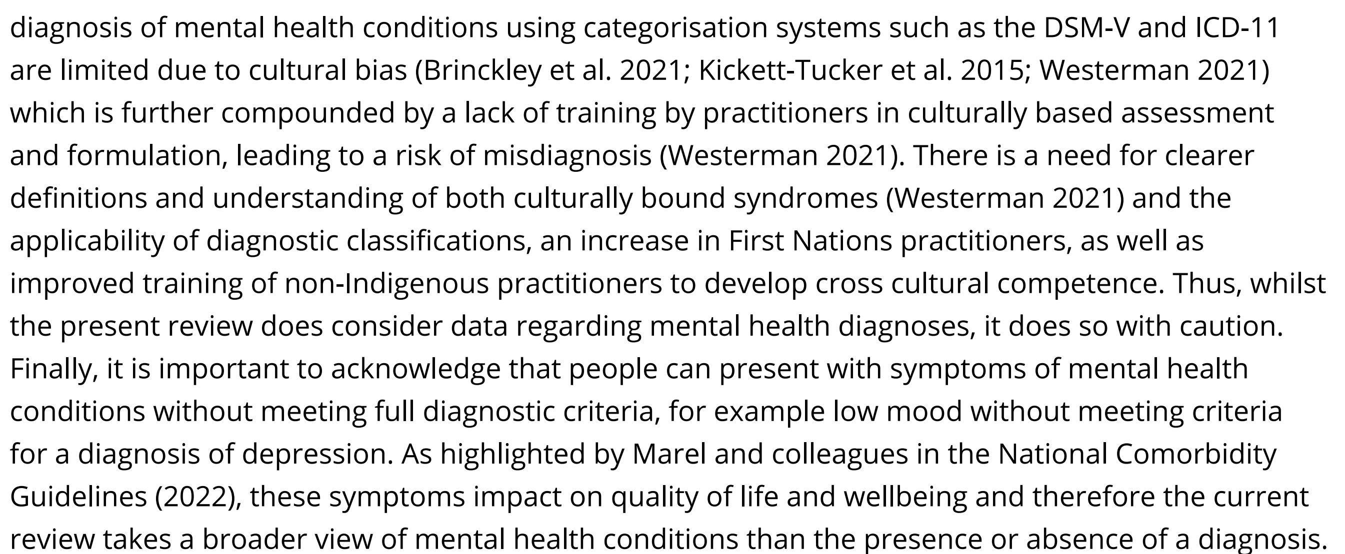
Mental health, mental ill-health, and psychological distress

To examine the relationship between harmful AOD use and mental health, the review is limited by the research available. To date, most research has defined negative states of SEWB in terms of mental health behaviours which come from a Western lens. While previous Clearinghouse papers (for example, the work of Martin et al. 2023) emphasise the importance of using SEWB domains when describing mental wellbeing for First Nations people, and caution at using the term ‘mental health’, research available for review tends to focus on the presence or absence of diagnosable mental health conditions and/or psychological distress as indicators of mental health and wellbeing (see also Martin et al. 2023). Consequently, this review considers diagnosable mental health conditions, symptoms of mental health conditions, psychological distress, and where available indicators of positive wellbeing states.

Psychological distress, mental health, and mental ill-health (MH) are broad, general terms used variously across the literature to denote the spectrum of mental wellbeing. In many instances the term mental health is used to denote challenges to mental health (i.e. mental ill-health) as opposed to a neutral or positive state of wellbeing, although, more recent research includes positive markers of wellbeing as measures of overall mental health (Gorman et al. 2021). Emerging First Nations research (Barry and Guerin 2024; Westerman 2021) highlights the importance of First Nations descriptions and cultural conceptualisation of mental health and mental health behaviours and the impacts of this on treatment – as this research continues to emerge, more nuanced and effective research and practice will follow. For this review there was a lack of research which describes culturally bound syndromes and their relationship to AOD.

Psychological distress (also worry and stress) can be thought of as the mental and/or emotional suffering experienced by a person, often in response to a stressful life event. Psychological distress is a contributor to mental ill-health and is a risk factor for suicide and harmful AOD use (Brinckley et al. 2021), but is distinct to a diagnosable mental health condition. There are benefits to measuring psychological distress in that it captures subthreshold as well as transdiagnostic elements of mental ill-health, as well as the experience of people who may meet diagnostic criteria for a mental illness but have not received diagnosis due to lack of contact with the mental health system. Psychological distress also captures the impacts and responses of negative life events, which are experienced at a higher rate by First Nations people (AIHW 2023a). Indeed, measurement of psychological distress actively prevents the pathologising of natural, often adaptive responses to trauma, grief, and adverse experiences. Psychological distress is often measured using the 10 item Kessler Psychological Distress Scale (K10) or a culturally adapted 5 item version (K5) (Brinckley et al. 2021; Martin et al. 2023).

Diagnosable mental health conditions are patterns of psychological functioning which meet criteria for specified distress and/ or negative psychosocial impact(s) in the DSM-V and/or International Classification of Diseases 11th Revision (ICD-11) classification systems. It is important to note that the



diagnosis of mental health conditions using categorisation systems such as the DSM-V and ICD-11 are limited due to cultural bias (Brinckley et al. 2021; Kickett-Tucker et al. 2015; Westerman 2021) which is further compounded by a lack of training by practitioners in culturally based assessment and formulation, leading to a risk of misdiagnosis (Westerman 2021). There is a need for clearer definitions and understanding of both culturally bound syndromes (Westerman 2021) and the applicability of diagnostic classifications, an increase in First Nations practitioners, as well as improved training of non-Indigenous practitioners to develop cross cultural competence. Thus, whilst the present review does consider data regarding mental health diagnoses, it does so with caution. Finally, it is important to acknowledge that people can present with symptoms of mental health conditions without meeting full diagnostic criteria, for example low mood without meeting criteria for a diagnosis of depression. As highlighted by Marel and colleagues in the National Comorbidity Guidelines (2022), these symptoms impact on quality of life and wellbeing and therefore the current review takes a broader view of mental health conditions than the presence or absence of a diagnosis.

Suicidality and non-suicidal self injury

This review considers suicidal behaviour along a continuum of death by suicide, attempted suicide, and suicide ideation (Rontziokos and Deane 2019). Suicidal behaviour is broader than mental ill-health, particularly in the context of First Nations people, and can be understood as an expression of profound distress which may or may not correlate with a diagnosable mental health condition (Martin et al. 2023). The relationship between AOD-related harm and suicide is addressed in the companion paper (https://www.indigenousmhspc.gov.au/publications/aod-suicide). This review does not consider non-suicidal self-injury (NSSI) (irrespective of it resulting in death) within the definition of suicide. NSSI is frequently co-occurrent with mental ill-health presentations, although it too cannot be reduced to a mental ill-health symptom.

Comorbidity and co-occurring AOD-related harm and mental ill-health (AOD-MH)

The term ‘comorbidity’ describes the co-occurrence of two or more diagnosed disorders or conditions experienced by a person at the same time. This review will use the term ‘co-occurring AOD-related harm and mental ill-health’ (AOD-MH) rather than ‘comorbidity’. Consistent with the National Comorbidity Guidelines (Marel et al. 2022) this includes harmful AOD use (irrespective of meeting diagnostic criteria) and symptoms of mental health conditions (irrespective of meeting diagnostic criteria) and/or psychological distress.

In reviewing the literature, it is important to acknowledge that within AOD-MH conditions there is great diversity in terms of the substance(s) used; the pattern and frequency of use; and the severity and characteristics of low SEWB. (For example, someone with co-occurring alcohol dependence and depression has vastly differing needs to someone who may use methamphetamine sporadically but who also has schizophrenia.) Furthermore, different substances have different direct short-term impacts on mental health (for example, causing anxiety, confusion, hallucinations and so forth) that may not result in ongoing co-occurring conditions.

The key contextual factors regarding AOD use and mental ill-health among First Nations people of Australia

Colonisation and intergenerational trauma

As described above, the adoption of SEWB requires active recognition of the ongoing oppressive impact of colonisation, racism, and intergenerational trauma (Darwin et al. 2023; Paradies 2005; Priest et al. 2013) as per the *Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing*. Of particular relevance to this review, it is acknowledged that the introduction of alcohol to First Nations people occurred during colonisation using processes of control and coercion (Krakouer et al. 2022).

In terms of mental health, the trauma of colonisation impacts the SEWB of First Nations people and communities intergenerationally, both through unaddressed historic experiences (disruption of kinship and separation from land and language) as well as through ongoing racism and structural inequities (Darwin et al. 2023; Paradies 2005; Priest et al. 2013; Truong and Moore 2023). Recent AIHW Clearinghouse publications specific to intergenerational trauma (Darwin et al. 2023) and racism (Truong and Moore 2023) provide comprehensive reviews of these topics and inform the current review. The ongoing impacts of colonisation have clear relevance to the social determinants of health and consequently on AOD use and SEWB (which will be briefly covered in a later section of this review).

Cultural strength and resilience

Resistance, resilience and the survival of First Nations people and communities (Darwin et al. 2023; Dudgeon et al. 2014) are important to recognise in any discussion related to SEWB. The protective role of culture, including cultural identity and cultural resilience, are well documented and are related to positive SEWB (Birdiya Maya Homelessness Research Project Team 2023; Jongen et al. 2023; Kickett-Tucker et al. 2015; MacLean et al. 2017). While ongoing research is needed to further define and measure cultural identity and self-esteem (Kickett-Tucker et al. 2015) the role of culture in maintaining and enhancing SEWB cannot be overlooked (Dudgeon et al. 2014; MacLean et al. 2017).

AOD use and related harms in First Nations communities

Prior to examining co-occurrence, a summary of the extent of AOD use and related harms within First Nations communities is presented below. Evidence suggests that First Nations people use AOD at 1.5 times the rate of non-Indigenous people and experience harms at 2.3 times the rate (James et al. 2020). This comparative data statement is presented to illustrate the potential for AOD to contribute to the health gap experienced by First Nations people and to guide policy and practice approaches (Thurber et al. 2022), not to contribute to a deficit-based discourse (Colonna et al. 2020; Dudgeon et al. 2021; Fogerty et al. 2018; Graham et al. 2021). Significant in these statistics is the elevated rate of harm comparative to use, which emphasises the need to look closely at prevalence and use data to understand the pattern and context of AOD use may lead to harm.

The majority of AOD relevant national data sets focus on prevalence of use and/or diagnosis of a use disorder, and in the case of alcohol, level of drinking risk. The most pertinent data for this discussion is from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2018–2019

(Australian Bureau of Statistics 2019); and is summarised below and in Table A1. Further detailed analysis is provided by the AIHW (AIHW 2023a, 2023b) and updated regularly.

In reviewing the data below, it is important to recognise that national surveys are likely underestimates of prevalence, and it cannot be assumed that identified patterns of consumption are consistent across regions of Australia.

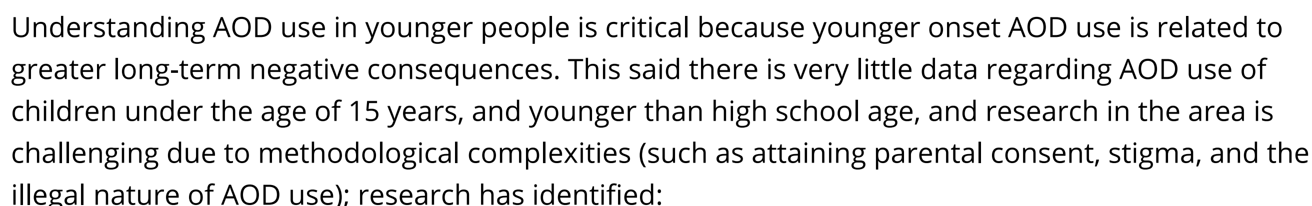
Within this caveat, data suggests:

- 50% of First Nations people over the age of 15 consumed alcohol above the single occasion risk guidelines (2018–19 NATSIHS) (AIHW 2023b).
- 28% of First Nations people over the age of 15 reported using drugs, in the previous 12 months (2018–19 NATSIHS) (AIHW 2023b).
- First Nations males are more likely than females to have used alcohol (at a lifetime risk level), cannabis and amphetamines, and are at greater overall risk for AOD-related harm (AIHW 2023a, 2023b).
- Those aged 45 and over were less likely to report they had used substances in the last 12 months than those under 45 years (21.2% compared with 32.9%) (AIHW 2023b).
- Little difference has been reported between remote and non-remote populations past year drug use (29% non-remote, 27% remote), and percentage exceeding the lifetime alcohol risk (19% non-remote and 16% remote) (AIHW 2023a). This said, there are remarkable differences between remote communities in terms of AOD use due to a range of policy, accessibility, social and cultural differences. Thus, data estimating remote community prevalence is unlikely to have relevance to specific localities and is therefore less useful in informing health promotion or policy making but does highlight the need to recognise the unique needs of remote communities.

Table A1: Prevalence of AOD use among First Nations people, aged over 15 years

	2018–2019 NATSIHS
Past year alcohol use	
Exceeding single occasion risk	50%
Exceeding lifetime risk	18%
Past year other drug use	
Any drug	28%
Cannabis	25%
Amphetamines	3%
Painkillers (non-medicinal)	3%
Tranquilisers (non-medicinal)	2%
Kava	1%
Inhalant	1%
Other	6%

Source: AIHW 2023a



Understanding AOD use in younger people is critical because younger onset AOD use is related to greater long-term negative consequences. This said there is very little data regarding AOD use of children under the age of 15 years, and younger than high school age, and research in the area is challenging due to methodological complexities (such as attaining parental consent, stigma, and the illegal nature of AOD use); research has identified:

- Onset of alcohol and cannabis use for some children occurs at, or prior to, 10 years of age (Wilson and Butt 2019; Wilson et al. 2013)
- Analysis of the most recent the Australian Secondary Survey Alcohol and Drugs (ASSAD) survey demonstrates high rates of use; 70% of First Nations participants had used alcohol in the past month and 25% had used cannabis (Graham et al. 2021; Heris et al. 2021). In the older cohort (16-17 years), prevalence jumped to 86.5% for alcohol and 42% for cannabis, figures higher than identified in the NATSIHS.
- Analysis of the GOANNA study (a cross-sectional survey of First Nations young people aged 16–29 years about sexual health and relationships) reported higher prevalence rates than the NATSIHS (79% and 47% in 2017–19 respectively), with cannabis being the most commonly used drug in the past year (35% in 2017-2019) (Ward et al. 2014; Ward et al. 2020).

Alcohol, cannabis, and amphetamines are the substances most associated with harm for First Nations communities across demographics (AIHW 2023a), they are also pertinent to discussion regarding mental health and as such are described in more detail below:

Alcohol use

Alcohol is the most widely used substance among First Nations people (Wilkes et al. 2014) and detailed analysis of alcohol use data can be found elsewhere (AIHW 2023a, 2023b; Gray et al. 2018). Research consistently shows a polarisation of use between abstinence and risky drinking. Analysis of national surveys and community samples consistently highlight high rates of abstinence among First Nations people (Weatherall et al. 2022). In the 2018–19 NATSIHS, 30% of respondents over the age of 15 years reported that they had abstained from alcohol over the previous 12 months (AIHW 2023b). To put this figure in context: 22% non-Indigenous Australians abstained from drinking in the past 12 months in the same period (AIHW 2023b). In contrast, levels of drinking above the single occasion risk and lifetime risk thresholds (see Table A1) are also greater than in the non-Indigenous population (AIHW 2023b; Ward et al. 2020; Weatherall et al. 2021). For example, the 2018–19 NATISHS data show that among those who drink, 37% drank 2–3 standard drinks per day, 15% consumed 3–4 and 48% consumed more than 4 standard drinks per day (AIHW 2023b). Similarly, data from the GOANNA study among young adults identified that 79% of drinkers exceeded the single occasion risk guidelines and 47% reporting drinking more than 7 drinks per drinking occasion (Ward et al. 2020).

This often-reported polarisation does not tell the full story – recent research has highlighted the need for community-level data and recognition of changing patterns of individual use (Zheng et al. 2022). Analysis of alcohol use among 775 participants in two discrete communities found that 77% were current drinkers, with the majority reporting high risk drinking, but that 74% drinkers also reported periods of not drinking (Zheng et al. 2022). This clearly demonstrates how, while useful, prevalence data does not adequately reflect the variability in peoples' drinking patterns. For prevention and treatment approaches to be of most benefit to detailed understanding of patterns of use beyond prevalence data is essential.

Cannabis use

Cannabis is the most commonly used illicit drug internationally, nationally, and among First Nations people. Detailed examination of cannabis use can be found elsewhere (for example, Butt et al. 2022). As summarised in Table A1, 25% of NATSIHS participants (over 15 years) used cannabis within the previous month, with use among males (31%) higher than females (18%) (Australian Bureau of Statistics 2019). Research conducted at a community level suggests this figure to be an underestimate – research conducted with the health workforce and within communities over the last two decades have consistently reported concern that cannabis use is highly prevalent and normalised (Bohanna and Clough 2012; Butt et al. 2022; Butt et al. 2010; Clough et al. 2002; Lee et al. 2007; Lee et al. 2009). For example, research in remote communities has identified very high rates of cannabis use (Bohanna and Clough 2012; Graham and Clough 2018), with 66% of males and 31% of females in one study from a single community reporting current use (Graham and Clough 2018). Whilst this research is both community and time specific and cannot be assumed as broadly representative, it does demonstrate the extent to which national survey methods may be under representative of community level cannabis use and, similarly to alcohol, therefore inadequate as a sole determinant of prevention and treatment planning.

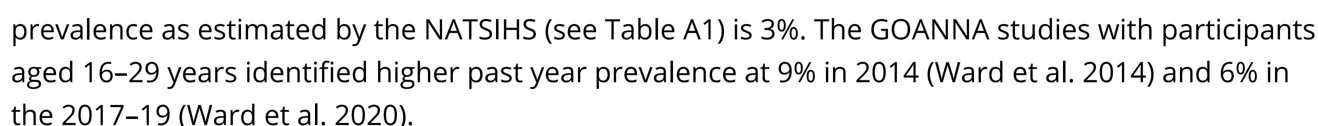
There is a lack of research into the pattern of use among those who do use cannabis. Data exists which suggests not only high prevalence but high dosage (amount of cannabis use):

- Among GOANNA study participants who used cannabis, 37% used daily and 24% used weekly (Ward et al. 2014).
- A small urban study looking at co-occurrent use of tobacco and cannabis identified that of the people using cannabis, 76% reported using daily, 15% reported using cannabis 3–6 times per week and 60% showing symptoms of dependence (Butt 2020).
- Among a remote community sample Bohanna and Clough (2012) reported that 37% of current cannabis users used daily and 34% used weekly; and of those using at least weekly, 68% reported cannabis dependence.

These findings highlight that although there is limited quality data on patterns of cannabis use – the existing research recognises that there are high levels of heavy use (Butt et al. 2022; Butt et al. 2010; Butt et al. 2014; Lee et al. 2007; Lee et al. 2009; Lee et al. 2015) and there are significant concerns that cannabis use is normalised (Bohanna and Clough 2012; Butt et al. 2022; Butt et al. 2010; Clough et al. 2002; Lee et al. 2007; Lee et al. 2009). The normalisation and high levels of use are particularly concerning considering that cannabis can have a direct, negative impact on mental health, including the onset, course, and severity of mental illness (including psychosis) (Campeny et al. 2020; Hall 2009).

Amphetamine and methamphetamine use

Methamphetamine has significant impacts on individual mental health as well as family and community functioning and wellbeing (Gendera et al. 2022; Reilly et al. 2020; Snijder and Kershaw 2019), and its use compounds challenges in mental health service provision. Detailed examination of the use of methamphetamine and its impacts is provided elsewhere (Snijder and Kershaw 2019) and demonstrate that there has been an ongoing concern about the impact of methamphetamine use in First Nations communities since the early 2000s (Snijder and Kershaw 2019). The past year



prevalence as estimated by the NATSIHS (see Table A1) is 3%. The GOANNA studies with participants aged 16–29 years identified higher past year prevalence at 9% in 2014 (Ward et al. 2014) and 6% in the 2017–19 (Ward et al. 2020).

Similar to cannabis, there is little research which investigates pattern of amphetamine use – the most detailed summary among current First Nations users is that by Reilly et al. (2020) who presented findings on 734 methamphetamine users including 416 First Nations people. Results showed little difference between First Nations and non-Indigenous participants with 17% of the sample reporting daily use and 50% of users reported injection as a primary mode of administration which presents additional harms.

Other drug use

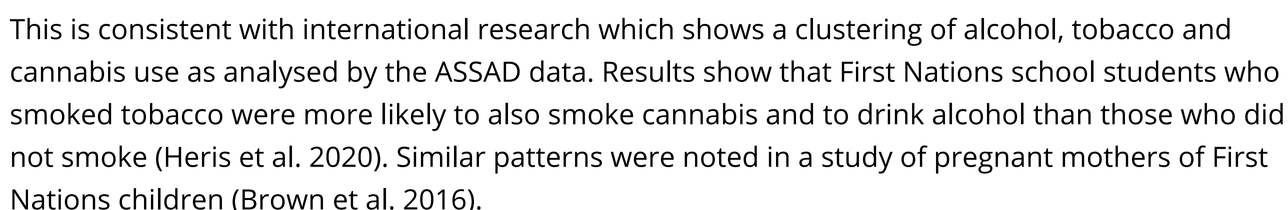
The use of volatile substances (including petrol) and the harmful use of kava have previously been identified as impediments to wellbeing of First Nations people (Gray and Wilkes 2010). There is a lack of detailed recent data on both these substances. As summarised in Table A1, the 2018–2019 NATSIHS estimated kava use at 1%. To understand this figure, it is important to note that kava use among First Nations people is largely limited to a handful of communities in the East Arnhem region of Northern Territory (Butt 2019). Available evidence suggests that its prevalence has decreased since a peak during the 1990s. Kava has a complex regulatory history in the Northern Territory and across Australia, and recent changes in legislation may increase its availability – and consequently, there are concerns that any increase in kava use may lead to increased harms (Butt 2019).

Similarly, the inhalation of volatile substances to achieve a high has historically caused significant harm within First Nations communities, and the introduction of Opal fuel has significantly reduced this harm (Midford et al. 2011). The use of other inhalants such as spray paint ('chroming') is very difficult to track and there is therefore a lack of current data about this. Within this caveat, most recent data suggests a prevalence of 1% as summarised in Table A1.

Finally, there is growing concern regarding the misuse of prescription medicines such as opiates, however detailed data regarding the use of these by First Nations people is also lacking. This area requires increased and ongoing monitoring, as there is a recognised global increase in the misuse of prescription medicines.

Polysubstance use

Many people use more than one substance (drugs and/or alcohol), which is referred to as polysubstance use. This includes the use of multiple substances on a single occasion and/or the use of different substances across the life span. Detailed data about prevalence and patterns of polysubstance use is lacking; yet the harms associated with polysubstance use are important to consider. For example, the majority of overdose deaths in Australia occur with polysubstance use (Penington Institute 2023). Existing research highlights that polysubstance use is common among community and treatment samples. For example, in a study reviewing client admission data in a remote Aboriginal community controlled residential rehabilitation service (85% First Nations), Munro and colleagues (2018) found that 69% of participants indicated using more than one drug of concern.



This is consistent with international research which shows a clustering of alcohol, tobacco and cannabis use as analysed by the ASSAD data. Results show that First Nations school students who smoked tobacco were more likely to also smoke cannabis and to drink alcohol than those who did not smoke (Heris et al. 2020). Similar patterns were noted in a study of pregnant mothers of First Nations children (Brown et al. 2016).

Alcohol and cannabis are also widely used with other drugs. For example, data from the NATSIHS (2018–19) indicates that those who used illicit drugs were more likely to also drink at levels exceeding the single occasion risk (72% and 49%, respectively) (AIHW 2023a). Regarding cannabis, qualitative research with AOD and health workers (Butt et al. 2010) and intake data from a residential rehabilitation service (Munro et al. 2018) identify cannabis as a common secondary drug of concern. Similarly, in a community sample of First Nations methamphetamine users, 57% reported also having used cannabis in the past month (Reilly et al. 2020).

Further research into patterns of poly drug use is warranted, particularly given the diversity in patterns of use of single drugs (for example, alcohol and cannabis). How other drugs fit into patterns of use is important and has implications for treatment and intervention planning as well as for understanding and preventing harm.

Prevalence of AOD use disorders

While not an adequate standalone measure of AOD-related harms, AOD-use disorders form part of the broader harms picture. This can be defined as a pattern of use which meets criteria in the DSM or ICD – generally with a focus on impaired function, impaired control over use and/or elevated distress (APA 2022). The prevalence of AOD use disorders among First Nations people is difficult to ascertain due to methodological limitations, including the use of appropriate assessment techniques and adequate community level sampling. However, existing research does suggest AOD use disorders to be of significant concern. Rates of admission to tertiary settings can be one way of estimating prevalence. A large birth cohort study in Queensland examined lifetime rates of psychiatric hospital admissions and found First Nations people were overrepresented across most psychiatric disorders, with the difference most pronounced for AOD use disorders (12.2% of the sample had an AOD use diagnosis by age 24 years compared to 2.6%; Ogilvie et al. 2021b). The authors identified that over representation in diagnosis begins in childhood and becomes more pronounced in adulthood (Ogilvie et al. 2021b), highlighting the critical importance of early intervention availability. Similarly high rates of prevalence were noted in a community-based study which found 17.1% of First Nations participants met criteria for an AOD use disorder (Nasir et al. 2018).

The proportion of people who use AOD who go on to become dependent or meet use disorder criteria is worthy of consideration and is necessary to understand to better develop prevention and treatment approaches. Nasir et al. (2018) did not report the total proportion of participants who used AOD alongside those who also met criteria for a use disorder, making the likelihood of progression to a disorder unclear. One study of note identified that among a representative sample of First Nations people over 16 years, 2.2% of participants who had consumed alcohol in the past year were likely dependent on alcohol (Weatherall et al. 2022). In contrast the cannabis data described by Bohanna and Clough (2012) suggests that a significant proportion of cannabis users in their study were dependent on cannabis. Therefore, further research in this area is warranted to better understand the relationship between AOD use and the development of use disorders.

Summary of AOD-related harms

Quantifying the broader harms associated with AOD use is complex as they occur at the individual, family, community, and society level. Additionally, and as described below, harms are intertwined with a range of other social complexities where AOD can both cause and compound harms which arise from disadvantage, systemic racism, and the legacies of colonisation – such as exposure to violence, engagement in the justice system, disrupted employment and education, and homelessness.

AOD-related hospitalisations and deaths provide indicators of direct harm. A 2018 IHPF calculation presented the rate of alcohol related death among First Nations people as 18 deaths per 100,000 people. Of note, this is a 40% decrease from 2008, but still higher than the national average. Drug related deaths in 2021 as reported by the Penington Institute (2023) were calculated as 20 deaths per 100,000 (three times the national figure). The Institute notes that the rate of unintentional drug-induced deaths among First Nations people has fluctuated, and they caution that calculations are volatile due to the lower numbers of deaths in First Nations communities, and incomplete data (Penington Institute 2023). However, the findings do highlight that the degree of AOD use that puts First Nations people at risk of death is concerningly high.

Detailed summaries of AOD-related hospitalisations are provided elsewhere, including by the IHPF (AIHW 2023a). Relevant to the present discussion over the decade to 2018–19, the age-standardised rate of drug-related hospitalisations for First Nations people increased nearly 2.5-fold, compared with only a slight increase for non-Indigenous Australians (AIHW 2013a). Thus, whilst prevalence of AOD use has remained stable (AIHW 2023b), the prevalence of hospitalisation is increasing. Whilst this may be due to a range of factors, including increase in service availability, it also raises cause for concern.

Beyond hospitalisations and deaths, AOD impacts a range of chronic health and mental health conditions. For example, alcohol increases the severity of a range of illnesses such as cardiovascular disease and diabetes, both of are also more prevalent among First Nations people (Gray et al. 2018). Similarly, cannabis use can impact respiratory health and the course of mental health conditions (Campeny et al. 2020). Harms associated with the ways people use drugs (for example, smoking, injecting) and harms experienced whilst intoxicated (for example, driving, unprotected sex) are also worthy of note, but hard to quantify. The GOANNA study identified that one quarter (27%) of respondents reported they were 'drunk or high' the last time they had sex, and 23% of those who reported injecting had shared needles/syringes (Ward et al. 2014). Importantly, and in considering AOD use through a SEWB lens, harms extend beyond the use of drugs and the period of intoxication – and includes the time and resources spent accessing, using and recovering from drugs and therefore associated with financial implications and time away from role responsibilities (for example, parenting and employment). In addition, there are harms related to accessing illicit drugs (including arrest and incarceration). In considering the harms of AOD on family, qualitative research has highlighted that First Nations people who experience harms related to drug use may rely more on family for support than non-Indigenous people, thereby extending the level of stress and the duty of treatment to family (Gendera et al. 2022; Reilly et al. 2020). Consistent with this and noted in the IHPF, problems caused by self or others drug use was described as a source of stress for 17% of respondents in the 2014–15 NATSISS (AIHW 2023a). AOD harms are complex and difficult to quantify – however as this brief discussion makes clear, the burden placed on families and communities is essential to acknowledge alongside harms to individuals and system costs.

Approaches to addressing AOD-related harm

Responses to AOD-related harm are formed by three interrelated pillars: supply reduction, demand reduction and harm reduction; and there exist successful First Nations community-led examples of all three pillars (Gray et al. 2000).

- Supply-reduction policies and strategies aim to reduce the availability of substances and can occur at the international, national, state and community level. Supply-reduction approaches include prohibition and policing of illegal drugs, and taxation and other price-control mechanisms for alcohol. (These approaches are not covered in detail in this review.)
- Harm-reduction policies and strategies aim to reduce the level of harm experienced by people who use AOD. These can include the provision of peer naloxone (Gray and Wilkes 2010) to prevent overdose deaths, needle and syringe programs and night patrols. These are also not addressed in detail in the current review.
- Demand reduction policies and strategies aim to reduce harm by reducing the demand for the substances. These includes both broad based prevention programs to reduce the uptake of harmful AOD use (such as health promotion campaigns and school-based education programs), and treatment programs to reduce demand for AOD among people who use (such as residential treatment, counselling and therapy, pharmacotherapy, brief intervention).

Comprehensive summaries of what works have been presented in numerous reviews (Butt et al. 2022; Butt 2019; Gray et al. 2000; Gray et al. 2014; Gray and Wilkes 2010; Heath et al. 2022; Krakouer et al. 2022; Snijder and Kershaw 2019; Wilkes et al. 2014). These summaries all highlight that there is an evidence gap around what works in a treatment sense, but, as highlighted by Dudgeon and colleagues (2021), much of this gap is related to Western concepts of evidence quality. Evidence indicates that to be most effective, supply, harm and demand reduction approaches need to be grounded in best practice. This includes First Nations self-determination and community control, actively acknowledging and incorporating existing community wisdom, cultural safety, and security, and being trauma informed (McGough et al. 2018; National Indigenous Drug and Alcohol Committee 2014).

Appendix B: Summary of reviewed strategies

Table B: National-level strategies and the focus on AOD, mental health and suicide

Title	Date range	First Nations people	Suicide	Mental health	Alcohol and other Drug	Comorbidities (AOD and Mental Health
National Drug Strategy[1]	2017–2026	Population	One mention	Priority population	Specific strategy	Priority population
National Alcohol Strategy[2]	2019–2028	Priority population	One mention	Priority population	Priority population	Priority population
National Tobacco Strategy[3]	2023–2030	Priority area	One mention	Priority consideration	Specific strategy	No specific mention
National Ice Action Strategy[4]	2015	Brief mention	No mention	Briefly mentioned as related	Specific strategy	One mention
The National Aboriginal and Torres Strait Islander Drug Strategy[5]	2014–2019	Specific strategy	Briefly mentioned	Identifies the importance of service provision	Specific strategy	No mention
National Mental Health and Suicide Prevention Agreement[6]	2022	Priority population	Specific strategy	Specific strategy	Priority population	Acknowledged
Fifth National Mental Health and Suicide Prevention Plan[7]	2017–2022	Priority area	Specific strategy	Specific strategy	Contributing factor	Briefly mentioned as related
National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social Emotional Wellbeing[8]	2017–2023	Specific strategy	Specific strategy	Specific strategy	Contributing factor	One mention
National suicide prevention strategy for Australia's health system[9]	2020–2023	Policy domain	Specific strategy	Specific strategy	Contributing factor	No mention
National Aboriginal and Torres Strait Islander Suicide Prevention Strategy[10]	2013	Specific strategy	Specific strategy	Specific strategy	Contributing factor	No mention

1 (Department of Health 2017)
2 (Department of Health 2019)
3 (DHAC 2023)
4 (Commonwealth of Australia 2015)
5 (Intergovernmental Committee on Drugs 2014)
6 (Commonwealth Government 2022)
7 (Commonwealth of Australia 2017b)
8 (Commonwealth of Australia 2017a)
9 (DHAC 2020)
10 (DHA 2013)

Appendix C: Summary of reviewed programs

Table C1: Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention[2]

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
Gippsland PHN Indigenous Dual Diagnosis Service (IDDS) https://gphn.org.au/what-we-do/programs/indigenous-dual-diagnosis-service/	Partnership between local ACCHO services and the Primary Health Network with emphasis on holistic, family centric practice and building workforce capacity to deliver culturally appropriate care. No further detail available of services provided.	Yes	Yes	Not specified	Psychological case-management Workforce capacity-building	No	N/A
'Bunjilwarra': developed and delivered by VAHS and YSAS with support from VACCHO (YSAS n.d.).	12-bed residential rehabilitation and healing program for First Nations young people. Bunjilwarra's model of care embeds a SEWB framework to address cultural, physical, and mental health through connections to land, culture, kinship, and community (Farrant and Weiss 2022).	Yes	Yes	Not specified	Psychological Psychosocial Cultural	Yes – partial	Bunjilwarra report that they reviewed the service model in 2021 and found that past and current clients reported positive SEWB outcomes across domains of body, mind, emotions, and culture (Farrant and Weiss 2022). Bunjilwarra use the Aboriginal Resilience and Recovery Questionnaire to effectively measure domains of SEWB pre- and post- engagement (Farrant and Weiss 2022). The evaluation report has not been published in full and further details are therefore not available for discussion.

(continued)

2 Note: Table C1 does not review either specific AOD or specific MH programs, as they are beyond the scope of the current review. Program approaches are described in Table C2.

Table C1 (continued): Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
Homeless Outreach Dual Diagnosis Service (HODDS) Homeless Health Care – Perth (Wood et al. 2022).	A pilot Outreach team working alongside a Primary Health team provides a collaborative response assisting people to access supports to manage their psychological, AOD-related and medical concerns in the community, and in accessible locations. This model aims to reduce or remove the barriers people experience through service siloing, allowing the complexities they experience to be addressed in service of improved overall health and wellbeing.	Yes	Yes	Not specified	Psychosocial Psychological Case management Primary health	Yes	Wood and colleagues (2022) presented an evaluation snapshot of the service which did not provide client outcomes overall but identified activity of the service and examples of positive outcomes for clients. Evaluation noted 536 episodes of care, with 24% of clients being First Nations, 70% male, primary diagnoses included PTSD, depression, and alcohol dependence. Case study evidence of positive outcomes included examples of effective and proactive management of health and mental health care leading to reduced severity of illness and length of hospital stay as well as relapse prevention and risk reduction.
Pilot AOD-MH brief intervention in remote primary health care (Nagel et al. 2009)	Two brief (1 hour) sessions including assessment and feedback; motivational care planning; and psychoeducation.	Yes	Yes	Not available	Psychological	Yes	(Nagel et al. 2009) conducted a brief randomised trial with 49 people in a remote community with AOD-MH comparing brief intervention with treatment as usual. Those receiving the brief intervention demonstrated greater and more sustained improvements in both mental health and alcohol dependence with a trend to reduced cannabis dependence.

(continued)

Table C1 (continued): Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
Ngarrang Gulinj-al Boordup https://www.each.com.au/service/aboriginal-health-wellbeing/ (EACH 2020)	Partnership between AHWT and mainstream dual-diagnosis service providing tailored, culturally responsive treatment for First Nations people.	Yes	Yes	Not specified	Psychological Psychosocial Cultural	No	N/A
Speak Out Dual-Diagnosis Program – Sydney https://www.weave.org.au/programs/speak-out-dual-diagnosis-program/ (Ryan and Gold 2021)	Mainstream youth (12–28 years) service providing dual-diagnosis counselling and case management and holistic care. Core elements of Speak Out are case work, counselling, group work, events, community development and Youth Advocates program. Speak Out describes its approach to working with young people as integrated and holistic, client-centred, non-judgemental, flexible in timing and collaborative with family members and carers where appropriate.	Yes	Yes	Not specified	Psychological Psychosocial	Yes	Evaluation (Ryan and Gold 2021) notes that three quarters of clients are First Nations, clients stay engaged with service for an average of 2.2 years. Clients are described as having complex needs including homelessness and unemployment in addition to co-occurring AOD-MH and psychological distress. Evaluation was qualitative and clients reported feeling safe and supported by the service, having increased knowledge and self-efficacy as well as improved linkages with external service providers. Evaluation noted several areas for improvement which were an increase in First Nation's staff members, retention of staff to prevent case worker turnover and the need for an increased capacity to deliver trauma counselling and support high end mental health concerns.

(continued)

Table C1 (continued): Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
Wada Wanti We can do this – online methamphetamine intervention. https://www.wadawanti.org.au/	Online intervention to support First Nations people to cut down or quit methamphetamine use	Yes	Yes	Not specified	Psychological Psychosocial Cultural	Yes	Results yet to be published (Reilly et al. 2019)
R U Ok – Stronger Together https://www.ruok.org.au/strongertogether	Suite of resources to support community capacity at asking questions about mental health, wellbeing, coping and suicide risk. Includes videos, posters, written stories, training packages.	Not specified	Yes	Yes	Psycho-education Capacity building	No	N/A
Strong and Deadly Futures – (Snijder et al. 2021b) https://strongdeadly.org.au/	School-based intervention (described in text). Based on an ecological model aimed at reducing AOD misuse and improving wellbeing for young people, specifically First Nations Young people. Was developed alongside First Nations young people and includes a computerised program that uses an illustrated story to convey prevention messages, combined with classroom activities facilitated by the teacher.	Yes	Yes	Not specified	Psycho-educational Cultural	Yes – initial	Research has demonstrated feasibility and acceptability of the intervention among First Nations young people (Routledge et al. 2022). Randomised controlled trial has commenced but outcomes are yet to be published.

(continued)

Table C1 (continued): Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
Derbarl Yerrigan – Weirn Mooditj https://dyhs.org.au/programs/mental-health	Counselling program within an ACCHO in Perth metro region; specifies working with both mental health and AOD difficulties.	Yes	Yes	Not specified	Psychological Supports linkages and connection to health service, AOD service and other services required by clients.	No	N/A
Moorditj Djerpin Wirrin – Richmond Wellbeing https://www.rw.org.au/moorditj-djerpin-wirrin/	Aboriginal specific outreach service providing dual diagnosis support through a lens of strong spirit and kinship. Staffed by First Nations people, auspiced by a mainstream NGO.	Yes	Yes	Not specified	Psychosocial Peer support Cultural Community based (home visiting) Supports family members	No	N/A
Culture Pathways Program – Wardliparingga Aboriginal Health Equity team – South Australian Health and Medical Research Institute (SAHMRI) Brodie et al., 2021	Case management approach utilising holistic screening of SEWB (including social domains), strength-based case management, goal setting and service connections. Includes supervision and support for case workers.	Not specified	Yes	Not specified	Psychosocial Case management	No	N/A

(continued)

Table C1 (continued): Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
Bega Garnbirringu Health Service – SEWB program https://bega.org.au/social-and-emotional-wellbeing/social-emotional-wellbeing/	AMS in the Kimberley region providing general counselling, inclusive of AOD use difficulties.	Yes	Yes	Not specified	Psychological Psychosocial	No	N/A
SWAMS – Kaat Darabiny https://www.swams.com.au/service/mental-health/	ACCHO service in southwest WA offering specified dual diagnosis counselling with an additional focus on family support as well as individual counselling. From 5 years up Connects to additional detoxification and rehabilitation support services where necessary.	Yes	Yes	Not specified	Psychosocial Psychological	No	N/A
AOD Youth Wellbeing Program – Aboriginal Alcohol and Drug Council	Confidential and voluntary, specialist service for young Aboriginal and non-Aboriginal people aged between 12 to 25 with AOD and/or mental health concerns. Identifies that clients may also be experiencing complex issues such as homelessness, domestic violence, injecting, pregnancy, and thoughts or actions of self-harm or suicide.	Yes	Yes	Yes	Psychological Psycho-educational Psychosocial Diversion activities	No	N/A

(continued)

Table C1 (continued): Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
*The Yiriman Project (Palmer 2013)	Assists local 'at-risk' Indigenous youth in a culturally appropriate manner (culture camps). Develops culturally appropriate. strategies to address self-harm and suicide among young people in the Fitzroy Valley.	Not specified	Not specified	Yes	Cultural	Yes	100% of young people on trips are involved in deep cultural immersion, it encourages leadership with 6 young people participants taking up a mentoring role, and 3–4 generations share stories on every trip. Program exceeded expectations with 40% more participants in community events in 2011. Evidence that Yiriman is providing important opportunities to youth in the Fitzroy Valley
*iBobbly (Joseph et al. 2017)	A mobile app for SEWB focussed on First Nations young people aged 15 years and above. An Acceptance and Commitment Therapy-based interactive and co-designed mental health intervention. App included three sequentially delivered content modules and self-assessments.	Not specified	Yes	Yes	Psychological Psycho-education	Yes	Randomised control trial Participants showed a statistically significant reduction in rates of depression and psychological distress. No significant changes on suicidality or impulsivity An eHealth app developed in partnership with Indigenous communities was accepted and promoted by the target community and improved mental health symptoms

(continued)

Table C1 (continued): Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
*Red Dust Healing (Jo Thompson Consulting 2019)	Cultural healing program in the form of workshops with specialised facilitators, written from a First Nations perspective and targeted toward Indigenous adults and families	Not specified	Yes	Yes	Cultural Psychological Psycho-educational	Yes	The program has a positive impact on the lives of interviewees. Increased ability to express deep-seated emotions, improved capacity to deal with grief and loss, and greater self-awareness. More than 55% of respondents said the program had encouraged and supported them to safely express deep-seated negative emotions. More than one-third reported increased self-awareness and clarity. Many respondents reported a 'ripple effect' of positive experiences extending to other family members and community.
*Deadly Thinking – 40 rural and remote locations. (Snodgrass et al. 2020)	Tailored emotional health and wellbeing workshop designed for First Nations people in rural and remote areas. Aims to increase emotional health and wellbeing literacy, improve help-seeking behaviours and decrease stigma using a two-day training 'train-the -trainer' workshop for First Nations community members.	Not specified	Yes	Not specified	Capacity building Psycho-educational Psychological	Yes	Most common source of stress for workshop participants were family worries (57%), loss of culture (41%) and racism (41%) For community participants, the key stressors were family worries (59%), racism (39%) and job worries (36%) Participants reported significantly greater help-seeking intentions towards partners, friends, parents, community leaders, emotional health professionals and family doctors following the workshop.

(continued)

Table C1 (continued): Review of prevention and intervention programs which include AOD and mental health and/or suicide prevention

Program	Program description	AOD inclusive	Mental health inclusive	Suicide inclusive	Program approach	Evaluation publicly available	Evaluation findings
							A total of 89.8% of participants reported the workshop as 'helpful' (highest score on a three-point scale)
*Stronger Smarter Yarns for Life – QLD, ACT, NT (Almeda et al. 2019)	Suicide prevention program developed with and for First Nations people using a 'yarning type' approach. Focussed on improving health literacy.	Not specified	Not specified	Yes	Psycho-educational Cultural Capacity-building	Yes	All participants reported that they had increased their knowledge about this topic. Participants were significantly more likely to engage in a yarn about mental health, to work out the practical steps needed to help a person at risk and take action, and to refer the person for help
*Yuendumu Warlpiri Youth Development Aboriginal Corporation programs, including the Warra-Warra Kan – Walpirri region. (Shaw 2015)	A counselling and mentoring service that combines formal, tertiary counselling skills with a local Warlpiri approach to target high-risk behaviours in Warlpiri people aged 12–25 years. Includes case management and afterhours crisis support. Focus on sustainable change through employment and reduction in risk behaviours.	Yes	Yes	Yes	Psychological Psychosocial Cultural	Yes	Evaluation using interviews and case studies. (Shaw 2015) Highlights significant increases in employment and reductions in risk taking behaviour.

Note: * indicates table adapted from summary in Hunter et al., 2022

Table C2: Program approaches

Approach type	How the intervention works
Psychological	Focusses on individual internal processes such as coping skills, emotional regulation, problem solving and distress tolerance. May include specific modalities and/or family system (specified if so).
Psychosocial	Focusses on person-in-context factors such as housing, transport, education, employment, and legal difficulties.
Psychoeducational	Focusses on provision of information to inform awareness of health and social consequences of personal choices
Cultural	Embedded in a cultural approach to healing and SEWB
Capacity building	Aims to increase the skills of the community or service staff in responding to issues.

Appendix D: Summary of AOD-MH best practice frameworks

Quality Service Delivery

	Non-Indigenous		First Nations-specific			
Core components	International review of principles of practice for AOD-MH care (Fisher et al. 2022)	National review of AOD-MH care Deady et al. (2015)	Comorbidity Action Network recommendations from client and advocate experiences (Hepsibah 2015)	Recommendations from (Lee et al. 2014) research with women experiencing	Comorbidity Guidelines – Aboriginal client's section (Marel et al. 2022)	AMSANT Framework for the delivery of AOD-MH care for First Nations people in the Northern Territory (AMSANT 2011)
Overarching Service Delivery Principles			System wide recognition of comorbidity		Connection to community control	Central component as ACCHO
			Recognition of comorbidity as core business			
			Acknowledge the social determinant of health			
Service Funding			Keeping the momentum (stable funding)			Funding required to implement full frameworks

(continued)

	Non-Indigenous		First Nations-specific			
Workforce	Professional development and competence of the workforce		Professional development	Supervision and support for the workforce	Professional developing including cultural competence for staff.	Increase in family support workers, nurses, psychologists, psychiatrists, allied health (Multidisciplinary)
					Retention of Aboriginal staff	
					Invest in staff stability	
'No wrong door' – comorbidity as a cross-sector responsibility	No wrong door	No wrong door	No wrong door (stop the referral runaround)			Referral at any entry point including self-referral and from screening
Flexible Service Delivery Frame works				Flexibility	Flexibility around appoints	
					Outreach availability	
				Childcare capacity	Childcare capacity	
				Ease of access to service		

(continued)

	Non-Indigenous		First Nations-specific			
Recognition of complex needs in service delivery		Assertive care to prevent treatment drop out				
			No punitive approaches to non-attendance		Focus on making appointments easy to attend	
			Full suite of programs that prevent escalation of ill-health and hospital admission			
						Rehabilitation framework
Community Engagement	Build trust with client's community				Relationship with community	Include community development framework
Active promotion of service			Information to community	Service promotion	Service promotion to community	
Interagency collaboration			Interagency collaboration		Collaboration	
Consumer engagement in service design			Consumer consultation			
Build in continuity of care	Continuity of care	Continuity of care: discharge and referral to be followed up.	Continuity of care			Use of primary health care as a hub for ongoing care
Incorporate care to families in service planning	Involve families			Involve families		Involve families and have family workers

(continued)

	Non-Indigenous		First Nations-specific			
Ensure ease of access to services		Screening at all services (AOD, MH and primary care)				
			Reduce referral confusion	Simplicity of referral process		
Service improvement measure		Evaluate				

Quality Services Delivered

	Non-Indigenous		First Nations-specific			
Cultural safety			Culturally appropriate care	Culturally safe care	Culturally safe	Cultural safety through embedding in ACCHO
Services provided		Care coordination		Care coordination		Clinical pathways
		Appropriate assessment				
		Clinically indicated best practice care including psychosocial support, counselling, and pharmacological support for both in the same intervention (that is, one doctor prescribing for both conditions)	Evidence based MH and AOD and comorbidity offerings.			Stepped care: screening and brief intervention (SBI), care plans which involve community, family, services and individual

(continued)

	Non-Indigenous		First Nations-specific			
	Patient centred care: tailor treatment, encourage autonomy and shared decision making, collaborative treatment goals	Focus on distress of client not on diagnosis		Psychosocial support included		Shared care with employment/ education/housing and acute settings
	Holistic care					
	Recovery oriented care					
	Trauma informed care		Recognition of trauma		Trauma informed care	
			Age-appropriate care			
Focus on the therapeutic relationship between client/ family and clinician/ workplace	Strong therapeutic relationship	Development of good rapport	Trust	Trust	Trust and rapport	
Peer support	Involve peer support			Involve peer support	Involve peer support and peer support groups	

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Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ADHD	attention deficit hyperactivity disorder
AHWT	Aboriginal Health and Wellbeing Team
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
ANCD	Australian National Council on Drugs
AOD	alcohol and other drug
AOD-MH	alcohol and other drug – mental health
ASD	autism spectrum disorders
ASSAD	Australian Secondary Survey Alcohol and Drugs
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Project
CAN	Comorbidity Action in the North
CBT	cognitive behaviour therapy
CRA	Community Reinforcement Approach
CRAFT	CRA Family Training
DSM, DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DUMA	Drug Use Monitoring in Australia
DV	domestic violence
GOANNA (or Goanna)	An Australian survey of knowledge, risk practices and health-service access for Sexually Transmissible Infections (STIs) and Blood Borne Viruses (BBVs) among young Aboriginal and Torres Strait Islander people
HHC	Homeless Healthcare
HODDS	Homeless Outreach Dual Diagnosis Service
HOPE	A support program dedicated to **H**earing **O**ther **P**eoples **E**xperiences
IHPF	Indigenous Health Performance Framework
IRIS	Indigenous Risk Impact Screen
LGBTQIA	lesbian, gay, bisexual, transgender, queer/questioning (one's sexual or gender identity), intersex, and asexual/aromantic/agender
MH	mental health
NACCHO	Aboriginal Community Controlled Health Organisation
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSIPDS	National Aboriginal and Torres Strait Islander Peoples Drug Strategy
NGO	non-government organisations
NIDAC	National Indigenous Drug and Alcohol Committee

NSSI	non-suicidal self-injury
NSW	New South Wales
NT	Northern Territory
NTNER	Northern Territory National Emergency Response
OCD	obsessive-compulsive disorder
PHN	Primary Health Network
PTSD	post-traumatic stress disorder
RHN	Rural Health Network
SAHMRI	South Australian Health and Medical Research Institute
SBI	Screening and brief intervention
SEWB	social and emotional wellbeing
THRIVE	A whole-of-health counselling program that is 'Trauma-informed, Holistic, Recovery-oriented, Integrated Care, Voluntary, and Engaging families'
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAHS	Virtual Allied Health Service / Victorian Aboriginal Health Service
WA	Western Australia
YSAS	Youth Support + Advocacy Service

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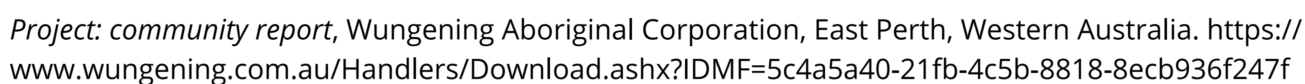

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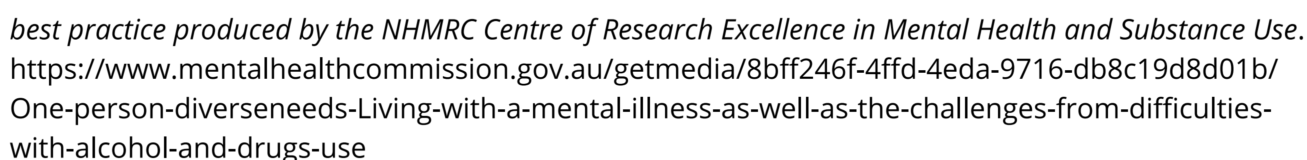

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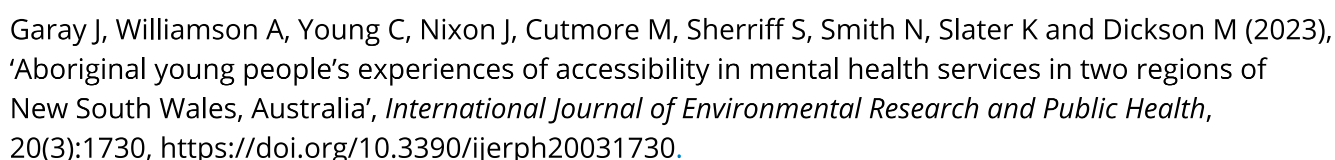

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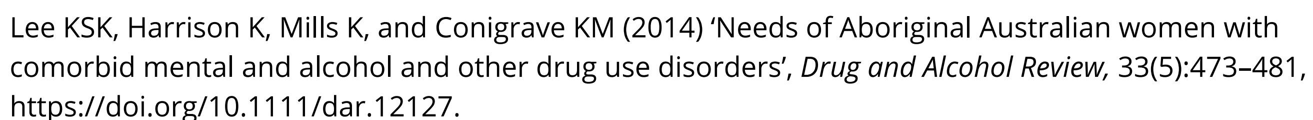

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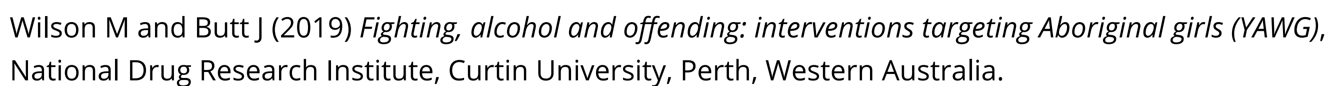

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Stronger evidence,
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