Turning Point

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SUBMISSION: ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Turning Point

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easternhealth

Submission to the Royal Commission into Victoria's Mental Health System

About Turning Point

Turning Point is a national addiction treatment centre, dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs and gambling, integrated with world-leading research and education. Turning Point is auspiced by Eastern Health and is formally affiliated with Monash University.

Turning Point reduces the harms caused by alcohol, drugs and gambling and promotes recovery through integrated activity that

1. Increases access to support and evidence-based practice through the use of innovative technologies.
2. Delivers high quality evidence-based practice.
3. Supports healthcare professionals nationally and internationally to provide high quality evidence-based practice.
4. Delivers workforce and community education programs to a broad range of populations
5. Undertakes policy and practice relevant research and provides key national population level data.
6. Provides policy advice to state and federal governments as well as expert comment.

Turning Point's Recommendations for consideration by the Royal Commission

Addressing stigma and promoting help-seeking

- Develop public health campaigns that counter persistent negative stereotypes about consumers with alcohol and other drug (AOD) use disorders, as well as community myths about addiction that act as barriers to accessing treatment.
- Widely promote free, confidential 24/7 helpline and online services for AOD use disorders as well as stories of recovery.
- Implement school-based intervention programs that build mental health literacy skills among young people and facilitate early help-seeking.

Building workforce capacity in managing alcohol and other drug use and other co-occurring mental illness

- Improve AOD training opportunities, including undergraduate and postgraduate clinical placements for doctors, nurses, psychologists, allied health professionals and paramedics.
- Address structural and organisational barriers to providing alcohol and other drug use disorder assessment and treatment by ensuring adequate workplace support, career development, leadership, and mentoring.
- Build capacity in the AOD sector to enable the management of co-occurring mental illness by increasing the availability and accessibility of postgraduate training opportunities in addiction psychiatry, psychology, and mental health nursing through accredited training posts.
- Invest in addiction medical specialist and accredited training positions within each public health service to ensure appropriate treatment for individuals with complex alcohol and other drug use and co-occurring mental illness.

Developing suicide prevention strategies for at-risk populations

- Develop suicide prevention responses that target consumers with AOD use disorders and/or those on long-term pharmaceutical opioids.
- Ensure AOD services are adequately skilled to identify individuals at risk of suicide, and that prevention and intervention strategies are sufficiently resourced within these settings.
- Utilise coded ambulance data, and other timely administrative datasets, to monitor emerging trends, magnitude, patterns, characteristics, geographic and temporal mapping of acute mental health and self-harm.

Building integrated service responses for co-occurring alcohol and other drug use and other mental ill-health

- Promote service integration and continuity of care across AOD and mental health services, by ensuring treatments for mental illness and co-occurring alcohol and other drug use disorders are provided at the same service (as opposed to in parallel or sequentially at separate services).
- Expand access to (and duration of) programs that provide evidence-based psychological treatment for consumers with complex co-occurring mental illness and alcohol and other drug use disorders.
- Ensure that integrated care is included within service specifications of commissioning bodies, is adequately funded, and spans the entire health system (including hospitals and emergency services).
- Develop a new integrated model of care for consumers with the most severe mental illness and alcohol and other drug use disorders.

Establish robust governance of AOD treatment responses

- Appoint a Chief Addiction Medicine Specialist, analogous to the Victorian Office of the Chief Psychiatrist, to guide and govern Victorian AOD practice.
- Establish an expert panel (aligned to Safer Care Victoria) to review complex pharmaceutical opioid and other drug dependence, as well as provision of oversight for critical incidents or near misses.

Responses to the Royal Commission's questions[1]

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Over the past two decades, there has been considerable success in increasing the community's understanding of anxiety and depression, through the work of government, Beyond Blue and others, which has led to reductions in stigma and increased levels of help-seeking and community support[2,3]. However, despite alcohol and other drug use disorders being categorised alongside other forms of mental illness within international diagnostic classification systems (e.g. the World Health Organisation's International Statistical Classification of Diseases (ICD); the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) for many decades, alcohol and other drug use disorders remain highly stigmatised and misunderstood within the community. It is therefore imperative that they are considered through the lens of a Royal Commission into Victoria's Mental Health System, to ensure that they receive similar levels of critical review and investment in terms of public policy and system design, funding allocations, service models, workforce planning, research initiatives and treatment responses.

Stigma significantly delays help-seeking, treatment and recovery

Research shows that stigma can lead to substantial delays in help-seeking (up to two decades for alcohol and other drug use disorders), as well as treatment noncompliance, reduced self-esteem, social exclusion, discrimination, and relapse[4,5]. It is therefore not surprising that the costs associated with alcohol and other drug -related harms to Australian society are estimated to exceed $55.2 billion annually, due to impacts on healthcare, crime, productivity and road crashes[6]. Individuals with alcohol and other drug use disorder and/or co-occurring mental illness face considerable stigma and a range of structural barriers to accessing treatment[7]. Indeed, the prevailing community thinking about addiction is that it is a moral condition that is self-induced, and this damaging paradigm is also applied to consumers with mental illness and co-occurring alcohol and other drug use.

Protracted delays in treatment-seeking directly contribute to poor clinical outcomes[8,9], including recurrent relapses and multiple complications (e.g. poor physical and mental health, fractured relationships and social instability). This highlights the importance of creating an accessible and effective treatment system for people who need treatment for their alcohol and other drug use, as well as earlier intervention for this group once problems manifest.

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[1] This submission does not include responses to questions 5, 6, 7 and 8 for the Royal Commission into the Victorian Mental Health System.

[2] Jorm, Christensen, and Griffiths, 'Changes in Depression Awareness and Attitudes in Australia: The Impact of Beyondblue: The National Depression Initiative', *Australian and New Zealand Journal of Psychiatry,* 40/1 (2006), 42-46.

[3] Mok et al., 'Stimulating Community Action for Suicide Prevention: Findings on the Effectiveness of the Australian Ru Ok? Campaign', *International Journal of Mental Health Promotion,* 18/4 (2016), 213-21.

[4] Balhara et al., 'Stigma in Dual Diagnosis: A Narrative Review', *Indian Journal of Social Psychiatry,* 32/2 (2016), 128-133.

[5] Evans-Lacko and Thornicroft, 'Stigma among People with Dual Diagnosis and Implications for Health Services', *Advances in Dual Diagnosis,* 3/1 (2010), 4-7.

[6] Collins and Lapsley, *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05* (Department of Health and Ageing Canberra, 2008).

[7] Priester et al., 'Treatment Access Barriers and Disparities among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review', *Journal of Substance Abuse Treatment,* 61 (2016), 47-59.

[8] Dennis et al., 'The Duration and Correlates of Addiction and Treatment Careers', ibid.28/2 (2005), S51-S62.

[9] Dawson et al., 'Estimating the Effect of Help-Seeking on Achieving Recovery from Alcohol Dependence', *Addiction,* 101/6 (2006), 824-34.

However, delivery of interventions within primary and acute care settings remains extremely low[10], even when alcohol and other drug use is directly related to the presentation, and is associated with higher rates of re-presentation and/or re-injury post-discharge[11,12]. Indeed, there are many primary care settings within Victoria that refuse to treat consumers with alcohol and other drug use disorders, even if they present with other mental illness, as they see this group as too difficult or complex to manage.

Failure to provide consumers with effective and timely intervention for their alcohol and other drug use disorder is a critical missed opportunity to engage a typically difficult-to-reach population at an earlier stage[13], and is symptomatic of a healthcare service system where AOD treatment is often siloed and ignored. It is also consistent with evidence that healthcare professionals feel under-skilled in managing alcohol and other drug use disorders, and actively discriminate against this population[14].

While engagement between health services and consumers is improving, persistent negative stereotypes about consumers with alcohol and other drug use disorders can influence how they are treated within the primary care, acute health, and mental health systems. These include the belief that individuals with AOD use disorders lack motivation, and are likely to be violent and aggressive[9]. This view has been reinforced by expensive advertising campaigns in recent years that depict alcohol and other drug users as either indolent, volatile and/or dangerous, while neglecting discussion of the positive responses to treatment experienced by the majority of alcohol and other drug users.

A recently released national study of ambulance responses to men's mental health (*Beyond the Emergency*) found that paramedics were less likely to correctly identify mental illness when they co-occurred with alcohol or other drug use. Moreover, they were more likely to hold stigmatising attitudes towards people experiencing mental illness when alcohol and other drug use was present, particularly the belief that these individuals were dangerous and unpredictable. This finding is consistent with negative societal attitudes towards individuals with alcohol and other drug problems, and is likely to act as a barrier to the provision of appropriate, high-quality support by frontline emergency services to those with co-occurring mental illness[15].

The need to address stigma through informed public campaigns and clinical training placements

Public discourse and policy typically separates alcohol and other drug use disorders from other mental health conditions, subserving and perpetuating stigma. This segregation makes it difficult for those with co-occurring issues to seek effective professional help for their problems, as a lack of

[10] Muench, 'Screening and Brief Intervention Practice Systems and Implementation', *Addressing Unhealthy Alcohol Use in Primary Care* (Springer, 2013), 171-88.
[11] Gacouin et al., 'At-Risk Drinking Is Independently Associated with Icu and One-Year Mortality in Critically Ill Nontrauma Patients', *Critical Care Medicine,* 42/4 (2014), 860-67.
[12] Clark et al., 'Alcohol Screening Scores and the Risk of Intensive Care Unit Admission and Hospital Readmission', *Substance Abuse,* 37/3 (2016), 466-73.
[13] Van Boekel et al., 'Stigma among Health Professionals Towards Consumers with Substance Use Disorders and Its Consequences for Healthcare Delivery: Systematic Review', *Drug and Alcohol Dependence,* 131/1-2 (2013), 23-35.
[14] Teesson et al., 'Alcohol-and Drug-Use Disorders in Australia: Implications of the National Survey of Mental Health and Wellbeing', *Australian & New Zealand Journal of Psychiatry,* 34/2 (2000), 206-13.
[15] Turning Point, 'Beyond the Emergency: A National Study of Ambulance Responses to Men's Mental Health', (Richmond, Victoria, 2019).

integrated strategies and funding models results in commonly comorbid conditions being triaged and treated by separate departments and workforces[16].

In Victoria, this separation of services has developed in the decades following the deinstitutionalisation of the mental health system and recommissioning of services. Previously, mental health and AOD treatment had been integrated within large public psychiatric hospitals, which provided training opportunities for health workforces as a core part of their career development. Following deinstitutionalisation, acute mental health services were integrated with hospitals, while AOD services were recommissioned to non-government organisations[17].

While the mental health system has been configured to allow for training of health workforces through undergraduate and postgraduate training placements and university curricula, the recommissioned AOD system was not supported to provide clinical placements for undergraduate and postgraduate students. Thus, for the past 20 years, nurses, doctors, psychologists and allied health workers trained in Victoria have had limited access to accredited AOD training placements and supervision, meaning that the bulk of the Victorian health workforce have limited skills and knowledge in assessing and managing alcohol and other drug use disorders.

This knowledge and skills gap within the health system has been further exacerbated by the absence of funding for a Victorian tertiary specialist workforce, with no statewide investment in addiction medical specialists and associated addiction training positions for general practitioners, psychiatrists and physicians. The resulting knowledge gap is at the core of why individuals with alcohol and other drug use disorder and/or co-occurring mental illness are highly stigmatised and face multiple barriers to effective care.

As stigma and discrimination are some of the biggest problems facing people with alcohol and other drug disorders and mental illness, education for the general community, families and employers is vital for recovery. Recent Australian campaigns targeting suicide, depression and anxiety have increased community awareness of mental illness and had a positive impact on attitudes towards seeking help[18,19]. This is a promising outcome, but efforts need to broaden, as campaigns that intentionally work towards reducing stigma are currently lacking in the AOD space.

Campaigns to reduce alcohol and other drug -related stigma should be evidence-based and developed in consultation with consumer organisations, and avoid drug prevention messages[20]. They should also promote the benefits of early help-seeking and treatment (including the availability of 24/7 helpline support) and address community myths about addiction (such as no-one improves and treatment does not work). As alcohol and other drug use disorders are less likely to be considered as mental illness and more likely to be considered self-induced compared to other mental health conditions[21,22], focusing on social inclusion/human rights and emphasising that people are not to blame for their problems may be most effective in reducing prejudice[23].

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[16] Lubman, Hides, and Elkins, 'Dual Diagnosis: Dual Disorders or a Dual System?', *Drugs and Public Health: Australian Perspectives on Policy and Practice* (Oxford University Press, 2008), 127-38.
[17] Whiteford and Buckingham, 'Ten Years of Mental Health Service Reform in Australia: Are We Getting It Right?', *Medical Journal of Australia,* 182/8 (2005), 396-400.
[18] Jorm, Christensen, and Griffiths, 'Changes in Depression Awareness and Attitudes in Australia: The Impact of Beyondblue: The National Depression Initiative', *Australian and New Zealand Journal of Psychiatry,* 40/1 (2006), 42-6.
[19] Mok et al., 'Stimulating Community Action for Suicide Prevention: Findings on the Effectiveness of the Australian Ru Ok? Campaign', *International Journal of Mental Health Promotion,* 18/4 (2016), 213-221.
[20] Lancaster, Seear, and Ritter, 'Reducing Stigma and Discrimination for People Experiencing Problematic Alcohol and Other Drug Use: Final Report', (A report for the Queensland Mental Health Commission, 2017).
[21] Schomerus et al., 'The Stigma of Alcohol Dependence Compared with Other Mental Disorders: A Review of Population Studies', *Alcohol and Alcoholism,* 46/2 (2010), 105-12.

2. *What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?*

Similar to other mental health conditions, alcohol and other drug use disorders commonly co-occur with other mental illnesses. Indeed, it has been estimated that more than one-third of individuals with an AOD use disorder in the community have at least one additional co-occurring mental illness, and among those in treatment for alcohol and other drug use disorders, the rate of comorbidity is considerably higher[24], estimated to range between 70%-90%.

Conversely, the prevalence of alcohol and other drug use disorders in people attending mental health services ranges between 11%-70%[25]. Depression, anxiety (including post-traumatic stress disorder) and borderline personality disorder are common among people attending AOD treatment services, with high rates of alcohol and other drug use disorder also evident among individuals accessing mental health services, particularly among those with serious mental illness, such as bipolar disorder and schizophrenia[26,27,28,29,30].

There are numerous factors that are believed to underlie this comorbidity. Some individuals with mental illness may self-medicate with alcohol or other drugs in an attempt to manage or cope with their symptoms. Regular alcohol and other drug use can also lead to mental illness, either directly (e.g. through neurochemical changes) or indirectly (e.g. through exposure to traumatic situations, or the creation of ongoing problems with finances, relationships, and/or physical health). There is also evidence that shared vulnerabilities can underlie the development of both AOD use and mental health problems. These can include common genetic factors, as well as environmental triggers (e.g. childhood abuse, trauma or poverty)[31,32].

Receiving a different response from mental health providers can lead to individuals with co-occurring alcohol and other drug use disorders and other mental illness being disadvantaged when seeking help. Outcomes can include consumers being turned away by mental health services[33,34], or

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[22] Angermeyer and Dietrich, 'Public Beliefs About and Attitudes Towards People with Mental Illness: A Review of Population Studies', *Acta Psychiatrica Scandinavica,* 113/3 (2006), 163-79.
[23] Clement et al., 'Mass Media Interventions for Reducing Mental Health-Related Stigma', *Cochrane Database of Systematic Reviews,* 7 (2013).
[24] Slade et al., '2007 National Survey of Mental Health and Wellbeing: Methods and Key Findings', *Australian and New Zealand Journal of Psychiatry,* 43/7 (2009), 594-605.
[25] Deady et al., 'Comorbid Mental Illness and Illicit Substance Use: An Evidence Check Review', (NSW Mental Health and Drug and Alcohol Office: Sax Institute, 2015).
[26] Kranzler and Rosenthal, 'Dual Diagnosis: Alcoholism and Co-Morbid Psychiatric Disorders', *The American Journal on Addictions,* 12 (2003), s26-s40.
[27] Xiong Lai et al., 'Prevalence of Comorbid Substance Use, Anxiety and Mood Disorders in Epidemiological Surveys, 1990–2014: A Systematic Review and Meta-Analysis', *Drug and Alcohol Dependence,* 154 (2015), 1-13.
[28] Nesvåg et al., 'Substance Use Disorders in Schizophrenia, Bipolar Disorder, and Depressive Illness: A Registry-Based Study', *Social Psychiatry and Psychiatric Epidemiology,* 50/8 (2015), 1267-76.
[29] Mortlock, Deane, and Crowe, 'Screening for Mental Disorder Comorbidity in Australian Alcohol and Other Drug Residential Treatment Settings', *Journal of Substance Abuse Treatment,* 40/4 (2011), 397-404.
[30] Regier et al., 'Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse: Results from the Epidemiologic Catchment Area (Eca) Study', *JAMA,* 264/19 (1990), 2511-18.
[31] Mueser, Drake, and Wallach, 'Dual Diagnosis: A Review of Etiological Theories', *Addictive Behaviors,* 23/6 (1998), 717-34.
[32] Kendler et al., 'The Structure of Genetic and Environmental Risk Factors for Common Psychiatric and Substance Use Disorders in Men and Women', *Archives of General Psychiatry,* 60/9 (2003), 929-37.
[33] Roberts and Maybery, 'Dual Diagnosis Discourse in Victoria Australia: The Responsiveness of Mental Health Services', *Journal of Dual Diagnosis,* 10/3 (2014), 139-44.
[34] Searby, Maude, and Mcgrath, 'The Experiences of Clinicians Caring for Older Adults with Dual Diagnosis: An Exploratory Study', *Issues in Mental Health Nursing,* 38/10 (2017), 805-11.

being told to address their alcohol and other drug use before any mental health treatment can be offered, even when other services do not have the skills or capacity to offer suitable treatment.

Accredited undergraduate and postgraduate training placements within AOD services, as well as targeted education and training are likely to aid health professionals in responding appropriately to co-occurring alcohol and other drug use disorders. Effective strategies to change individual clinician behaviour include regular educational meetings, educational outreach, prompts and reminders, and auditing and feedback[35]. However, it is important to note that the effectiveness of these strategies is likely to be influenced by the prevailing organisational culture. Workforce development approaches should therefore have a 'systems focus' that targets organisational and structural factors in addition to addressing the education and training of individual workers. This perspective emphasises the importance of ensuring adequate workplace support, career development (including clinical supervision), leadership and mentoring, among other key areas[36].

Additional training opportunities may be of particular benefit for general practitioners, as they are typically the first (and sometimes only) point of call for people with alcohol and other drug use disorder and co-occurring mental illness, and are well-placed to aid in early intervention efforts. However, training GPs in opioid pharmacotherapy has been far more challenging than engaging this group in mental health treatment. Nevertheless, any attempt to address the community impact of alcohol and other drug use disorder and co-occurring mental illness should aim to improve its diagnosis and management within general practice. Ideally, this would involve building on knowledge and skills that are taught at the undergraduate level, and reinforced during intern and fellowship training.

While alcohol and drug training was implemented across medical schools in Australia in the 1990s, many universities lack the funding to continue offering this material in depth, which warrants review[37], especially given the prevalence and impact of these disorders in the community. Active learning (e.g. interactive case studies and clinical scenarios) and authentic tasks (e.g. tasks that involve the experiences of general practitioners already involved in AOD work) should be prioritised over the passive dissemination of information[38]. However, it is increasingly recognised that efforts need to go beyond simply offering individualised education and training programs. In general practice, this may involve addressing structural barriers in order to increase confidence and perceptions of role legitimacy, and reducing isolation and perceptions of a lack of specialist support[39].

While early treatment is widely recognised as a protective factor for alcohol and other drug use and mental illness[40], adolescents are often reluctant to seek professional help, preferring to rely on their

[35] Bywood, Lunnay, and Roche, *Effective Dissemination: A Systematic Review of Implementation Strategies for the Aod Field* (National Centre for Education and Training on Addiction, 2008).
[36] Roche and Nicholas, 'Workforce Development: An Important Paradigm Shift for the Alcohol and Other Drugs Sector', *Drugs: Education, Prevention and Policy,* 24/6 (2017), 443-54.
[37] Lubman et al., 'Health Professionals' Recognition of Co-Occurring Alcohol and Depressive Disorders in Youth: A Survey of Australian General Practitioners, Psychiatrists, Psychologists and Mental Health Nurses Using Case Vignettes', *Australian & New Zealand Journal of Psychiatry,* 41/10 (2007a), 830-35.
[38] Roche, Hotham, and Richmond, 'The General Practitioner's Role in Aod Issues: Overcoming Individual, Professional and Systemic Barriers', *Drug and Alcohol Review,* 21/3 (2002), 223-30.
[39] Skinner et al., 'Health Professionals' Attitudes Towards Aod-Related Work: Moving the Traditional Focus from Education and Training to Organizational Culture', *Drugs: education, prevention and policy,* 16/3 (2009), 232-49.
[40] Lubman et al., 'Intervening Early to Reduce Developmentally Harmful Substance Use among Youth Populations', *Medical Journal of Australia,* 187/S7 (2007b), S22-S25.

peers for support[41]. However, research indicates that many young people demonstrate poor mental health literacy[42], as indicated by a limited ability to recognise specific disorders, knowledge and beliefs about help-seeking that act as barriers to seeking professional help, stigma, fears about lack of confidentiality, reliance on oneself and concerns about helper characteristics[43]. These help-seeking beliefs and preferences highlight the importance of building the mental health literacy and help-seeking skills of adolescents, including ensuring that they know when and how to assist their peers to access support.

Importantly, by equipping young people with the skills to help their peers, there is strong evidence that such knowledge also assists young people to seek professional help for themselves, ensuring timely access to effective care. In this regard, school-based intervention programs have been found to play an important role in facilitating early help-seeking for mental illness. For example, a recent NHMRC-funded Victorian trial of the *MAKINGtheLINK* intervention[44] demonstrated that the program effectively improves the help-seeking behaviour, attitudes and intentions of young people experiencing mental illness, and equips them to not only support their peers, but also themselves. Programs such as *MAKINGtheLINK* make a significant contribution to early intervention and prevention efforts by equipping adolescents with effective help-seeking skills, and highlight the need for such programs to be embedded within the Victorian school curriculum.

3. What is already working well and what can be done better to prevent suicide?

Alcohol and other drug use presents one of the strongest modifiable risk factors for suicide prevention. The absence of strategies to specifically address substance use represents a critical missed opportunity in suicide prevention policy. As highlighted in a recent article that Turning Point published in the Australian and New Zealand Journal of Psychiatry[45], the risk of suicidal behaviour is particularly elevated in those diagnosed with an alcohol and other drug use disorder. Globally, alcohol and other drug use disorders were responsible for almost one-fifth of suicide-related disability-adjusted life years in 2010, with 13.3% of this burden attributable to alcohol use disorders alone[46], second only to depression. Although research consistently estimates that between one-quarter to one-third of suicide decedents meet diagnostic criteria for alcohol use disorder, there has been little conversation regarding the potential value of policies aimed at reducing alcohol availability as a way of further reducing the suicide rate in Australia. In terms of other use disorders, the risk of suicide in people with other drug use disorders, relative to the general population is also substantial, ranging from 6.9 (opioid dependence), to 8.9 (stimulant dependence) and as high as 16.9 (cocaine dependence)[47].

A recent systematic review of international suicide prevention policies identified only three countries globally that identified strategies specifically targeting alcohol and other drug use

[41] Gulliver, Griffiths, and Christensen, 'Perceived Barriers and Facilitators to Mental Health Help-Seeking in Young People: A Systematic Review', *BMC Psychiatry,* 10/1 (2010), 113.
[42] Jorm, Wright, and Morgan, 'Where to Seek Help for a Mental Disorder?', *Medical Journal of Australia,* 187/10 (2007), 556-60.
[43] Jorm et al., '"Mental Health Literacy": A Survey of the Public's Ability to Recognise Mental Disorders and Their Beliefs About the Effectiveness of Treatment', *Medical Journal of Australia,* 166/4 (1997), 182-86.
[44] Lubman et al., 'A School-Based Health Promotion Programme to Increase Help-Seeking for Substance Use and Mental Health Problems: Study Protocol for a Randomised Controlled Trial', *Trials,* 17/1 (2016), 393.
[45] Witt and Lubman, 'Effective suicide prevention: Where is the discussion on alcohol?', *Australian and New Zealand Journal of Psychiatry*, 52/6 (2018), 507-508.
[46] Ferrari et al., 'The Burden Attributable to Mental and Substance Use Disorders as Risk Factors for Suicide: Findings from the Global Burden of Disease Study 2010', *PloS One,* 9/4 (2014), e91936.
[47] Kalk et al., 'Addressing Substance Misuse: A Missed Opportunity in Suicide Prevention', *Addiction,* 114/3 (2019), 387-88.

disorders[48]. The Australian National Suicide Prevention Strategy (**NSPS**), first introduced in 1999, formalised and coordinated suicide prevention activities, as well as provided for greater funding and investment in suicide prevention research. Complementing the NSPS, most states and territories also outline their own responses.

Yet despite the increased risk of suicidal behaviour in those diagnosed with an alcohol and other drug use disorder, specific suicide prevention strategies focusing on individuals with such disorders remain notably absent, with this population infrequently identified as an important 'at risk' group within suicide prevention strategies and initiatives. This is particularly relevant in the context of male suicide, given that men are less likely to seek help for suicidal ideation and/or behaviours until they reach a crisis point. Indeed, the recent Beyond the Emergency[49] report identified that over 65% of ambulance attendances for male suicide attempts across the country involved alcohol and other drug use. This is consistent with research showing that males with depression are more likely to report problems with alcohol use, whereas females are more likely to report 'classical' symptoms of depression[50]. Therefore, when males do seek help, given their focus on alcohol, they are more likely to be referred for AOD treatment in the first instance. It is therefore important that AOD services and helplines are adequately skilled to identify individuals at risk of suicide, appropriate prevention and intervention strategies are sufficiently resourced within these settings, and effective partnerships are in place with local mental health providers to provide support and referral pathways.

Increasing rates of drug overdose in Victoria also need to be considered through the lens of suicide prevention. These deaths have raised public and professional concern about the prescription of potent opioid medications for chronic non-cancer pain and led to the recent implementation of a real-time prescription monitoring system (*Safescript*) in Victoria. However, it is important to note that studies of consumers who are prescribed opioids for chronic non-cancer pain report high rates of depression, suicide attempts and suicidal ideation[51], highlighting the need for suicide prevention initiatives to broaden the scope of populations that they target.

Given that only around one-third of suicide decedents were in contact with mental health services in the year preceding their death, other public health initiatives are also required to meaningfully reduce suicide rates. At the population level, rates and patterns of alcohol consumption have been consistently associated with suicide rates across a number of countries, particularly for males. Data from a number of eastern European countries suggest increasing per capita alcohol consumption is associated with an increase in overall suicide rates, with the proportion of suicides attributable to alcohol as high as 66.4% in countries that predominately consume spirits and 34.5% in countries that predominately consume non-spirits-based alcoholic beverages[52]. Such findings highlight the need for a more robust public discussion about the relationship between alcohol and suicide in Australia and that, similar to the current community conversations concerning the link between alcohol and cancer, future suicide prevention strategies must advocate for policies that effectively reduce alcohol consumption, such as increasing the price of alcohol through taxation and limiting marketing and promotion.

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[48] Ibid.

[49] Beyond the Emergency A National Study of Ambulance Responses to Men's Mental Health, Beyond Blue, 19/5 (2019)

[50] Cavanagh et al., 'Differences in the Expression of Symptoms in Men Versus Women with Depression: A Systematic Review and Meta-Analysis', *Harvard Review of Psychiatry,* 25/1 (2017), 29-38.

[51] Campbell et al., 'The Pain and Opioids in Treatment Study: Characteristics of a Cohort Using Opioids to Manage Chronic Non-Cancer Pain', *Pain,* 156/2 (2015), 231-42.

[52] Landberg, 'Alcohol and Suicide in Eastern Europe', *Drug and Alcohol Review,* 27/4 (2008), 361-73.

Effective intervention and policy development requires detailed understanding of the magnitude, characteristics and patterns of the intersection between acute mental health, suicide and alcohol and drugs over time and across regions. Few population based datasets have the capacity to capture that detail in a timely and consistent way. For example, emergency department and hospital data only includes those who present to hospital and are admitted and the coding systems cannot capture suicidal ideation, specific substance types and nuances between self-harm and suicide attempt.

For over 20 years, Turning Point has been providing a Victorian alcohol, illicit and pharmaceutical drug surveillance system using coded paramedic data in partnership with Ambulance Victoria. This world-first surveillance system has recently applied the same methodology to mental health, as part of the recently released Beyond the Emergency study. Beyond the Emergency found national morbidity data appears to significantly underestimate the burden of self-harm in Australian men, and the coded ambulance data (for only six Australian jurisdictions) indicated rates amongst men almost three times higher than hospitalisation data[53]. These data could be utilised as an ongoing surveillance system to inform policy responses, reduce suicide and self-harm behaviours and evaluate existing interventions.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

The separation and fragmentation of the AOD and mental health service sectors is a significant barrier in access to effective care. Individuals frequently present to AOD services with complex mental health issues that can interfere with alcohol and other drug use treatment. Indeed, those with co-occurring alcohol and other drug disorder and mental illness are also more likely to rely on emergency services (including police and ambulance services) for mental health responses[54,55], be dependent on welfare benefits, have limited social supports and financial resources, and be at high risk of relapse, suicide, aggression, medical comorbidity, homelessness and incarceration. They frequently present with underlying trauma that may be masked by the use of alcohol and other drugs as a coping strategy. Because of these issues, they are generally less able to navigate between, engage with, and remain in treatment.

The separation of treatment for alcohol and other drug use disorders from treatment of other mental illnesses can result in pressure to place consumers in the 'correct' system based on a primary diagnosis, which can, in turn, lead to treatment of one disorder at the expense of the other. In reality, the relationship between alcohol and other drug use disorders and mental illness is bidirectional, with both conditions serving to maintain or exacerbate the other[56]. The boundaries created by treating co-occurring disorders in separate systems can also impede consumer progress and prognosis[57]. Often, consumers are passed back and forth between AOD and mental health

[53] Turning Point (2019). Beyond the Emergency: A National Study of Ambulance Responses to Men's Mental Health. Richmond, Victoria.

[54] Dickey and Azeni, 'Persons with Dual Diagnoses of Substance Abuse and Major Mental Illness: Their Excess Costs of Psychiatric Care', *American Journal of Public Health,* 86/7 (1996), 973-77.

[55] Graham et al., 'How Much Do Mental Health and Substance Use/Addiction Affect Use of General Medical Services? Extent of Use, Reason for Use, and Associated Costs', *The Canadian Journal of Psychiatry,* 62/1 (2017), 48-56.

[56] Teesson, 'Mental Health and Substance Use: Opportunities for Innovative Prevention and Treatment', (Mental Health Commission of New South Wales, 2014).

[57] Baker, *Coordination of Alcohol, Drug Abuse, and Mental Health Services* (US Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1991).

services, inevitably falling through the gap over time. These outcomes can lead to the perception that treatment is ineffective, or that consumers are responsible for poor treatment outcomes, when in reality they have received disparate care that failed to adequately address their individual needs.

The need for a 'no wrong door' policy that is equipped to work

A common aim of models of service delivery is that all consumers will be provided with appropriate treatment services or referral regardless of where they enter the treatment system, the 'no wrong door' approach. This concept needs to be further consolidated, with the needs of consumers being addressed in the services they access, rather than requiring referrals to multiple agencies.

The implementation of 'The Orange Door' initiative within Victoria, which represents a shift in the way services are coordinated to respond to consumer needs within the family violence space, may be informative in this regard. Establishing 'safety hubs' via partnerships between government and community service organisations, which help connect victims of family violence directly to services via a single point of entry, is an important model to consider in addressing issues of integrated and coordinated care for consumers.

In 2017, Turning Point was commissioned by the Victorian Department of Health and Human Services to conduct a review of AOD service planning across the state. The review identified key elements of an effective AOD service system, in particular one that increases the availability of specialist treatment services whilst taking into account the varying needs of a complex population where consumers require varied level of care. As part of the review, the Victorian treatment-seeking population was segmented into tiers, in order to match consumers with differing levels of addiction severity and complexity to 'packages' of care[58]. Using a 5-tier model, most consumers were classified as Tier 3 or above (i.e. presenting with alcohol and other drug dependence plus one or more complexity factors), with approximately 20-25% percent of these classified as Tier 5 (the most complex consumers in the system). Within each Tier, the presence of complexity factors, which included comorbid mental illness, was critical in determining the level of care a consumer was to receive.

Managing consumers with co-occurring alcohol and other drug use disorder and mental illness requires a highly skilled AOD workforce. Within the AOD service system, high prevalence mental health disorders (in particular, mood and anxiety disorders) are common. Indeed, it has been estimated that the rate of co-occurring mental illness among consumers accessing residential AOD treatment within Australia ranges from 64%-71%[59]. In contrast, public mental health services typically provide care to individuals with 'serious mental illness' (i.e. the low prevalence conditions of schizophrenia and bipolar disorder) that are frequently accompanied by alcohol and other drug use disorders[60]. Differences in consumer profiles mean that neither service sector is ideally equipped to deal with the issue of co-occurring disorders.

However, simply improving referral pathways may not necessarily result in improved outcomes. There are inherent differences in the AOD and mental health sectors, including differences in the language and service philosophies, as well as a general lack of understanding among workers of the different models of care and service constraints[61]. Efforts have been made at Commonwealth and

[58] Lubman, Manning, and Cheetham, 'Informing Alcohol and Other Drug Service Planning in Victoria', (Turning Point, 2017).
[59] Mortlock, Deane, and Crowe, 'Screening for Mental Disorder Comorbidity in Australian Alcohol and Other Drug Residential Treatment Settings', *Journal of Substance Abuse Treatment,* 40/4 (2011), 397-404.
[60] Hall, Lynskey, and Teesson, 'What Is Comorbidity and Why Does It Matter', *National Comorbidity Project,* (2001), 11-17.
[61] Lubman, Hides, and Elkins, 'Dual Diagnosis: Dual Disorders or a Dual System?' In Moore and Dietze. *Drugs and Public Health: Australian perspectives on policy and practice (2008),* 127-138.

State levels to improve approaches to co-occurring disorders through 'Dual Diagnosis' initiatives, and these have largely focused on building workforce awareness and knowledge. While these approaches have been well-intentioned, they have struggled to advance the clinical capacity required by the treatment sector to manage the levels of complexity seen in individuals with co-occurring mental illness and alcohol and other drug use disorder.

There is a need to build capacity in the AOD sector to enable the management of co-occurring mental illness. Currently, the minimum qualification for delivering AOD treatment in Victoria is a Certificate IV in Alcohol and Other Drugs, meaning that clinicians have limited experience or expertise in managing co-occurring mental illness. A lack of skills and experience necessary to appropriately assess and manage co-occurring mental illness within the AOD sector has been identified as a key barrier to effective service provision, and building workforce capabilities has been identified as a priority for the Victorian Government[62]. In order to address this gap in service provision, there is a need for greater support of postgraduate training opportunities in addiction to psychiatry, psychology and mental health nursing within the AOD sector. Effective capacity building also requires the recruitment of clinicians experienced in managing co-occurring disorders, who can assist in training and service development[63].

An example of a program that incorporates a skilled workforce is *Making Waves*[64], a specialist service provided by Turning Point that offers evidence-based treatment for co-occurring alcohol and other drug use disorders and complex mental health presentations. Making Waves delivers 12 individual face-to-face treatment sessions with a focus on learning new strategies for making alternative choices, particularly around alcohol and other drug use, as well as building skills in better managing and tolerating emotional stress and improving interpersonal relationships.

Evidence-based psychological treatment for this level of complexity (in particular, for complex trauma) dictates continuity and consistency in care, as considerable time is required to forge a therapeutic alliance, with consumers requiring more than 12 sessions to achieve successful recovery. Indeed, expanding access to, and the duration of programs, such as *Making Waves*, could reduce chronicity and relapse, particularly as referrals to new services are difficult to action on discharge because few other services exist in the public sector to support individuals with this level of complexity.

The importance of effective service integration

There is strong evidence that an integrated response, whereby treatments for mental illness and co-occurring alcohol and other drug use disorders are provided at the same service (as opposed to in parallel or sequentially at separate services), is necessary to adequately treat such disorders[65,66].

Commonwealth initiatives through the National Comorbidity Initiative and the National Action Plan on Mental Health (2006-2011) have targeted this issue, and have included funding to enhance mental health capacity within the AOD sector. However, while such strategies are to be

[62] Department of Health and Human Services, 'Victoria's Alcohol and Other Drugs Workforce Strategy', (Victoria, 2018).
[63] Lubman, Hides, and Elkins, 'Dual Diagnosis: Dual Disorders or a Dual System?'. In Moore and Dietze, *Drugs and Public Health: Australian perspectives on policy and practice (2008),* 127-138.
[64] Hall et al., 'Emotional Dysregulation as a Target in the Treatment of Co-Existing Substance Use and Borderline Personality Disorders: A Pilot Study', *Clinical Psychologist,* 22/2 (2018), 112-25.
[65] Torrens et al., 'Psychiatric Co-Morbidity and Substance Use Disorders: Treatment in Parallel Systems or in One Integrated System?', *Substance Use & Misuse,* 47/8-9 (2012), 1005-14.
[66] Morisano, Babor, and Robaina, 'Co-Occurrence of Substance Use Disorders with Other Psychiatric Disorders: Implications for Treatment Services', *Nordic studies on alcohol and drugs,* 31/1 (2014), 5-25.

commended, the segregation of the AOD and mental health sectors remains a fundamental issue in Victoria, and Australia as a whole[67]. Implementing effective integration responses necessitates improved models of integration between mental health and AOD directorates within the Victorian Department of Health and Human Services in their policy and funding priorities.

Ensuring that integrated care is included within service specifications of commissioning bodies and is adequately funded is critical in effective integration[68], and funding AOD and mental health system design and policy separately is likely to be contributing to an ongoing fragmented system[69]. Currently, both sectors face considerable demand for services and are significantly under-resourced.

An integrated response also needs to span the entire health system, including hospitals and emergency services. Appropriate treatment and a holistic approach to meeting consumer needs will reduce the pressure on public health services, including ambulance attendances, emergency department presentations, and admissions to acute mental health facilities. The extent of this issue was highlighted by the recent *Beyond the Emergency* project, where the volume and complexity of presentations and re-presentations to ambulance services (where 78% were transported to hospital, with >60% of attendances occurring after hours) reinforced the need for a comprehensive review of service responses and a more flexible and integrated service system[70]. *Beyond the Emergency* interviews with men who had accessed ambulance services as well as paramedics consistently highlighted problems associated with a mental health sector in which long wait times, financial costs, and difficulties accessing appropriate services are extra barriers to ongoing professional support. Alternative models of delivering emergency care for those experiencing acute mental illness should therefore be explored, and investment is needed in systems and responses that reduce the many barriers to accessing timely support.

The importance of funding models that promote continuity and service integration is further highlighted by the results of the *Patient Pathways* study, which found treatment outcomes were influenced by continuity in AOD treatment[71]. The study also found that treatment reduced emergency service use[72]. As with other chronic health problems, alcohol and other drug use disorders appear to be best managed through continuing care models, involving ongoing monitoring and coordination between different services, rather than by an acute episodic treatment approach.

A strong evidence base also exists around linkage to peer and community 'aftercare' support (i.e., ongoing follow-up and support post-specialist AOD treatment, which may include telephone or online counselling as well as linkage with peer support and mutual aid, such as 12-step groups). While most studies on the benefits of mutual aid have been conducted in the US and UK, in the Australian Patient Pathways study, consumers with alcohol but not illicit drugs as their primary drug of concern were two-and-half times as likely to be abstinent or to have reliably reduced their drinking if they attended mutual aid (e.g. Alcoholics Anonymous) or other recovery meetings following AOD treatment. There was also a trend for higher rates of treatment success among those attending more meetings in the previous 12 months, with more than 31-50% of those attending

[67] Lubman, Hides, and Elkins, 'Dual Diagnosis: Dual Disorders or a Dual System?'. In Moore and Dietze, *Drugs and Public Health: Australian perspectives on policy and practice (2008),* 127-138.
[68] Savic et al., 'Strategies to Facilitate Integrated Care for People with Alcohol and Other Drug Problems: A Systematic Review', *Substance Abuse Treatment, Prevention, and Policy,* 12/1 (2017), 19.
[69] Canaway and Merkes, 'Barriers to Comorbidity Service Delivery: The Complexities of Dual Diagnosis and the Need to Agree on Terminology and Conceptual Frameworks', *Australian Health Review,* 34/3 (2010), 262-68.
[70] Turning Point, 'Beyond the Emergency: A National Study of Ambulance Responses to Men's Mental Health'.
[71] Manning et al., 'Substance Use Outcomes Following Treatment: Findings from the Australian Patient Pathways Study', *Australian & New Zealand Journal of Psychiatry,* 51/2 (2017), 177-89.
[72] Lubman et al., 'A Study of Patient Pathways in Alcohol and Other Drug Treatment', *Fitzroy: Turning Point,* (2014).

meetings at least monthly on average responding to treatment[73]. Overall, there is robust evidence that peer support/mutual aid improves treatment outcomes and linkage to these programs as a form of aftercare needs to be a core part of any service delivery model[74].

9. *Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?*

The need for a sustainable addiction medical workforce

There is an urgent need to build a tertiary specialist workforce within the AOD system. Up to a quarter of Victorians in the AOD treatment system can be considered Tier 5[75], presenting with levels of clinical complexity concomitant with tertiary sector opinion and management. However, mainstream care within the Victorian AOD sector is typically provided without ready access to medical or psychiatry support, dependent on private GPs or emergency departments for their most at-risk cases. The relative absence of a tertiary AOD sector, and associated evidence-based multidisciplinary team management, has a critical impact on recovery and outcomes for individuals with complex alcohol and other drug use and co-occurring mental illness.

Currently, there is overwhelming demand for provision of assessment and treatment in areas of medical and psychiatric complexity, such as co-occurring pain, anxiety and addiction, heroin and depression, prescription opioid and other pharmaceutical misuse, complex trauma, alcohol and liver disease, methamphetamine and psychosis. There is also high demand from residential rehabilitation settings that require specialist assessment and management of consumers with co-occurring alcohol and other drug use disorder and mental illness prior to admission.

The roll-out of mandatory real-time prescription monitoring (*SafeScript*) in Victoria over the coming year will increase the visibility of prescribing of high-risk medications, including a range of psychotropic drugs such as opioids, benzodiazepines, sleep medications and quetiapine, further contributing to demand for addiction medical specialist opinion and management both within the AOD treatment system, and from mental health and primary care. Through this lens of high-risk prescription medications, it will become increasingly difficult to inform safe and effective withdrawal, stabilisation, treatment and recovery plans without access to addiction medicine and psychiatry expertise.

Training for doctors specialising in the treatment of addiction is provided by the Chapter of Addiction Medicine (under the Royal Australasian College of Physicians or RACP) and the Royal Australian and New Zealand College of Psychiatry (**RANZCP**), however barriers to entering addiction medicine and psychiatry in Australia have contributed to a shortage of clinicians in this field. (The 2017 RANZCP Victorian Branch workforce report estimated only 3.0 EFT of funded addiction psychiatry positions in the public AOD sector across the state.)[76]

The numbers of trainees and qualified addiction specialists are particularly low in Victoria due to a chronic lack of investment in training and specialist positions: New South Wales, by way of contrast, has almost six times the numbers of addiction doctors in training as Victoria, as well as funded addiction specialist positions within each health service. Careers in addiction medicine were given

[73] Manning et al., 'Substance Use Outcomes Following Treatment: Findings from the Australian Patient Pathways Study', *Australian & New Zealand Journal of Psychiatry,* 51/2 (2017), 177-89.
[74] Lubman, Manning, and Cheetham, 'Informing Alcohol and Other Drug Service Planning in Victoria', (Turning Point, 2017).
[75] Ibid.
[76] Royal Australian and New Zealand College of Psychiatrists (Ranzcp), 'Psychiatry Attraction, Recruitment and Retention Needs AnalysisProject', (Victoria, 2017).

some momentum in recent years due to changes in Medicare Benefits Scheduling that recognised the specialty by allocating physician type item numbers. However, this has not been enough to attract adequate trainees to replace those specialists lost through the attrition or retirement.

The lack of a career pathway for doctors interested in pursuing a career in addiction medicine or addiction psychiatry, including consultant positions within the public system, means that Victoria is facing a future without such expertise, with an exodus of specialists to funded positions interstate in recent years, and many of the remaining cohort of addiction specialists nearing retirement. As addiction psychiatry and medicine provide the tertiary specialist support needed to develop a workforce capable of treating co-occurring disorders, as well as providing appropriate clinical expertise to consumers in Tier 5, appropriate funding of addiction medical specialists within the health system remains an urgent priority for Victoria[77].

Oversight and governance models for managing co-occurring disorders in the Safescript era

Contrasts between the mental health and AOD sectors are necessary given approaches to mental illness and alcohol and other drug use disorders often require different emphases and strengths. However, the AOD sector can also learn from established models within mental health, such as the statutory clinical governance provided by roles such as Victoria's Chief Psychiatrist.

Some jurisdictions have adopted such roles for addiction medicine, with Victoria trialling such a role before discontinuing it some years ago. The role of a Chief Addiction Medicine Specialist, analogous to the Chief Psychiatrist position, has the potential to guide and govern Victorian AOD practice. Given the recent launch of the *Safescript* real time prescription monitoring system, most clinicians in the sector predict increasing numbers of complex clinical challenges will become visible in primary care. Without appropriate governance, general practitioner management of pharmaceutical drug use disorders, including those complicated by mental health comorbidity, will potentially lead to GPs discharging (or abandoning) consumers with comorbid prescription medicine dependence, pain and mental illness or referring them to services with limited expertise in such conditions or significant access barriers, such as public pain clinics.

A structured governance system in addiction medicine would complement the Chief Psychiatrist role. The position would be well placed to lead innovative approaches such as an expert panel (aligned to Safer Care Victoria) to review complex pharmaceutical opioid and other drug dependence, as well as provision of oversight for critical incidents or near misses. Currently, there is no clinical governance model that oversees non-hospital high-risk medication prescribing, nor review of critical clinical incidents in the AOD sector, including deaths. Models of incident review are well established in public health services.

However, no systematic review of serious events related to medication misuse are applied to the private fee-for-service general practitioner and non-government AOD settings (including rehabilitation services) that deliver the majority of care for alcohol and other drug use disorders and mental illness in Victoria. Translating a system of clinically governed expert committee risk review to the state-wide level would be an ideal way to reduce the harm related to inappropriate use of medication through stewardship of the prescribing of opioids, benzodiazepines, stimulants and sedating psychiatric drugs.

[77] Frei and Clarke, 'Meeting the Challenge in Care of Co-Occurring Disorders', *Medical Journal of Australia,* 195/3 (2011), S5.

New model of care for consumers with the most complex needs

Currently, there is no effective service model in place for consumers with the most severe mental illness and alcohol and other drug use disorders within Tier 5, with many of these individuals falling through the gaps in existing service provision. Given the nature of their complexity, which often involves repeated presentations to emergency services, risky behaviours and poor adherence to treatment, these consumers cannot be managed through simply improving referral pathways between services, particularly as they are unable to navigate one system let alone multiple. Instead, these consumers require an integrated model of care and multidisciplinary clinical expertise that is qualitatively different from what is currently offered across existing services. Ideally, this integrated service model would incorporate tertiary specialist expertise from both the AOD and mental health sectors working within one team and one philosophy, spanning both outpatient and inpatient care, with access to community housing, employment support, peer support and integrated long-stay residential rehabilitation.

In terms of outpatient models of care, assertive community treatment (**ACT**) is an intensive mental health program involving a multidisciplinary approach to consumer care that differs conceptually and empirically from traditional case management. A team of professionals support consumers who are at risk of psychiatric hospitalisation, but who do not readily use clinic-based services, with contact typically occurring in community settings. In 2001, Bond and colleagues[78] noted that ACT was one of the most comprehensively researched models of treatment in regard to mental illness, with 25 randomised controlled trials evaluating its effectiveness. The results of these trials indicate that ACT can substantially reduce psychiatric hospital use, increase housing stability, engage consumers in treatment, and result in a moderate improvement in symptoms and quality of life. While costly, this is offset by the reduction in hospital use amongst high-needs consumers.

Although implemented primarily in the mental health field, assertive community treatment has been recommended for consumers with serious mental health and co-occurring AOD use disorders, particularly when integrated with other treatments or interventions. In particular, it is a potential treatment model for consumers with severe co-occurring alcohol and other drug use disorders and medical disorders who are difficult to engage in treatment (such as those with alcohol dependence and liver cirrhosis). Indeed, a recent randomised controlled trial found that alcohol dependent consumers who received ACT had better treatment engagement and less unplanned healthcare use than those who received treatment as usual[79] .

Drake and colleagues argue that assertive outreach is a critical component of treatment given that many consumers with serious mental illness and alcohol and other drug use disorders struggle to manage linkages between services and maintain participation in treatment[80]. As such, assertive outreach is arguably of most benefit to a subgroup of consumers who are severely ill and difficult to engage. A review of Australian mental health stakeholders' (mental health service providers and mental health non-government organisations) views on such clients revealed that over 80% believed assertive outreach to be moderately to very effective[81] .

A study comparing assertive case management and standard case management amongst consumers with serious mental illness and co-occurring alcohol and other drug use disorders found that participants in both conditions improved over time, with greater decreases in substance use than would have been anticipated without treatment. They concluded that integrated treatment can be

[78] Bond et al., 'Assertive Community Treatment for People with Severe Mental Illness', *Disease Management and Health Outcomes,* 9/3 (2001), 141-59.
[79] Drummond et al., 'Assertive Community Treatment for People with Alcohol Dependence: A Pilot Randomized Controlled Trial', *Alcohol and Alcoholism,* 52/2 (2016), 234-41.
[80] Drake et al., 'Implementing Dual Diagnosis Services for Clients with Severe Mental Illness', *Psychiatric Services,* 52/4 (2001), 469-76.
[81] Cleary et al., 'Views of Australian Mental Health Stakeholders on Clients' Problematic Drug and Alcohol Use', *Drug and Alcohol Review,* 28/2 (2009), 122-28.

delivered successfully by either method of care[82] . However, qualitative evidence suggests that building trust through ongoing involvement as well as a feeling of personal responsibility for taking part in treatment may be crucial elements of successful ACT amongst consumers with co-occurring serious mental illness and alcohol and other drug use disorders[83] .

Concluding comments

Turning Point recommends a move away from the concept of a standalone 'mental health system' and towards an integrated 'system of care.' Building capacity in the AOD sector to enable the management of co-occurring mental illness within AOD services will provide a better quality of care and, over time, reduce the burden on health and emergency services, including ambulances, police, emergency departments and public mental health inpatient beds, as well as correctional and welfare services. Proposed improvements need to be informed by consumer voices from the initial planning stages, with iterative co-design and ongoing consultation shaping development. This applies to the AOD service sector as much as it does the mental health system. Whilst AOD consumer peak bodies are occasionally consulted for input into service delivery, there remains a lack of a systematic and co-ordinated consumer movement in AOD recovery, in comparison to the progress made by mental health consumer bodies. Individual consumers in the AOD system, faced by substantial stigma, may not feel empowered to advocate for change. The requirement of consumer representation on all AOD-related commissioning bodies can help redress this.

For further information contact:
Professor Dan Lubman
Executive Clinical Director, Turning Point, Eastern Health
Professor of Addiction Studies and Services, Monash University
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[82] Susan M Essock et al., 'Comparison of Act and Standard Case Management for Delivering Integrated Treatment for Co-Occurring Disorders', *Psychiatric Services,* 57/2 (2006), 185-96.
[83] Pettersen et al., 'Engagement in Assertive Community Treatment as Experienced by Recovering Clients with Severe Mental Illness and Concurrent Substance Use', *International Journal of Mental Health Systems,* 8/1 (2014), 40-52.