November 2020

Exploring the place of alcohol and other drug services in the mental health system.

360edge.

360edge

© 360Edge 2020

This report was written by Professor Nicole Lee and Professor Steve Allsop, with assistance from Brigid Clancy and Steven Bothwell.

Lee, N. and Allsop, S. (2020) Exploring the place of alcohol and other drug services in a successful mental health system. Melbourne: 360Edge.

hello@360edge.com.au | 360edge.com.au | 1300 988 184

About 360Edge.

We are a leading Australian health consultancy, specialising in the alcohol and other drug, and allied, sectors. We provide a full suite of advisory services to help organisations accelerate change. We work with leading international organisations, governments and not for profit agencies across Australia and internationally.

Our vision is for a thriving society that provides the best policy and practice responses right across the spectrum of alcohol and other drug use. Our mission is to ensure governments and services have the tools they need to respond effectively and efficiently to people who use alcohol and other drugs to minimise harms.

We are driven to make a positive impact in the world and strongly believe in social justice and human rights, and it drives all of our work. We believe that everyone has the right to the opportunities and privileges that society has to offer. Our values of excellence, transparency and integrity are at the core of everything we do. We live these values within the team and with our customers and collaborators.

Our team of experienced 'pracademics' take a 360 approach to viewing situations from multiple perspectives. We collaboratively and holistically work with our clients at every stage, wherever they are in the cycle of change, to achieve their goals.

In the spirit of reconciliation, we acknowledge the traditional custodians of country throughout Australia and their connection to land, sea and community. We pay our deep respects to elders past, present and future, and to all Aboriginal and Torres Strait Islander peoples today.

About the authors.

Professor Nicole Lee

Founder and CEO, 360Edge

Nicole is Chief Executive at 360Edge and Adjunct Professor at the National Drug Research Institute. She is a member of the Australian National Advisory Council on Alcohol and other Drugs (ANACAD) and board member, and chair of the Clinical Governance Committee, at Hello Sunday Morning. She is an International leader in co-occurring mental health and alcohol and other drug practice and policy and has published widely on the topic. Nicole is a psychologist with 30 years' experience in the alcohol and other drug and mental health sectors and has provided key policy advice to state, commonwealth and international governments, as well as major global health organisations like the World Health Organization and the United Nations Office on Drugs and Crime. She is Deputy Editor of Drug and Alcohol Review and Fellow of the Australian Association for Cognitive and Behaviour Therapy.

Professor Steve Allsop

Professor, National Drug Research Institute, Curtin University

Steve Allsop has worked in the drug field for over 35 years and been involved in policy, prevention and treatment research and professional development for health, police, education, welfare staff and community organisations. He is Professor at the National Drug Research Institute at Curtin University having served as Director from 2005-2016. He is Deputy Chair of the Australian National Advisory Council on Alcohol and other Drugs (ANACAD). Steve has previously worked as the A/Executive Director, Drug and Alcohol Office, Western Australia and the Director of the National Centre for Education and Training on Addiction, Flinders University of South Australia. He has an interest in research, prevention, treatment and policy responses to alcohol and other drug problems.

Acknowledgements.

This report was supported by a grant from the National Mental Health Commission.

Our thanks to Professor Steve Allsop, National Drug Research Institute, Curtin University for collaborating with 360Edge on this report.

Our thanks also to the key experts who took the time to share their expertise with us and those who provided feedback on the first draft of this document. Some key experts participated in the consultation and review process but asked not to be identified.

This report does not necessarily reflect the personal or professional views of all stakeholders but reflects the weight of expert opinion and evidence.

Our thanks to these key experts who participated in consultations that were the basis of this report:

Dr Shalini Arunogiri	Addiction Psychiatrist and Deputy Clinical Director Treatment Services at Turning Point
Professor Amanda Baker	National Health and Medical Research Council Senior Research Fellow at University of Newcastle
Wendy Casey	Director of Aboriginal Health at Western Australian Department of Health
Gary Croton	Clinical Nurse Consultant at Victorian Dual Diagnosis Initiative
Professor Adrian Dunlop	Area Director and Addiction Medicine Senior Staff Specialist at Hunter New England Local Health District
Professor Diana Egerton-Warburton	Director Emergency Medicine Research and Innovation at Monash Medical Centre
Cecelia Gore	Senior Director Mental Health, Alcohol and other Drugs at Northern Territory Government
Neil Guard	Former Chief Executive Officer at Richmond Wellbeing
Kerry Hawkins	President at Western Australian Association for Mental Health

Rebecca Lang	Chief Executive Officer at Queensland Network of Alcohol and Other Drug Agencies (QNADA)
Clare Mason	Program Manager Alcohol and other Drugs at Queensland Mental Health Commission
Jack Nagle	Director at Real Drug Talk and Experience Matters
Dr John Reilly	Addiction Psychiatrist, Chair RANZCP Subcommittee on Advanced Training in Addiction Psychiatry
Jill Rundle	Chief Executive Officer at Western Australia Network of Alcohol and Other Drug Agencies (WANADA)
Debbie Warner	Director at Alcohol, Pharmaceuticals and Other Drugs Family Drug Support (APOD)
Associate Professor Scott Wilson	Chief Executive Officer at Aboriginal Drug and Alcohol Council South Australia

Our thanks to these key experts who gave detailed feedback on the first draft of the report:

Paul Dessaur	Outreach Coordinator at Peer Based Harm Reduction WA
Angela Corry	CEO at Peer Based Harm Reduction WA
Dr Paul Grinzi	Specialist General Practitioner at Royal Park Medical
Professor Paul Haber, AM	Clinical Director, Drug Health Services at Sydney Local Health District and Head, Discipline of Addiction Medicine at University of Sydney Central Clinical School
Professor Katherine Mills	Director of Early Intervention and Treatment Research at the Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

Contents.

Executive summary.

Introduction

There is a high co-occurrence of alcohol and other drug use and mental health problems in the Australian community, which is amplified in both treatment sectors. We have struggled for 30 years to find effective responses. In this report, we look deeply at this issue to understand why previous attempts have failed and consider what both the evidence and key experts in both sectors tell us about what is required.

Approach

We interviewed 18 key experts from peak bodies, clinical services, researchers, service users and people with lived experience, and policy makers. We also received feedback on the first draft from 4 additional key experts.

We used the interviews to identify the key issues, barriers and possible solutions for thinking about the place of alcohol and other drug services in a successful mental health system. We then reviewed the peer reviewed literature, grey literature and policies and approaches in similar systems internationally to examine the feasibility and effectiveness of these potential approaches.

Is alcohol and other drug use a mental health issue?

Alcohol and other drug use, and even adverse outcomes from use, does not automatically equate with dependence. Some drug use has been associated with improved mental health for some people, at least subjectively, some has no impact, some creates various social and health problems and a proportion results in dependence. The latter may be considered a mental health condition, but most alcohol and drug use does not fall under this banner.

> *“But not all people with alcohol and other drug issues have mental health issues… there is an overlap but it is not necessarily the case that alcohol and other drug is always a mental health issue*

As a result, the alcohol and other drug sector provides services that address a range of harms from the full spectrum of primary, secondary and tertiary prevention. This goes beyond the, historically, largely clinical perspective the mental health sector operates under. The sector’s work also goes beyond health to encompass supply control, criminal justice and human rights.

The unique nature of alcohol and other drug use and responses means that the alcohol and other drug sector is a specialist sector.

The complexity of responding to comorbidity

There is a huge diversity of the combination and severity of co-occurring alcohol and other drug and mental health problems.

This creates a nearly infinite range of problems and gives rise to an equally large diversity in treatment needs and preferences.

People fall through the gaps in the health service system when their specific combination of needs cannot be met.

Should services be integrated?

The term integration has very different meanings for different people. In this report, we distinguish between three types of integration: integrated systems, integrated services, and integrated treatment.

Systems integration

Systems integration involves combining policy, funding, budget or administration of different services.

We found that one of the key problems with previous attempts at systems integration has been a loss of skill and willingness to address co-occurring disorders. A further unintended consequence has been a loss of funding for alcohol and other drug services.

Service integration

Service integration attempts to integrate between different types of services, such as alcohol and other drugs and mental health

However, people with alcohol and other drug problems or mental health issues, also have a range of other morbidities that are served in other sectors. Why give precedence of one over any other service?

> *Why would we try to integrate these particular two services when there are overlaps with many other health issues?*

There are some advantages to service integration, including that service users prefer a 'one stop shop' and it may help to keep comorbidity top of mind.

However, a number of factors that distinguish alcohol and other drug services from mental health services mean that service integration is a complex task and have been barriers to service integration in the past.

The culture and philosophy, workforce, and intervention approaches are very different between alcohol and other drugs and mental health services.

The types and severity of co-occurring disorders in both sectors are quite different. For example, mental health problems among people in the alcohol and other drug sector are primarily the higher prevalence disorders, rather than low prevalence disorders seen in mental health.

> *Addiction services are a cultural mismatch with mental health services*

People with alcohol and other drug problems face additional stigma, including from health professionals, with some people believing that alcohol and other drug problems are not 'real' health problems and that people have 'brought it on themselves' for choosing to use drugs.

The question is whether we can get the benefits of service integration another way.

Treatment integration

Treatment integration is the treatment of multiple problems with a single practitioner or service.

Fully integrated treatment which addresses both disorders simultaneously, including the interaction between them, is effective, but no more effective than other forms of dual treatment, and not always what service users want. For example, parallel and sequential treatment has also been found to be effective, especially for people with higher prevalence mental health disorders.

Effective specialist work also has an impact on outcomes.

Integrated versus holistic care

Ultimately the aim of systems, service and treatment integration is to provide a service that can address multiple service user needs.

But systems and service integration has been problematic in previous attempts. Integration is resisted by both alcohol and other drug services and mental health services. It shows mixed results and is not always what service users want.

It is time to stop trying to fit the square peg into the round hole. Rather than trying to integrate services or treatments, ensure there are structures in place for all health services to take a holistic approach to support service users' needs.

> *We should be looking at conceptualising the whole person [in every service] rather than trying to integrate services... we should be looking at holistic care.*

There are a number of models of care that our key experts identified that could support holistic care, including care coordination, colocation of services, specialist dial diagnoses services, multidisciplinary teams, secondary consultation, support and training, monitoring capability and monitoring outcomes.

A system for the future

If we are to approach responses to co-occurring alcohol and other drug and mental health problems in a holistic rather than 'integrated' way, the final question is how to achieve this efficiently.

Holistic treatment means identifying and understanding the service user's needs and wants and offering responses that address all of those needs and wants. It means working collaboratively in partnership with other agencies. It means building capacity and capability within all of our health and social services to respond in this way and, where indicated, being able to provide coordinated care.

Each of the related service systems that overlap with the alcohol and other drug sector, including mental health, primary care, and social services, as well as the private sector, require different capacity building measures to enable them to work holistically.

The specific approaches that are required for alcohol and other drug services are not the same as those for mental health services. Within this framework, a more nuanced approach to this kind of complexity will be needed. The problem is complex, and the solution will not be simple.

We identified four key areas.

Maintain specialisation

Although comorbidity is high in both sectors, the two sectors are very different in philosophy, intervention approach, structure, workforce, and funding.

To develop specialisation, both sectors need to:

- Have a clearly documented philosophy, approach and models of care. This will also assist in understanding whether, where and how to refer if needed
- Measure outcomes and impact of services

In addition, the alcohol and other drug sector needs to further develop the professional capacity of key disciplines, especially medicine, psychology, nursing and allied health.

Improve internal capability

The alcohol and other drug sector has participated in a number of initiatives that have improved the sector's capability in responding to service users' mental health issues, including sector wide implementation of the DDCAT service capability measure, and the development of sector wide comorbidity guidelines. There has also been a significant amount of training and workforce support offered to the sector in integrating mental health responses, such as the Pathways to Comorbidity Care and the Victorian Dual Diagnosis Initiative.

The equivalent initiatives in the mental health sector, accompanied by effective dissemination activities, could support the sector to feel more confident in responding to most co-occurring alcohol and other drug issues without needing to refer to a specialist service.

The next step for the alcohol and other drug sector is the introduction of mental health specialists within alcohol and other drug services. Psychiatrists, psychologists, mental health nurses and other allied health trained in the treatment of high prevalence disorders. This would support the needs of the sector to have advanced mental health capability without the disadvantages of integrating alcohol and other drug services into mental health.

Increase external collaboration

This includes formal mechanisms for cooperation, coordination and collaboration between alcohol and other drug and mental health services. It also includes mechanisms for cooperation, coordination and collaboration with other areas of health, including primary care.

Provide adequate funding and accountability

The right amount of funding in the right place is critical for good outcomes from treatment. Studies have found that the amount of funding, the source of funding and the types of services funded all have substantial impacts on outcomes such as relapse rates.

Both systems are underfunded, but alcohol and other drug services particularly so. It attracts around a tenth of the funding of mental health services. Forty one per cent of full time alcohol and other drug workers earn less than the average Australian income. It's difficult to attract and retain qualified professionals to a sector that is so chronically underfunded, which makes it difficult to improve specialisation.

The regular use of benchmarking and fidelity tools, such as the DDCAT and the DDMHT also provide internal and external accountability measures to ensure funding is having an impact on services' ability to respond effectively to complexity.

About this report.

Background.

In 2019, the Australian Health Minister tasked the National Mental Health Commission with developing the Vision 2030 Blueprint for Mental Health and Suicide Prevention. Vision 2030 provides a national direction for mental health and wellbeing in Australia.

Vision 2030 is a long-term blueprint for a successful, connected, and well-functioning mental health and suicide prevention system to meet the needs of all Australians. In late 2019, the National Mental Health Commission completed the first step in this process, producing the Vision 2030 framework.

In 2020, the National Mental Health Commission is developing an implementation roadmap that will examine in detail what is required from a policy, system design, service design and outcomes, funding mechanisms and workforce perspective.

Vision 2030 views mental health through an integrated wellbeing lens that accommodates a more sophisticated understanding of health, encompassing the connected social, emotional, spiritual and cultural, physical, nutritional, economic and mental wellbeing of individuals and communities.

It takes a stepped care approach to identifying need and delivering treatment, so that the least intensive effective treatment is provided to an individual at the time that it is needed, with the ability to move seamlessly into other levels of intensity of care.

The need to address alcohol and other drug responses has been consistently raised by stakeholders during the development of Vision 2030.

There is a high level of co-occurrence between alcohol and other drug and mental health problems in Australia.

The need to address co-occurring disorders has been recognised for more than 30 years without successful resolution. It is a challenge that has been well studied, and the problems are well understood, but very few programs translate to meaningful care.

In light of this, the National Mental Health Commission engaged 360Edge to develop a report that explores the role of alcohol and other drug policy, services, prevention and supports in a successful mental health system.

This report is not intended to be a comprehensive exploration of co-occurring alcohol and other drug use and mental health problems. It is focused on how to address alcohol and other drug responses in the mental health sector.

Our approach.

We interviewed 18 key experts from alcohol and other drug, mental health and primary care sectors, including peak bodies, clinical services, researchers, service users and people with lived experience, and policy makers (see page 4).

We used the interviews to identify the key issues, barriers and possible solutions for thinking about the place of alcohol and other drug services in a successful mental health system.

We then reviewed the peer reviewed literature, grey literature and policies and approaches in similar systems internationally to examine the feasibility and effectiveness of these potential approaches.

The original key experts who were interviewed, plus a number of additional experts, were invited to review a draft of the report.

Understanding the issues.

Since at least the mid 1990s, Australia has recognised the interplay between alcohol and other drug use and mental health.

We know that they commonly co-occur in the general community. We know that for some people they don't.

We know that they both commonly co-occur with a range of other social and health issues. We know that among people who use health services, the co-occurrence is amplified.

We know that for some people, alcohol and other drug use is a mental health problem. We know that for the majority of others, it is not. We know that alcohol and other drug use can sometimes generate or exacerbate other mental health problems.

We also know that some people with mental health problems are at increased risk of harmful alcohol and other drug use.

And we know that because of this complexity, many people 'fall through gaps' in the health system, not getting their needs met. [1]

People with multiple morbidities often have trouble accessing help.[2] Navigating the often complex pathways through the health system can be particularly challenging for people with co-occurring disorders and can influence whether they stay in treatment.

Stigma is also a major issue that influences treatment outcomes. It impacts on people's willingness to seek help and on the level of care they receive when they do.[3] It is borne out of fear and misunderstanding.

People with mental health problems experience significant stigma. People who use alcohol and other drugs experience even greater stigma, especially those who use drugs that are illegal. They are often seen as 'bringing it on themselves' for choosing to use drugs.

What is clear is that the thinking and actions to date have only touched the edge of the problems, and we need a new approach.

Many previous attempts to address the issue have been driven by factors other than the evidence base, from a narrow perspective, and rarely evaluated or evaluated well.

There are key differences between the alcohol and other drug and mental health service sectors, service providers, treatment philosophies, and operations that can explain how care gaps can occur.

These differences make partnering to meet service users' needs a complex endeavour. Even when there is good intent, the structures, or lack of them, can be a barrier to collaboration.

The question that remains is how to meet service users' (and the community's) alcohol and other drug and mental health needs wherever they are in the health system: 'No wrong door'.

Fundamentally, people working in both sectors, and across the health system more generally, want to provide the best possible holistic care, but how to achieve this is still a challenge.

In this report we look at current similarities and differences between drug and alcohol and mental health service systems; what works in addressing multiple morbidities; key issues and barriers to achieving greater cooperation and integration; and short and long term options for action.

The report is specifically focused on the place of the alcohol and other drug sector in the mental health system. It is not a comprehensive analysis of responses to co-occurring alcohol and other drug use and mental health problems.

As a result, it is necessarily, and intended to be, more focused on the perspective of the alcohol and other drug sector and where it fits in relation to mental health, while at the same time taking in the broader context.

Is alcohol and other drug use a mental health issue?

In order to understand the place of alcohol and other drug services in the mental health sector, the very first question is whether alcohol and other drug use can be conceptualised as a mental health issue.

The answer is complex. At one level, some alcohol and other drug problems, such as dependence, might be considered a mental health problem. They are recognised in relevant mental classification systems. At another, alcohol and other drug use can create or amplify mental health problems. Sometimes they are unrelated.

The solution? Alcohol and other drug use cannot always be considered a mental health issue. It is broader, deeper and wider. So we must consider the two sectors as related and overlapping, but unique.

Alcohol and other drug use is broader than mental health

Like most things, alcohol and other drug use exist on a continuum. At one end, where people experience problems with their use such as dependence, there are social, physical and mental health sequelae.

At this end of the use spectrum, in many ways, alcohol and other drug problems are similar to, or a subset of, mental health problems because they affect mood, wellbeing and cognitive functioning. They are considered a mental health disorder in classification systems.

Here, alcohol and other drug services, like mental health services, are focused on the most complex problems and the people in most need of assistance. However, this is only one part of the very wide spectrum for alcohol and other drug services.

Unlike mental health issues, for many people alcohol and other drug use is an enjoyable experience with few problems, and may have functional value. Mental health issues, on the other hand, tend to be viewed as negative experiences, even at the non-problematic end of the spectrum.

Not all alcohol and other drug use has psychological and social impacts that would put them within the realm of a mental health issue.[4] Some people use drugs to reduce negative mental health symptoms.

From our consultations:

> *I don't automatically conceptualise use of alcohol and other drugs as a mental health issue. There's a whole spectrum of use, from people who have problems but no mental health issues. And then there are a significant number of people who overlap... but this is not everyone. The issues don't automatically fit together.*

The majority of people who use alcohol and other drugs do so occasionally, do not become dependent, and don't experience severe or long term problems as a result of their use.

The most recent National Drug Strategy Household Survey[5] found that around 80% of adults drink alcohol but 70% of those drinking weekly or less; 11.4% of adults have used cannabis in the past year with two thirds using just once a month or less; and 1.3% of adults have used methamphetamine in the past year with more than 80% of those using 12 times a year or less. Most people who use alcohol or other drugs do not require treatment.

Because most alcohol or other drug use does not result in problems, the primary driver of alcohol and drug policy in Australia is a public health perspective.

From our consultations:

> *I think in recent years there has been a change in how we view alcohol and other drugs because they are more embedded in the mental health space. But not all people with alcohol and other drug issues have mental health issues... there is an overlap but it is not necessarily the case that alcohol and other drug is always a mental health issue and if perceived this way it can act as a barrier to seeking help – because of the stigma.*

The continuum of alcohol and other drug use spans from no use to occasional use to regular use to dependent use. Dependence is only one aspect of problematic use. People may experience harms or problems along the spectrum of use. There are a number of other problems that may be associated with alcohol and other drug use that would not be considered a mental health condition (for example increased risk of using and experiencing violence), taking problematic alcohol and other drug use outside the usual definition of a mental health condition.

The continuum of responses goes beyond mental health interventions

To respond to this continuum of alcohol and other drug use in Australia, there is a very broad range of services that address alcohol and other drug harms, from prevention to harm reduction to early and brief intervention to tertiary treatment.

Primary prevention aims to prevent alcohol or other drug use in people who have not started using. Secondary prevention aims to reduce harms of current use and reduce the risk of increased problems among people who have already started using alcohol or other drugs. Most alcohol or other drug use does not progress to heavy use or significant problems, but secondary prevention is designed to prevent problems developing for those at risk, and also to address emerging harms so they do not become problematic. Tertiary intervention is for people who are experiencing more significant problems with alcohol or other drugs, including dependence.

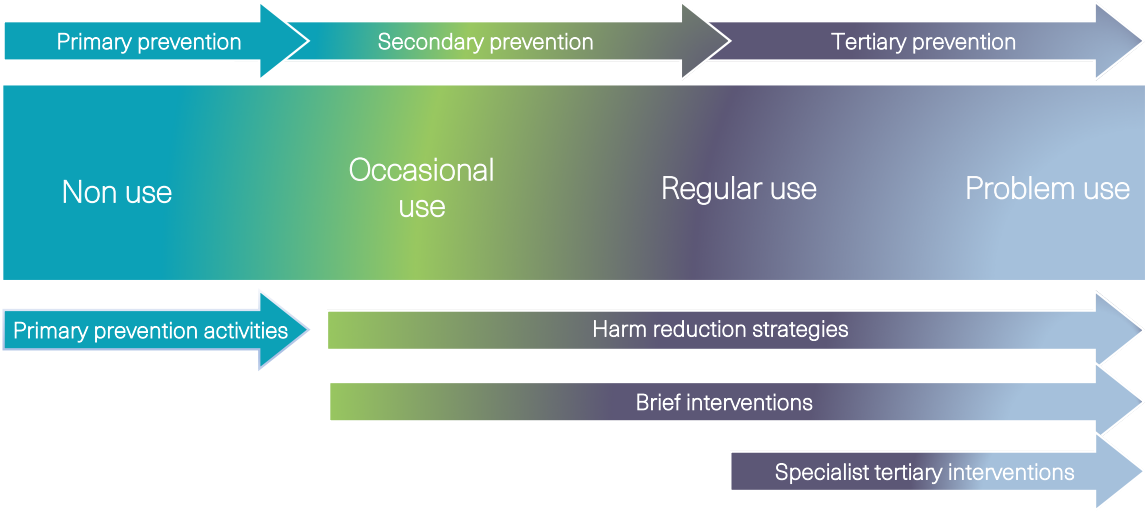
There are corresponding interventions across the spectrum of alcohol and other drug use. Prevention activities are largely delivered through schools and other

community groups to people before they use alcohol or other drugs and to those who have or at risk of using alcohol or other drugs. Examples include the Climate drug education program for schools[6, 7] and the Good Sports program[8] for sporting groups. Prevention also includes activities aimed at modifying the social and structural determinants of health such as poverty, education and employment.

Secondary prevention activities are typically delivered to people who use occasionally or regularly right through the health system. They are sometimes referred to as 'early intervention' in some areas of health. An example is Hello Sunday Morning, an online community that provides support for people who do not need tertiary treatment but who want to reduce their drinking or the negative consequences of their drinking. Secondary prevention can be delivered by non-specialists in alcohol and other drugs, such as general practitioners and mental health clinicians, as well as alcohol and other drug specialists.

Harm reduction strategies are specifically designed to reduce harms associated with any level of use. Examples include needle and syringe programs,[9] drug checking services at festivals,[10] random breath testing of drivers.[11]

Brief interventions are for anyone who uses alcohol or other drugs. They are delivered right through the health system by specific harm reduction organisations, non specialists and specialists in alcohol and other drugs. They are sometimes opportunistic (for example, someone seeing their GP for a general health issue is asked about their alcohol consumption). Brief interventions can be as little as 5 minutes up to a few hours and have been shown to reduce use and harms among people across the spectrum of use, although effectiveness varies across brief intervention types. Examples include a 2 or 4-session counselling intervention for people who are



Continuum of use of alcohol and other drugs and treatment in Australia

dependent on methamphetamine[12] and screening and 5-minute opportunistic interventions in primary care.[13]

Tertiary interventions are delivered primarily through specialists in alcohol and other drug treatment, including government, not for profit and private services. Examples include counselling, residential rehabilitation, opioid pharmacotherapy and outpatient and inpatient withdrawal services.

This continuum of responses goes beyond the clinical perspective in the mental health sector. The mental health sector typically focuses on acute crisis presentations and management of chronic mental illness. Neither of these applies to the large majority of people who access the range of interventions available in the alcohol and other drug sector.

Alcohol and other drug use goes beyond health

Arguably, more than other areas of health, alcohol and other drug use and harms are not only a clinical health and a public health issue, but also a human rights issue. There are human rights implications across all areas of health, but the question of human rights has gained significant focus in recent years, and is made more significant in the alcohol and other drug sector, because many drugs are illegal.

From our consultations:

> *There is a socio-political overlay in alcohol and other drugs that doesn't exist in the mental health sector, so it can be difficult for them to understand that concept and take account of it. Mental health has more of a medical framing.*

There are questions about the right to self determination (that is the right to choose to use alcohol and other drugs if it is not affecting others negatively) and the right of all people to life, health and wellbeing as outlined in the Universal Declaration of Human Rights.[14]

The provision of treatment is a human right, especially ensuring that it is both equitable and effective, which raises questions about compulsory treatment, for example.[15]

In addition, because some drugs are illegal, alcohol and other drug responses also have to consider criminal justice perspectives. This is a constantly evolving area, as demonstrated by the changes to both recreational and medical cannabis regulation.

Alcohol and other drugs as a specialist health area

Alcohol and drug problems have historically been treated as separate and distinct from mental health disorders. This is at least in part because problems with alcohol and other drug use were initially seen as a moral deficit (for example, temperance movement), and then as a criminal issue, rather than a health issue. The shift to truly applying a health perspective is much more recent.

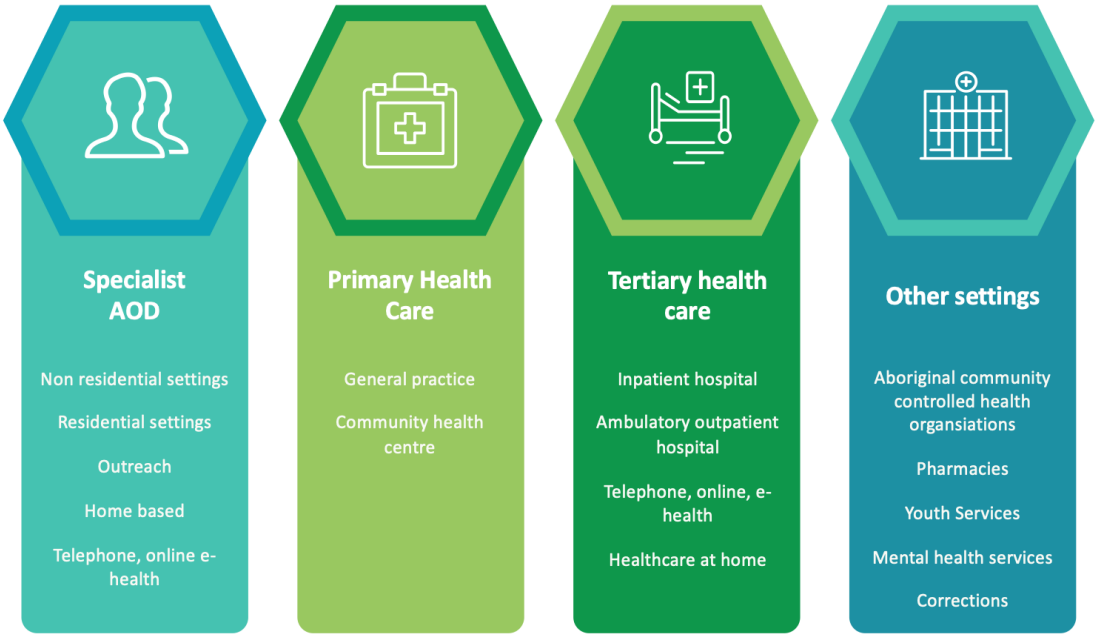
Early forms of intervention in the alcohol and other drug sector were peer driven and focused on people with very significant problems with their alcohol or other drug use, starting with mutual aid groups such as

Alcoholics Anonymous. Professionalisation of the sector, in line with other areas of health, came much later.

As a result, the alcohol and other drug sector may not be seen by other sectors as a specialist health area. It has itself, only relatively, recently realised its own specialist capabilities and its place in the broader health system. This is reflected in the development of addiction medicine specialists and nurse practitioners with specialty skills in alcohol and other drugs.

The National Framework for Alcohol, Tobacco and other Drug Treatment 2019-2029 is the first clear national conceptualisation of the varied settings in which alcohol and other drug intervention occurs, including specialist alcohol and other drug, primary health care, tertiary health care and other specialist settings including mental health. In the framework it is seen as a distinct speciality, not as a subspecialty of another sector, such as mental health.

If alcohol and other drug use is not considered wholly a mental health issue, and the alcohol and other drug sector is viewed as a specialist area, the question then arises about its relationship with the mental health sector.



Alcohol and other drug treatment settings in Australia

Source: The National Framework for Alcohol, Tobacco and other Drug Treatment 2019-2029

The problem of comorbidity.

What is comorbidity?

Co-occurring disorders describe the presence of two or more disorders or illnesses at the same time in the same person. Other terms used to describe co-occurring disorders include dual diagnosis, co-existing disorders, concurrent disorders, and comorbidity.

Co-occurring alcohol and other drug and mental health disorders are one type of comorbidity, but there are a number of other co-occurring health and social issues that impact on people with alcohol and other drug and mental health disorders, such as physical health, family violence, legal problems, and child protection issues.

The co-occurrence of alcohol and other drug use with mental health problems is relatively high in the community and amplified in both treatment services.

Alcohol and other drug use among people with mental health problems

In the Australian general community, 28 per cent of men and 14 per cent of women who have an anxiety disorder, and 34 per cent of men and 16 per cent of women who have an affective disorder, also met criteria for an alcohol or other drug disorder.[16]

People with psychotic disorders use alcohol and other drugs at much higher rates than the general population.[17, 18] One in 4 people with a serious mental illness like major depression, schizophrenia, and bipolar disorder, are likely to also have a co-occurring substance use problem.[19]

People with a mental health condition are twice as likely to smoke daily (20% compared with 9.9%); around 1.2 times more likely to drink alcohol at levels that exceed the lifetime risk (21% compared with 17.1%) and single occasion risk guidelines (31% compared with 25%); 1.7 times more likely to use any illicit drug (26% compared with 15.2%); and twice as likely to have used methamphetamine (2.6% compared with 1.2%) and pharmaceuticals for non-medical purposes (7.6% compared with 3.6%).[5]

In clinical mental health services, the rate of problematic alcohol and other drug use have been estimated between 11 and 71 per cent.[20]

Mental health problems among people who use alcohol and other drugs

Between 70 and 90 per cent of people in alcohol and other drug treatment services in Australia meet diagnostic criteria for at least one mental health disorder,[20] and at least a third have multiple co-occurring disorders.

A proportion of cases probably go unrecognised. Only half of alcohol and other drug service users have a mental health disorder documented in their medical records.[21]

The most common mental health disorders among people receiving alcohol and other drug treatment are depression, anxiety, post-traumatic stress disorder and personality disorders.[22]

Over 60 per cent of adolescents in community-based alcohol and other drug treatment programs also meet diagnostic criteria for a mental illness.[23]

Suicide

There is a complex relationship between alcohol and other drugs, mental health and suicide. There is a higher risk of suicide among people who have either mental health problems or who use alcohol or other drugs.

The causal direction is not well established, but probably reflect the various aetiologies that apply to the co-occurrence of alcohol and other drug and mental health problems.

Substance use disorders are strongly associated with increased risk of suicidal ideation, suicide attempt and death.[24, 25]

Collectively, substance use disorders put someone at a 10-14 times greater risk of suicide than someone from the general population.[26] There is a significant gap in the literature for rates of suicide for Aboriginal and Torres Strait Islander peoples who have attended substance abuse treatment.[27]

From our consultations:

> *The role of alcohol and other drugs in suicide presentation is underestimated and minimised [in the mental health sector]. There is a tendency to dismiss cases where someone is intoxicated.*

There are strong associations between mental health and suicide,[28] but a mental health disorder in combination with a substance use disorder puts someone at significantly greater risk of suicide.[29] Combined alcohol use disorder and depression in men has the highest risk of suicide. [29]

From our consultations:

> *The biggest thing that upsets me is the lack of understanding or acknowledgement of how much someone's alcohol and drug use can impact them on making that decision around suicide; can be overall use, but especially on that specific occasion and they use drugs. When people are talking about suicide and how to prevent it, there doesn't seem to be an acknowledgement of [the impact of] alcohol and drug use.*

Causes of co-occurring disorders

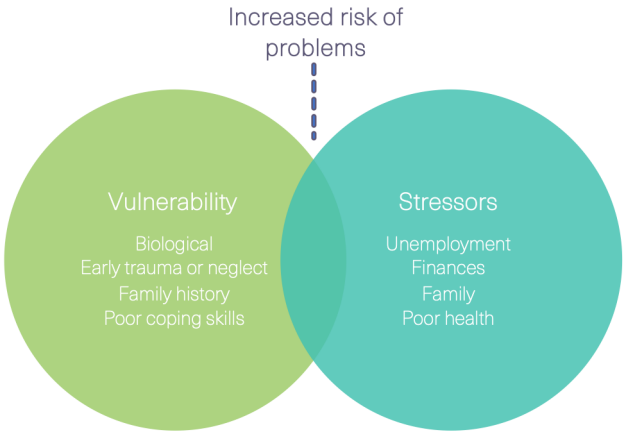
There is not a single causal mechanism in the development of co-occurring alcohol and other drug and mental health problems. There may be a direct or indirect causal link, or common aetiological factors, or sometimes simple coincidence, especially in the case of the higher prevalence disorders. In all likelihood, one or more of these may apply to a single individual.[22]

The stress-vulnerability model draws these potential causes into a single conceptualisation.[30-32] An individual's psychological or physical makeup increases their vulnerability to developing symptoms of mental health or alcohol and other drug use disorders.

This is referred to as the stress vulnerability model. It explains why some people experience co-occurring problems while others do not. Social, psychological and genetic factors combine to influence individual vulnerability; then exposure to risk and protective factors impact on the development of mental health and/or alcohol and other drug problems.

From our consultations:

> *The Stress-vulnerability model provides a simple evidence-based tool for education to explain the relationship between substance use and mental health. It is equally applicable to both AOD and MH specialties. If both services take this approach it provides a consistent message, which up until now has been missing.*



Stress vulnerability model

Regardless of aetiology, there is a bi-directional relationship between alcohol and other drug use and mental health problems: mental health problems can increase alcohol and other drug use and alcohol and other drug use can increase mental health problems. Even when there are potentially common causes, the resulting problems are nonetheless distinct.

From our consultations:

> *Early life disadvantage, for example, impacts on poorer education, employment and income outcomes, but the social systems responses to these outcomes are different. Although there may be common factors in the development of alcohol and other drug and mental health problems, the resulting problems require different solutions.*

Risks and harms associated with comorbidity

The co-occurrence of one disorder increases the risk of harm and relapse in both problems.[33]

The clinical profile of people presenting with co-occurring disorders is complex[34] and can include poorer general physical and mental health, greater drug use severity, and poorer functioning, a higher risk of suicidality, greater social impairment and poorer treatment outcomes than those with only one disorder.[22, 35, 36]

From our consultations:

> *We work in siloed healthcare systems that specialise, but it means we tend to forget that the people accessing care have a range of needs.*

People with co-occurring mental health-substance use concerns are at greater risk of a range of other harms, including increased treatment costs; more frequent hospitalisations; compounded trauma; involvement in the criminal justice system; homelessness; unemployment and work instability; and violence and exploitation.[37]

The current service system means that some people affected by co-occurring alcohol and other drug and mental health and drug use disorders can 'fall between the gaps' in services, not receiving optimal care.

Responding to comorbidity.

The complexity of responding to comorbidity.

There is a huge diversity of the combination and severity of co-occurring alcohol and other drug and mental health problems. There are multiple mental health conditions and multiple drugs that people use. Both exist on a continuum of severity from none to mild to moderate to severe.

This creates a nearly infinite range of problems and gives rise to an equally large diversity in treatment needs and preferences.

From our consultations:

> *...what is needed is an array of different alcohol and other drug and mental health services – each service with their particular 'job' [cohorts or particular needs or treatment support they specialise in] but all with a developed ability to recognise and provide or facilitate integrated treatment for the people they serve (and sophisticated No Wrong Door engagement and referral processes for people who arrive whose needs are best met elsewhere).*

People fall through the gaps in the health service system when their specific combination of needs cannot be met.

Should services be integrated?

What is integration?

'Integration' is the 'go to' solution to the challenges of comorbidity. What is clear from the key expert consultations for this report is that the term 'integration' has very different meanings for different people.

One early literature review identified at least 175 different definitions of the term 'integration' in health care systems, with many distinct terms, such as 'integration', 'integrated care' and 'integrated service delivery' used interchangeably.[38]

As a broad concept, the goal of integration is to ensure all a service user's needs are met in some kind of coordinated and seamless way. It involves organised management of care in some form. It can operate at multiple levels including policy, funding and budget, administration, organisational, service delivery and clinical.[39] [40]

In this report, we distinguish between three types of integration: integrated systems, integrated services, and integrated treatment.

Systems integration involves combining policy, funding, budget or administration of different services.

Service integration aims to integrate different types of services, such as alcohol and other drugs and mental health, or withdrawal and residential services that are independently operated.[41, 42]

Treatment integration is the treatment of multiple problems with a single practitioner or service. For example, a psychologist who can treat both alcohol dependence and an anxiety disorder, or a residential rehabilitation service that has mental health nurse as part of their treatment team.

Systems integration

Since mainstream recognition of the need to address co-occurring disorders began in the 1990s, there have been attempts to operationalise a better connected system.

Chief among them have been several attempts to integrate systems at the funding and policy level.

Although there has been no evaluation of systems integration, this has been, by all accounts, ineffective with unintended consequences.

One of the key problems has been a loss of skill and willingness to address co-occurring disorders – the opposite of what is intended with systems integration.

From our consultations:

> *Mental health and alcohol and drug services in NSW separated in the 1980s. Up until then mental health provided alcohol and drug services, but it was more cost effective to have people with lived experience to deliver alcohol and other drug services. Funding was taken from mental health services to deliver to alcohol and other drug services and a clear message was given to mental health not to deal with alcohol and other drug issues because they were not funded for it. Then later it was realised people with serious mental illness were developing substance use problems, so in the late 1990s mental health staff were starting to be told again that they should be dealing with alcohol and other drug issues, which was a challenge to get through after the previous messaging and training that they should not be focusing on.*

A further unintended consequence of this approach has been a loss of funding for alcohol and other drug services.

From our consultations:

> *Integrating alcohol and other drug services into mental health services is like integrating Australia into the USA... We became integrated with mental health through a Director General who had an interest in both domains. Initially, we were resistant to the idea and strongly advocated our concerns. Forcing integration... well we [alcohol and other drug services] lost their identity - the mental health dog wagged the alcohol and other drug tail. Mental health services simply overwhelmed the alcohol and other drug domain. We experienced problems like budget raiding. Integration with all health services is important but it shouldn't just be a situation where alcohol and other drug services are simply taken over by mental health.*

The experience of integrating alcohol and other drugs into mental health at the policy level has also had mixed results. Examples of this are integrating alcohol and other drugs and mental health public service divisions;

integrating administration of alcohol and other drug and mental health funding within the Primary Health Networks; and placing alcohol and other drug policy under the mental health commissions.

A common outcome is that alcohol and other drug policy becomes overwhelmed by mental health policy. Mental health policy and strategy has often been applied directly to the alcohol and other drug sector in an attempt to align the two areas, without consideration of the unique contexts.

Examples offered by key experts include the application of the mental health recovery model to alcohol and other drug services, and the application of the mental health staged care model to alcohol and other drug treatment.[43]

In some jurisdictions, where mental health commissions, funding bodies or public service departments are responsible for both alcohol and other drugs and mental health policy, the vast majority of resources tend to be allocated to mental health. In one, for example, although multiple people may have input into alcohol and other drug policy, 95% of staff are specialists in mental health with little or no alcohol and other drug sector expertise.

This means that, not only is the mental health perspective dominant, but often that perspective is applied to alcohol and other drug policy without an understanding of the nuances of each system. Because people assume that alcohol and other drug use is a mental health problem, they may not realise that a different perspective even exists.

From our consultations:

> *[Alcohol and other drugs] is always an afterthought. The resourcing is not right. It's out of balance. Mental health is usually dominant. It's an issue across the board [in policy]. Alcohol and other drugs is not understood broadly across different departments and sectors.*

Service integration

Arguments for integrating services

Service users prefer a 'one stop shop'

Service users prefer to receive as much of their health care in one place as possible.[44]

They prefer not to have to tell their 'story' to multiple providers.[45] They find it difficult to assimilate different philosophical perspectives (for example, abstinence only versus flexible goals) from different practitioners.[46]

From our consultations:

> *There's confusion around alcohol and other drug issues and their complexity, and how to relay that to consumers. We need some clear, synthesised agreed upon messages... at the moment, some [practitioners] will say [an alcohol and other drug problem] is a disease, others say it's a mental health problem, another will say it's [a symptom of] trauma, another will say it's just a behavioural manifestation.*

People with co-occurring disorders have higher rates of satisfaction with integrated mental health and alcohol and other drug treatment compared to standard treatment

that doesn't have a co-occurring disorder focus.[47]

Out of sight out of mind

One key expert interviewed was explicitly in favour of full systems and services integration, more specifically bringing alcohol and other drug services under mental health services as a subspecialty.

They noted that without integration, mental health services, in particular, do not see addressing co-occurring disorders as core business and tend to deprioritise treatment for that group.

The subsuming of alcohol and other drug treatment as a subspecialty of mental health would potentially normalise the treatment of alcohol and other drug responses for mental health service providers. Integrated care also offers consistency of advice, which can be more difficult to achieve with distributed care.

From our consultations:

> *How do we train mental health services to do alcohol and other drug work? We have to make it part of core business... While there is still a separate service system, mental health will continue to say it's not our problem... Mental health services lack interest, knowledge, capacity [to respond to alcohol and other drug issues].*

Others from both sectors agreed that it has been difficult to get mental health services to view responding to alcohol and other drug issues as core business.

From our consultations:

> *[Mental Health] don't want to see alcohol and other drug clients. This is the main reason they want to integrate.*

Arguments against integrating services

From our consultations:

> *There has been pressure on the mental health commission to just tumble them together. I think it would cause more problems, with people accessing alcohol and other drug services falling through the gaps.*

Why integrate only alcohol and other drugs and mental health?

People with alcohol and other drug problems and people with mental health problems both have higher rates of a range of other morbidities that the general population[47, 48] including physical health, housing and homelessness, legal problems, child protection, and family violence.

From our consultations:

> *Why would we try to integrate these particular two services when there are overlaps with many other health issues?*

An argument could be made for the vertical integration of any or all of these other services with either alcohol and other drug services or mental health services. Integrating all the services required for people with alcohol and other drug, or mental health, problems, or giving precedence of one over any other service, is unrealistic.

From our consultations:

> *We know that both substance use (as well as mental health) impact on physical health but nobody wants to integrate those services do they? We just want to have those services functioning well and collaborating effectively.*

Different cultures, philosophies and interventions

From our consultations:

> *Alcohol and other drugs and mental health should be separate industries because the deeper you get into it, the more you understand the differences involved in the sectors. The reason they need to be separate [is that] there are very different interventions that need to occur, it's too much to expect one person to know it all.*

The nature of interventions across the two sectors is quite different. The alcohol and other drug sector has a large investment in prevention, supply control, harm reduction and brief interventions along with more specialist tertiary treatment.

Public mental health services have a strong focus on the management of acute crises and responses to long term chronic illness, like psychotic disorders and acute suicidality.

As a result, the private sector (for example, private general practitioners, psychiatrists, psychologists and other allied health in private practice, and private mental health hospitals) takes up a sizeable proportion of mental health care for the higher prevalence disorders, such as anxiety and depression. Prevention of mental health problems is more often in the form of mental health promotion and addressed outside the clinical and community mental health sector.

From our consultations:

> *Part of the problem in some locations is that the majority of alcohol and other drug services are in [non government] community settings... and mental health services are part of public mental health – different policies, processes, methods of treatment and philosophies can be a challenge.*

The central approach of most mainstream alcohol and other drug services is harm reduction, even those that are abstinence oriented for the purposes of treatment. For example, in many residential rehabilitation services, a short lapse to use is not an automatic reason for discharge.

From our consultations:

> *Addiction services are a cultural mismatch with mental health services.*

Most alcohol and other drug services that provide specialist treatment also deliver interventions for acute and chronic presentations and engage in secondary

prevention and harm reduction activities. There is a concern in the alcohol and other drug sector that alcohol and other drug services will lose the capacity for the broad range of interventions they provide if merged with a clinical system that is focused almost exclusively on acute low prevalence disorders.

From our consultations:

> *We talk about the issues as though they are the same thing... the same solutions for mental health are just applied to alcohol and other drugs, and it doesn't work. There are so many differences between the sectors. They just have completely different cultures.*

Service user crossover is minimal

Although the rate of comorbidity is high in both alcohol and other drug and mental health services, the types of mental health disorder seen in public mental health treatment services differs from those seen in public alcohol and other drug treatment services, and the severity of alcohol and other drug disorder differs between the two types of services. The two sectors have quite distinct service user groups, with limited overlap.

Mental health problems among people in alcohol and other drug services are primarily the higher prevalence disorders, including anxiety (up to 70%) and depression (up to 60%), and personality disorders (up to 70%).[22] Prevalence of psychotic disorders among people in alcohol and other drug treatment is elevated but still relatively low at around 10 per cent, and are typically chronic and stable, rather than acute. The opportunity and need to refer to public mental health services is minimal, especially as alcohol and other drug services have continued to build expertise to manage these issues within their own services.

Public mental health services primarily treat people with low prevalence disorders such as schizophrenia, bipolar affective disorder and acute suicidality.[49] The range of alcohol and other drug problems in mental health services may span from non-problematic use to severe problems, while those in specialist alcohol and other drug treatment (aside from harm reduction services) are typically moderate to severe.

From our consultations:

> *Mental health services need to account for non problematic use. The question [for mental health] is, who are the drug using population that they need to worry about. It's not everyone. Just because someone is using drugs does not mean they need to be sent to [alcohol and other drug services].*

Alcohol and other drug services need the capability to respond to mental health problems that are generally higher prevalence, not acute and less severe. Mental health services need the capability to respond to a range of alcohol and other drug problems in people who primarily have lower prevalence mental health problems. There is also a need to ensure good assessment, effective case management, and referral if needed in both sectors.

The service structures are different

There is a huge structural difference between the way alcohol and other drug

treatment and mental health treatment is offered.

Public mental health services are provided primarily through clinical mental health services such as psychiatric services in general hospitals, long stay facilities and specialist psychiatric services.[50]

There are also community mental health services. These are largely peer based. They offer services such as helpline counselling, accommodation support and outreach, self-help and peer support; employment and education; family and carer support; information, advocacy and promotion; and leisure and recreation services.[50]

Public non-residential alcohol and other drug services, are referred to as 'community services' but are generally more similar to clinical mental health services than community mental health services.

They are referred to as community based because they rarely operate from hospitals or medical services. They provide a range of therapeutic services. The most common treatment type is, counselling at around 42 per cent of episodes of care.[51]

Community based alcohol and other drug treatment sometimes includes integrated peer support services.

The range of service providers varies between states and territories. In most states and territories, except NSW, the majority of these services are non-government organisations.

The bulk of publicly funded alcohol and other drug services, including clinical services, are provided through non-government organisations.

Residential alcohol and other drugs services are mostly provided by non-government organisations and generally not hospital based. There are some hospital based withdrawal services.

State or territory	% NGO services
Australian Capital Territory	88
New South Wales	36
Northern Territory	80
Queensland	66
South Australia	63
Tasmania	69
Victoria	99
Western Australia	91

Source: National Minimum Dataset 2018-19. Data is based on number of agencies, not funding.

There are also peer based services in the alcohol and other drug sector that serve a range of support functions, including harm reduction and peer education and support.

From our consultations:

> *While the term 'peer' is used in both sectors, the understanding of what this term means is quite different. Our experience with integration of alcohol and other drug and mental health services is … that it tends to lead to a prioritising of mental health services over alcohol and other drug services and a diminution of the scope of AOD work. This imbalance also extends to recruiting peer workers and consumer representatives, where people who may identify as a peer in the 'mental*

health space' are assumed to be adequately qualified by their status as a consumer of mental health services to engage effectively with, or represent the interests of, people who use alcohol and other drugs.

In addition, both alcohol and other drugs and mental health services are provided through general practitioners and private health professionals, partially supported by Medicare and private health funds.

The workforces are different

There are some practitioners in alcohol and other drug services with medical, nursing, psychology and other professional backgrounds, but the workforce is made up of a large proportion of non professionals in generic positions, although there are considerable jurisdictional differences.[52]

The most common occupation is 'drug and alcohol counsellor' (23%), and only 58 per cent of workers have an undergraduate degree or higher.

Sixty-seven per cent of people in client service roles have specialist qualifications in alcohol and other drugs, most commonly Certificate IV level. A large proportion of the workforce have lived experience in terms of their own use or treatment (50%), or have cared for someone else who has (68%).

From our consultations:

> *Alcohol and other drugs - and maybe mental health - need to grow the professional workforce to grow as a specialty.*

Forty one per cent of full time alcohol and other drug workers earn less than the average Australian income.[52]

The clinical mental health workforce is much more professionalised than the alcohol and other drug workforce, and have a high proportion of psychologists, mental health nurses and psychiatrists.[53]

Stigma and discrimination

Stigma is when people view someone in a negative way because they use alcohol or other drugs, or have a mental health problem. It is largely a result of misunderstanding these problems. It can lead to discrimination (being treated negatively).

Stigma and discrimination make alcohol and other drug and mental health problems worse. They can affect how people feel about themselves, the messages they are given about their use, their willingness to seek help the access to and quality of treatment they receive, and their treatment outcomes; it impacts on treatment seeking and increases self stigma.[54-56]

Although people in both sectors experience stigma, a significant amount of work has been undertaken in the general community to reduce the stigma associated with common mental health problems.

Significant stigma and discrimination still face people who use alcohol and other drugs. Our key experts noted that the mental health sector had done very well in reducing stigma towards people with common mental health problems in the general community,

but it was still a major problem for people who use alcohol and other drugs.

From our consultations:

> *We have come some distance in addressing [stigma and discrimination in the community] in mental health, but we are almost at ground zero with substance use.*

People with alcohol and other drug problems face similar stigma to people who have mental health problems but experience additional stigma because some drugs are illegal. There is also considerable discrimination against those who use prescribed opioids and other pharmaceuticals, who are often assumed to be 'drug seeking' for non therapeutic purposes.

The general community and some health professionals sometimes have a view that alcohol and other drug problems are not 'real' health problems and that people have 'brought it on themselves' for choosing to use drugs.[56, 57]

From our consultations:

> *People who use [illicit] drugs are seen as criminals who do not deserve treatment because they should have chosen not to take the drugs.*
>
> *It's hard to destigmatise something that is illegal.*
>
> *The community still sees alcohol and other drug use as a self discipline problem.*

Many key experts from both sectors noted that, in their experience, people who used drugs were often turned away from general health and mental health services under the guise of referral because mental health professionals have stigmatised views about people who use drugs.

From our consultations:

> *Perspectives on alcohol and other drugs within mental health are outdated – we still see the view 'they brought it on themselves'.*
>
> *People who work in mental health still tend to be pretty judgemental about people who use drugs and alcohol and they still turn people away and just think that they shouldn't be using [alcohol and other drugs].*
>
> *Stigma around alcohol and drug use prevents a lot of things happening...mental health clinicians don't want to work with people that use ice for example [because of stigma]. [Also applies to] funders and broader society.*

The stigma experienced by people who use alcohol and other drugs also extends towards services and workers, making it more difficult to attract people to the sector.

From our consultations:

> *Stigma is a very major issue for services and staff [in alcohol and other drug services]. It is reflected in 'low priority' services that are poorly funded. They get the old worn out building etc... have you ever seen a purpose-built alcohol and other drug facility? I can't recall one.*

People with alcohol and other drug use problems but who do not have a mental health issue also may be dissuaded from seeking help through mental health services because of the stigma they face.

Key experts noted that until stigma towards people who use alcohol and other drug is addressed within mental health services, alcohol and other drug responses will continue to be viewed as less important, and people are more likely to have access to treatment denied.

From our consultations:

> *Mental health [services] don't think [alcohol and other drug treatment] is important – we need to change that at the leadership level.*

Treatment integration

From our consultations:

> *We need to integrate care not services*

Treatment integration is the treatment of two or more issues within a single service or by a single practitioner. It may be fully integrated, parallel or sequential.

In smaller regional and rural areas, services are often integrated, and when people adopt pragmatic and person-centred approaches, services can be quite effective.

From our consultations:

> *There is some sense in this when there are modest resources and staff and expertise.*

There is evidence that meeting both alcohol and other drug and mental health needs improved outcomes, but the evidence is mixed.[42]

Fully integrated treatment which addresses both disorders simultaneously, including the interaction between them, is effective, but no more effective than other forms of dual treatment.

A recent Cochrane review[58] found no benefit of treatment integration over standard care for people with severe mental illness. There was no difference in numbers lost to treatment, deaths, alcohol or other drug use, global functioning or general life satisfaction. An earlier systematic review found no benefit of integrated care over non-integrated care.[59] A more recent review found mixed results for integrated treatment when compared to single focused treatments.[60]

There is some evidence that parallel treatment, in which both disorders are addressed at the same time but by separate clinicians, improves both alcohol and other drug and mental health symptoms more than single interventions.[61] Parallel treatment has not been found to be effective for people with psychotic disorders or other more severe diagnoses.[62]

Sequential treatment involves addressing both disorders, but one at a time. There is evidence that only addressing alcohol and other drug needs can improve mental health,[63-67] but may increase the likelihood of relapse[68] and is not as effective as dual treatment.[69]

When there is a need to improve cognitive or physical functioning related to one diagnosis before beginning treatment of another diagnosis, sequential treatment may be appropriate.[59]

These findings suggest that for most people with co-occurring disorders who would be eligible for mental health services in

Australia, fully integrated treatment is better than other forms of dual treatment.

For people with multiple morbidities in alcohol and other drug services, fully integrated or parallel treatment would have benefit, and sequential treatment is better than not addressing mental health issues at all.

Integrated versus holistic care.

Ultimately the aim of systems, service and treatment integration is to provide a service that can address multiple service user needs.

But systems and service integration has been problematic in previous attempts.

Integration is resisted by both alcohol and other drug services and mental health services. It shows mixed results and is not always what service users want.

It is time to stop trying to fit the square peg into the round hole. Rather than trying to integrate services or treatments, ensure there are structures in place for all health services to take a holistic approach to support service users' needs.

From our consultations:

> *We should be looking at conceptualising the whole person [in every service] rather than trying to integrate services… we should be looking at holistic care.*

Models that support holistic care.

Care coordination

Care coordination is a partnership approach that offers support services and structures, such as case management, to coordinate an individual's care and link service users in with appropriate treatment resources.

Coordinated care approaches improve treatment initiation by addressing systems barriers to initiation, which leads to positive treatment outcomes.[70]

Adequately resourced case management involving team-based, multi-disciplinary, patient-oriented and clinically coordinated care has some impact on reducing alcohol and other drug use and improving quality of life but seems to have less effect on mental health symptoms.[44]

Case workers with alcohol and other drug knowledge and training in mental health services provide more effective treatment to people with co-occurring alcohol and other drug and mental health issues compared to workers solely trained in mental health. The combined focus of alcohol and other drug and mental health improves coordination between alcohol and other drug and mental health services and improves the accessibility of these services for individuals.[71]

In a system that is often described as 'fragmented' and 'siloed', case workers capable of meeting both alcohol and other drug and mental health needs would help service users navigate the system, streamline referrals between services, and improve retention in treatment.

From our consultations:

> *People end up bouncing between sectors. We need a person responsible for delivering coordinated care and development of relationships... for the right people in the right service at the right time.*

Whether or not the service delivery follows a parallel or fully integrated model, well-coordinated services are significant when it comes to treatment outcomes, as are multidisciplinary teams, specialist-trained personnel, include a range of program types and provide long-term follow up.[72]

From our consultations:

> *We have a mental health coordinator and we try to get all the services to come together weekly to case manage. Rather than the previous system of parallel systems of care that didn't relate, we now have coordinated case management. We agree to share information with the permission of the client and we can identify the one key principle service supporter and we can link to a psychiatrist (in this case a fly in person) and also identify and*

coordinate other issues such as housing. We need that kind of coordination. We can deal as an alcohol and other drugs service much better with alcohol and other drugs clients who also have mental health problems, so there's a need to have the staff and expertise and resourced coordination.

LikeMind

LikeMind is a pilot program funded by the NSW Ministry of Health designed to provide support for people with mental health concerns, as well as their families and carers. The focus is on providing holistic care for people with mental illness. This includes the development of coordinated care plans for consumers that connect them in with services like mental health care, drug and alcohol services, employment and training support, housing assistance, and access to general practitioners and other allied health. There are four LikeMind centres in New South Wales.

Colocation of services

Colocation of services places a number of relevant services in a single location with the aim of increasing access to services that meet an individual's needs. For example, community health centres often have multiple co-located health services, including alcohol and other drug, mental health and primary care.

There are few studies that have examined the effectiveness of co-locating services for people with co-occurring disorders. A series of case studies found that having behavioural health providers co-located in community health centres increased the likelihood that primary care providers would screen for alcohol and other drug and other behavioural health care needs and facilitated transition from primary care to specialist services.[73]

Adolescents with co-occurring disorders who received treatment at clinics with collocated psychiatric and alcohol and other drug services are more likely to become abstinent from alcohol and other drugs.[74]

There is also evidence that clinicians who work in locations where mental health and alcohol and other drug services are co-located have more instances of interdepartmental communication and "hallway consultations", and appear to have more knowledge about the other department's referral and intake procedures than those that were not co-located.[75] The close proximity and collegiality between providers is hypothesised to increase the potential for coordinated care.[74]

On-site delivery of services has been identified as the most reliable way to link alcohol and other drug use clinics with ancillary services such as routine medical care, financial counselling, and housing assistance.[76]

Specialist dual diagnosis services

A number of specialist services have been trialled in Australian and internationally. Very few have published outcome evaluations.

Mental Health and Substance Use Service, Newcastle NSW

The Mental Health and Substance Use Service in Newcastle, NSW, has been operating in various iterations for about 30 years. It is based on a tailored version of the New Hampshire Integrated Treatment model of care and SAMSHA's Integrated Dual Disorder Treatment Model.

It is primarily community based with two inpatient units. The model includes assertive inreach into acute inpatient mental health settings to engage people into ongoing staged, motivational community treatment after discharge.

A recent independent fidelity review using the Dual Diagnosis Capability in Mental Health Treatment[77] found the service was 'dual diagnosis capable/enhanced'.[78]

Pivotal to the successful implementation of the acute inpatient unit was the recruitment of staff with strong therapeutic backgrounds (for example, clinicians with alcohol and other drug or psychotherapy backgrounds), rather than redefining the functions of an existing acute mental health team. From inception, the service has promoted a strong, well-articulated model of care, and passionate leaders are driving the program.

There has been no evaluation of the outcomes of the program to date.

Dual diagnosis residential rehabilitation, Victoria

In 2018 the Victorian Department of Health and Human Services funded a new specialist dual diagnosis residential service, operating in Bendigo and in Melbourne's western suburbs.

The service is designed for people who have mental health symptoms that need active treatment (such as unresolved anxiety or depression, or low-level active positive psychotic symptoms) or overnight support (such as low-level active post-traumatic stress disorder symptoms), or people who need regular or 'as needed' medication overnight. Also, those that need additional assistance to manage cognitive problems, such as with executive functioning or memory; have poor impulse or emotional control or who have a history of frequent drop-out from alcohol and other drugs, mental health or other treatment.[79]

Those with milder or well managed mental health symptoms are able to be accommodated in mainstream alcohol and other drug residential rehabilitation services, and those with more severe symptoms are expected to be responded to in the mental health system, regardless of their alcohol and other drug status.

These services are relatively new, so there has been no evaluation to date.

Multidisciplinary teams

Alcohol and other drug emergency hubs, Victoria

Up to a third of patients in emergency department settings have current alcohol

and other drug problems, which are often not identified by hospital staff.[80]

Alcohol and other drug hubs are being implemented in six emergency departments across Victoria. The hubs are designed to improve emergency department responses to people who present with drug and alcohol use and mental health issues. They are an integrated service delivered by the emergency department, mental health and alcohol and other drug clinicians operating 24 hours a day, seven days a week. No evaluation is available as they are in the very early stages of implementation. They are based on a model of care that makes use of speciality skills in each of the comorbidity areas.

The hubs are for people that present to the emergency department in crisis related to substance use, behavioural and mental health issues, who:

- are directed to present to emergency department triage by an area mental health service
- require urgent medical treatment and have an acute psychiatric comorbidity
- require urgent medical treatment and have an acute drug and alcohol comorbidity
- are mental health clients presenting with high acuity
- present with suicidal ideation or following self-harm and
- present with drug and alcohol dependence with the symptoms of acute intoxication or withdrawal.

Patients are assessed by emergency department triage then streamed to the hub for appropriate assessment and treatment. For patients who have both physical and alcohol and other drug or mental health treatment needs, a senior emergency department clinician decides if the emergency department or the hub is the best place for treatment.

The hubs provide a 'non-admitted service' in dedicated space within the emergency department, where patients receive a comprehensive assessment followed by appropriate treatment which may include brief therapeutic interventions, peer support and referral. Short stay units of four to six beds are built within the emergency department for patients who need short stay (24 hours) stabilisation and intensive support.

From our consultations:

> *Often [in the emergency department] the primary problem is with alcohol or other drugs but they all have to go to mental health because the emergency department has no alcohol and other drug service access [because it's not usually a hospital based service]. Then mental health says it's*

not a mental health problem and there's no intervention. Works fine if people have both a mental health and an alcohol and other drug issue, but not so much for people that only have an alcohol or other drug problem. The new hubs are a multidisciplinary team rather than integration. [The team] can choose which expertise is most needed. There's very few [clinicians] who know both [alcohol and other drugs and mental health]. We don't ask diabetes specialists to manage kidney disease even if the kidney disease is related to their diabetes.

Integrated dual diagnosis treatment model, USA

This has been the preferred model of care for comorbidity adopted by the Substance Abuse and Mental Health Services Administration in the USA. It involved multidisciplinary intensive case management teams, using an integrated staged model with individual and group treatment. There is no time limit to the services.

Evaluation has shown the model to be effective in reducing alcohol and other drug use, mental health symptoms, crime, and homelessness, and improving general functioning. Comparison of outcomes with other forms of treatment has not been undertaken.

Secondary consultation, support and training

Pathways to Comorbidity Care

Pathways to Comorbidity Care is a program for alcohol and other drug services aimed at improving the management of comorbidity and identifying barriers and facilitators of implementation of integrated treatment. It includes seminars, workshops, identification of 'clinical champions', individual clinical supervision, and provision of online information.

One study compared three services that implemented pathways to comorbidity care with three that continued with usual care. It found that the program was favourably received by staff, and there were significant improvements in identification of comorbidity through screening and assessment, clinical self-efficacy, and increased knowledge and positive attitudes to responding to comorbidity. Clinical champions were an important and effective component.

Victorian Dual Diagnosis Initiative

The Victorian Dual Diagnosis Initiative was first formed in 2001 with the intention to provide an improved service response for people with co-occurring disorders in Victoria.

It consists of four clinical teams providing secondary consultation and support for

alcohol and other drug and mental health services to respond more effectively to people with dual diagnosis, and a training unit. Initially, the teams struggled to engage with organisations or make substantial progress.[81]

A later evaluation found a positive trend in the number of people being screened and assessed for co-occurring disorders in both the mental health and alcohol and other drug sector. It also found that clinicians valued the support of VDDI teams in primary, secondary and tertiary consultations.

One of the initiatives of the VDDI was the Reciprocal Rotations program funded in 2005-2006. It allowed clinicians from alcohol and other drugs to be placed in a mental health service organisation, and vice versa, for 12 weeks. Significant funds were allocated for backfill. However, there was significant skills drainage from the alcohol and other drug sector to mental health because of the significant differences in pay scales, and the program was discontinued.[81]

National Comorbidity Guidelines

The National Comorbidity Guidelines are designed for alcohol and other drug workers, although they also may be useful for others who are not mental health specialists.

They aim to provide alcohol and other drug workers with evidence-based information on the management of co-occurring mental health conditions in alcohol and other drug treatment settings.

The intended outcome of the guidelines is increased knowledge and awareness of comorbid mental health conditions in AOD treatment settings, improved confidence and skills of AOD workers, and increased uptake of evidence-based care.

The guidelines are currently in their second edition, which is about to undergo another revision.

Online and face-to-face training has also been developed to support the implementation of the guidelines.

An early evaluation of the guidelines found they have been well received by alcohol and other drug workers. The majority of workers found the guidelines useful and said that they were able to implement some of the information in their practice.[82] An evaluation of the second edition is currently underway.

There are currently no corresponding guidelines for the mental health sector.

Mental Health CARE Hub

The Mental Health Collaborative and Responsive Engagement (CARE) Hub is a new initiative developed by the Western Australian Association for Mental Health (WAAMH) and the community mental health sector.

It provides support in five key areas of the mental health sector:

1. Communities of Practice learning networks
2. Collating, adapting and developing practice frameworks and tools

3. Providing sector-responsive online interactive learning opportunities
4. Facilitating a communication and consultation hub where sector-relevant updates, scenario planning and peer conversations can occur, and
5. Establishing a skills-matching and recruitment platform.

Monitoring capability

Being able to benchmark and monitor capability to respond to complexity is critical in service development. There are a number of ways to do this, but the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index and the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) have both been trialled in Australia. They provide program-level benchmarking of capability.

The instruments assess seven areas:

1. Program Structure
2. Program Milieu
3. Clinical Practice: Assessment
4. Clinical Practice: Treatment
5. Continuity of Care
6. Staffing
7. Training

Based on the score in these areas, the program or agency is categorised as:

- Addiction Only Services (AOS)
- Mental Health Only Services (MHOS)
- Dual Diagnosis Capable (DDC)
- Dual Diagnosis Enhanced (DDE).

Monitoring outcomes

From our consultations:

> *What gets counted gets acted upon*

Much of the current approach to addressing the complexity of co-occurring alcohol and other drug and mental health disorders has not been evaluated, and our key experts noted that outcomes are rarely monitored.

From our consultations:

> *Reporting at regular intervals on progress with comorbidity is essential [services need to take a] continuous quality improvement focus. It builds sustainability, managerial understanding and buy-in.*
>
> *Requiring agencies to develop their internal capacities to report on actual prevalence rates in their service is another very powerful strategy.*

Both sectors have a National Minimum Dataset, which is collected several times a year and reported on annually. But these data are primarily outputs (for example number of bed days or number of episodes of care). They do not record treatment outcomes or even rates of other morbidities among their respective service user groups.

Nuanced solutions to a complex problem.

Comorbidity as a 'wicked' problem.

How best to respond to comorbidity has been described as a 'wicked' problem.[83] A wicked problem is one that is complex to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognise.

The solutions aren't simple, but they are feasible.

These kinds of problems don't respond to traditional approaches that use linear thinking.

They require holistic, innovative and flexible thinking and the ability to understand the interrelationships between the full range of causal factors and policy objectives, working across organisational boundaries, deep accountability and effective engagement.[83] There may be multiple solutions that need to operate simultaneously.

Comorbidity is a complex problem to solve because the solution depends on the perspective from which the problem is viewed.

There are contradictory requirements that mean a single solution benefits one perspective over another.

But an effective solution promises the real potential for better outcomes in both the alcohol and other drug and mental health systems.

Systems integration is a linear solution.

Integrating alcohol and other drug services with mental health services is a linear solution to the complex problem of addressing comorbidity.

There is a complex relationship between alcohol and other drugs and mental health problems that varies considerably between the different service sectors. Integration of alcohol and other drugs with mental health services is just one approach to one problem and ignores the many other levels at which comorbidity operates. It is a one size fits all approach when the confluence of alcohol and other drugs and mental health occurs at many levels and also has a multitude of connections to other service needs.

From a mental health services perspective, service users may use a range of drugs and some proportion of those have problems with them, so having access to broad specialist alcohol and other drug capability is important.

From an alcohol and other drug services perspective, the types of mental health problems that most service users experience are not the types of problems that mental health services specialise in, so alcohol and other drug services are more likely to require access to mental health specialists, such as psychologists, that are mainly located in the private sector.

Service integration is a solution that has little evidence to support it and has been shown to have the unintended consequence of prioritising mental health services over alcohol and other drug services.

It decreases the specialisation of the alcohol and other drug sector and diminishes its ability to reduce harms of occasional and regular use by placing the sector in solely in the clinical area.

The opposite is required. The clear message from our consultations is that we need to increase the specialisation of both sectors to respond to their core service user group. In conjunction, we need to build the capacity of services and providers in both sectors to respond holistically to all service users, including addressing physical health, mental health, and wellbeing. Alcohol and other drug use may impact on all these areas.

From our consultations:

> *...keeping specialisation on alcohol and other drug issues helps it to grow and attract a greater more sophisticated workforce as its seen as a specialist issue, not just lumped in together with mental health.*

This approach is also more consistent with what consumers want. They want to rely on their treating clinician to be able to recognise and respond at some level to all their interconnecting needs. Surveys have consistently found that consumers prefer a 'one stop shop' and a single point of contact to assist them in accessing services.

From our consultations:

> *For people that have comorbidity, it's important that their treating clinicians are skilled in both areas.*

The question then becomes whether mental health services can acquire or access alcohol and other drug specialist expertise without subsuming the alcohol and other drug sector.

A system for the future.

If we are to approach responses to co-occurring alcohol and other drug and mental health problems in a holistic, rather than 'integrated', way the final question is how to achieve this efficiently?

Holistic treatment means identifying and understanding the service user's needs and wants and offering responses that address all of those needs and wants. It means working collaboratively in partnership with other agencies. It means building capacity and capability within all of our health and social services to respond in this way, and if needed, provide coordinated care across the health and social services system.

Each of the related service systems that overlap with the alcohol and other drug sector, including mental health, primary care,

and social services, as well as the private sector, require different capacity building measures to enable them to work holistically.

The specific approaches that are required for alcohol and other drug services are not the same as those for mental health services. Within this framework, a more nuanced approach to this kind of complexity will be needed. The problem is complex, and the solution will not be simple.

From our consultations:

> *The alcohol and other drug sector needs a Vision 2030 of its own.*

In the past, systems changes, milestones and measures of success have been poorly defined. There is fatigue in both sectors from so many unsuccessful attempts to address the issue of treatment complexity that leads to a loss of traction.

Four key focus areas for both services are:

- Increase unique specialisation
- Improve internal capacity and capability to respond holistically
- Enhance pathways for external collaboration
- Provide adequate funding and accountability for implementation

Increase unique specialisation

Integration, and specifically subsuming of alcohol and other drugs as a subspecialty of mental health, was not a popular solution among our key experts.

There is no evidence that it is effective. Based on previous experience, many of our key experts were concerned that it is likely to lead to unintended outcomes that put alcohol and other drug services at further disadvantage.

The two sectors are very different in philosophy, intervention approach, structure, workforce, and funding, so amalgamating the two has been, and will continue to be, culturally difficult.

Although comorbidity is high in both sectors, there is little crossover of service user because the mental health conditions seen in mental health services (severe, low prevalence disorders) are very different from those in alcohol and other drug services (mild to moderate high prevalence disorders).

Mental health services have a greater need for alcohol and other drug services expertise

than alcohol and other drug services have for mental health services expertise. This is because the types of mental health problems that public clinical mental health services are expert in are relatively rarely seen in alcohol and other drug services. So, integration tends to benefit the mental health sector more than the alcohol and other drug sector.

It is also important to note that a sizeable proportion of service users in both services systems have no comorbidity, so integration is of no benefit to this group.

The alcohol and other drug sector offers a broader range of interconnected responses than just those for clinical conditions, from prevention to harm reduction to treatment. If subsumed under a broader mental health banner, which is largely medically and clinically focused, there is a real concern that many important services will be diminished, lost or disconnected from treatment providers, potentially creating silos within the alcohol and other drug sector.

A more effective solution is to increase the capability and capacity within each system to respond more effectively to the specific needs of that sector. Rather than decreasing specialisation by blending the two sectors, the solution is to increase specialisation.

To do this, both sectors need to:

- Have a clearly documented philosophy, approach and models of care. This will also assist in understanding whether, where and how to refer if needed
- Measure outcomes and impact of services
- Improve internal capability

In addition, the alcohol and other drug sector needs to further develop the professional capacity of key disciplines, especially medicine, psychology, nursing and allied health.

Improve internal capability to respond holistically

In a truly 'no wrong door' system, the majority of people with co-occurring alcohol and other drug and mental health issues would be treated in the service where they are assessed, with only a few requiring referral or specialist comorbidity intervention.

From our consultations:

> *[specialist dual diagnosis services] can only cater for a very small specialised percentage of the total numbers of people with co-occurring alcohol and other drug and mental health disorders. I'm very conscious that central policy and planning can fall into the trap of thinking that, once these units are created, they have solved all the wicked problems associated with alcohol and other drug and mental health.*

To do this effectively, both services require enhanced care coordination for people with co-occurring alcohol and other drug and mental health disorders. This is likely to require an increase in funding or a reallocation of funding to provide additional case management to be effective.

From our consultations:

> *...there needs to be a greater skillset across both disciplines to be able to provide interventions and have capacity to deal with both issues at the same time.*

Capability improvement in the mental health sector

The alcohol and other drug sector has participated in a number of initiatives that have improved the sector's capability in responding to service users' mental health issues including sector wide implementation of the DDCAT service capability measure and the development of sector wide comorbidity guidelines. There has also been a significant amount of training and workforce support offered to the sector in blending mental health responses, such as the Pathways to Comorbidity Care and the Victorian Dual Diagnosis Initiative.

The equivalent initiatives in the mental health sector, accompanied by effective dissemination activities, have not been available. These could support the sector to feel more confident in responding to most co-occurring alcohol and other drug issues without needing to refer to a specialist service.

From our consultations:

> *Client complexity needs to be addressed. Many clients have multiple vulnerabilities and they get stuck in a cul-de-sac of assessment instead of assistance. We need to approach clients as complex rather than comorbid so they can access the assistance they need for all their problems...*

Key among these is understanding the continuum of alcohol and other drug use, how it interacts with mental health issues and appropriate treatment at different parts of the continuum.

Not all alcohol and other drug use is so problematic that it needs treatment, so understanding the when and what type of treatment is indicated is key. Also understanding that, although addressing both issues is important, integrated, sequential and parallel treatment all have some benefit.

From our consultations:

> *The whole thing is really about mental health getting clear about what part of the agenda falls in mental health... There's a lot mental health can do without [the alcohol and other drug sector].*

Just doing good speciality work has some benefit, so even when specialist alcohol and other drug treatment may be helpful, it may not be necessary in the first instance. When indicated, it must be based on good assessment of need and effective coordinated care.

The introduction of alcohol and other drug specialists within mental health teams, including psychologists and psychiatrists trained in alcohol and other drug treatment, would support the needs of the sector to have alcohol and other drug capability without the disadvantages of integrating alcohol and other drug services into mental health.

From our consultations:

> *Severe mental illness should be treated by the mental health service. But we [mental health] lack the interest, knowledge, capacity [to deal with alcohol and other drugs]. If normally seen in mental health that's where they should be treated.*

These specialists can support assessment, provide parallel or integrated treatment and assist in effective referral. They would also help reduce stigma towards people who use alcohol and other drugs. These would be additional mental health-funded specialised positions, and/or supported through Medicare and private health funds.

Undergraduate, postgraduate and professional development training were all raised as priorities for mental health services.

From our consultations:

> *Addiction needs to be part of initial undergraduate training. And all psychiatry trainees need to have an addiction rotation... Psychiatrists need to be addiction competent.*

Many Primary Health Networks have developed formalised health pathways to assist practitioners in making effective referrals within their local area.[84] These could provide mental health services with additional tools for decision making about referrals.

Capability improvement in the alcohol and other drug sector

The workforce needs in the alcohol and other drug sector are different from those in the mental health sector. Alcohol and other drug services have already had significant opportunity, and invested much time and effort, into the development of baseline comorbidity capabilities.

Many of our key experts from both sectors agreed that the sector had made significant inroads in responding to comorbidity, which has also had a flow on effect to how comorbidity is viewed.

From our consultations:

> *When you put mental health clinicians in a room alcohol and other drugs doesn't rate in their top 10, but number one for alcohol and other drugs is comorbidity.*

Most alcohol and other drug workers generally now have had the opportunity to gain a basic understanding of the common mental health problems they are likely to encounter and have a number of tools at their disposal.

Professional development training, guidelines and benchmarking tools have been available and utilised for more than a decade.

Most services have policies and procedures in place that refer to co-occurring mental health problems, including trauma-informed care.

The next step is the introduction of mental health specialists within alcohol and other drug services. Psychiatrists, psychologists, mental health nurses and other allied health trained in the treatment of high prevalence disorders. This would support the needs of the sector to have advanced mental health capability without the disadvantages of

integrating alcohol and other drug services into mental health.

From our consultations:

> *Advisory services and secondary consultation is available but they are limited in what they can offer and alcohol and drug workers still need to know enough about mental health so that they know when to call for help.*

Clearer models of care and referral criteria are required for each service type to clarify the key pathways into alcohol and other drug services. An example is the model of care for Victoria's dual diagnosis residential rehabilitation.[79]

From our consultations:

> *The ability of alcohol and other drug sector to manage mental health, and the mental health sector to manage alcohol and other drugs should be core competencies embedded in a National Minimum Qualifications Framework for both sectors.*

The alcohol and other drug sector are developing peer worker capability and capacity, but less attention has been paid to carer and consumer input into services.

From our consultations:

> *A key learning for the alcohol and other drug sector from mental health is the need for better-developed carer and consumer input into services - how they run and advocacy for them*

There is a need for an overarching peer agency that can address and which reflects the spectrum of the sector framework uniting the of alcohol and other drug interventions from prevention to harm reduction to treatment.

Like the professional workforce, there is a gap in training for the peer workforce that reflects the spectrum of work they might be engaged in. In particular training for people with a lived experience on how to share their experience ethically and in a way that is helpful to those they are supporting, including education on mental health issues among people who use alcohol and other drugs.

A national network of peers that can be accessed to provide information and experience into future service design of alcohol and other drug and mental health services would be a helpful addition to the sector.

Responding to severe co-occurring disorders

There is a small group of service users who have more severe alcohol and other drug and mental health problems than either services system is designed to respond to.

In these cases, there is an argument for the introduction of specialist dual diagnosis services.

They could operate independently, but since the greater need is likely to be in mental health placed within the mental health system.

An example is the recent Victorian Dual Diagnosis Residential Rehabilitation Service and the long-standing Mental Health and Substance Use Service in Newcastle.

These services have strict entry criteria and are reserved for people with very severe alcohol and other drug and mental health disorders that need to be stabilised before they can be managed in another service.

These services fill a gap for people with severe problems, but it is not feasible to expect specialist comorbidity services to respond to people with milder problems. These need to be managed within either the alcohol or other drug service or the mental health service.

Increase external collaboration

Collaboration between alcohol and other drugs and mental health

Alongside sector specific strategies, to reduce the likelihood of 'falling through the gaps', formalisation of a collaborative care approach would encourage both services to work together to identify alternative options for those unsuited to one service or another.

From our consultations:

> *Everyone is passionate about their work and keen to do the right thing... but it's rarely about intent. The architecture is lacking. It needs to be articulated in operations and funding and governance frameworks. Look at the family violence schemes - there's a process and incentive to come together to talk about patients.*

Collaboration with primary care and other sectors

General practice is often the first port of call for the community when they experience issues with alcohol and other drugs or mental health. This is especially the case for mild problems.

A significant part of the non-specialist alcohol and other drug and mental health workforces are general practitioners. Mental health and alcohol and other drugs are estimated to make up 12.4 per cent of all general practitioner encounters.[53]

They are also experts at coordinated care. Connection with primary care providers is critical, especially for people with alcohol or other drug problems because there are multiple physical health sequelae from drug use, and the sector has a very small number of medical staff.

From our consultations:

> *Alcohol and other drug sector is too alcohol and drugs focused. How do we get access to primary care? It's not going to be through addiction medicine specialists or addiction psychiatry. We need stepped care models that include GPs.*

But providing reciprocal support to primary care is essential if they are to continue managing people who use alcohol and other drugs and/or have mental health problems effectively.

One key expert suggested a liaison service, focused on supporting the work already done in general practice whilst allowing the alcohol and other drug and mental health

sectors to actively collaborate with general practice. It may be a role for the specialist comorbidity service.

These approaches are also relevant for collaboration with other key sectors including child protection, law enforcement, family violence.

From our consultations:

> *Such a collaboration would allow each sector to better understand, learn from each other, and ensure patients remain actively linked with their primary healthcare provider.*

Accountability and funding

The right amount of funding in the right place is critical for good outcomes from treatment. Studies have found that the amount of funding, the source of funding and the types of services funded all have substantial impacts on outcomes such as relapse rates.[15]

Both systems are underfunded, but alcohol and other drug services particularly so. It attracts around a tenth of the funding of mental health services.

Forty one per cent of full time alcohol and other drug workers earn less than the average income.[52] It is difficult to attract and retain qualified professionals to a sector that is so chronically underfunded. This makes it difficult to maintain or improve specialisation.

Spending on mental health services is around $9 billion; $5.4 billion of this is specifically for mental health services delivered through the states and territories, and $3.5 billion through the Australian Government and private health funds, a small proportion of which may be for alcohol and other drug treatment.

From our consultations:

> *If you don't have enough funding it's not surprising that services need to gatekeep and with the stigma about drug use it's easy to pick them to gatekeep.*

Australia's public investment in alcohol and other drug treatment is around $1.3 billion per year, which provides services to around 200,000 Australians. We know that funding for alcohol and other drug specialist treatment is cost effective; for every $1 spent on services, the community saves $7 in other costs.[15] But we also know that funding in the alcohol and drug sector is only about half of what is required to meet demand.[15]

We don't know how much is spent on alcohol and other drugs through Medicare because most item numbers don't distinguish between mental health and alcohol and other drug treatment. Overall $1.2 billion is spent on Medicare subsidised mental health item numbers, which includes alcohol and other drug treatment.[85]

From our consultations:

> *How can you measure increase in capacity in a system that is already at capacity?*

The regular use of benchmarking and fidelity tools, such as the DDCAT and the DDMHT also provide internal and external accountability measures to ensure funding is having an impact on services' ability to respond effectively to complexity.

References.

1. NSW MHC. Submission to the special commission of inquiry into the drug 'ice'. 2019.
2. State of The Sector 2015. Recovery Partnership; 2015.
3. Committee on the Science of Changing Behavioral Health Social Norms, Board on Behavioral C, and Sensory Sciences, Division of Behavioral and Social Sciences and Education, et al. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington (DC): National Academies Press (US); 2016.
4. American Psychiatric Association. Substance-Related and Addictive Disorders. Diagnostic and statistical manual of mental disorders (5th ed)2013.
5. Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Canberra, AIHW; 2019.
6. Lee NK, Cameron J, Battams S, et al. What works in school-based alcohol education: A systematic review. Health Education Journal. 2016;75(7):780-98.
7. Teesson M, Newton NC, Barrett EL. Australian school-based prevention programs for alcohol and other drugs: A systematic review. Drug and Alcohol Review. 2012;31(6):731-6.
8. VicHealth. The Good Sports Program: VicHealth's operational model in action. Melbourne: Victorian Health Promotion Foundation; 2018.
9. Fernandes RM, Cary M, Duarte G, et al. Effectiveness of needle and syringe Programmes in people who inject drugs – An overview of systematic reviews. BMC Public Health. 2017;17(1).
10. Measham FC. Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking' service. The International journal on drug policy. 2019;67:102-7.
11. Henstridge J, Homel R, Mackay P. The long-term effects of random breath testing in four Australian States: A time series analysis. Canberra: Federal Office of Road Safety; 1997.
12. Baker A, Lee NK, Claire M, et al. Brief cognitive behavioural interventions for regular amphetamine users: a step in the right direction. Addiction. 2005;100(3):367-78.
13. Kaner EF, Beyer FR, Muirhead C, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database of Systematic Reviews. 2018.
14. United Nations. The Universal Declaration of Human Rights. Paris; 1948.
15. Ritter A, Berends L, Chalmers J, et al. New Horizons: The review of alcohol and other drug treatment services in Australia. National Drug and Alcohol Research Centre, UNSW; 2014.
16. Teesson M, Slade T, Mills K. Comorbidity in Australia: findings of the 2007 National Survey of Mental Health and Wellbeing. Aust N Z J Psychiatry. 2009;43(7):606-14.
17. Morgan VA, Waterreus A, Jablensky A, et al. People living with psychotic illness in 2010: the second Australian national survey of psychosis. Aust N Z J Psychiatry. 2012;46(8):735-52.
18. Lubman DI, King JA, Castle DJ. Treating comorbid substance use disorders in schizophrenia. Int Rev Psychiatry. 2010;22(2):191-201.

19. National Institute on Drug Abuse. Common Comorbidities with Substance Use Disorders Research Report. 2020.
20. Deady M, Barrett EL, Mills KL, et al. Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Mental Health and Drug and Alcohol Office 2014.
21. Kingston REF, Marel C, Mills KL. A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. Drug and alcohol review. 2017;36(4):527-39.
22. Marel C, Mills KL, Kingston R, et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales; 2016.
23. Hser YI, Grella CE, Hubbard RL, et al. An evaluation of drug treatments for adolescents in 4 US cities. Arch Gen Psychiatry. 2001;58(7):689-95.
24. Hesse M, Thylstrup B, Seid AK, et al. Suicide among people treated for drug use disorders: a Danish national record-linkage study. BMC Public Health. 2020;20(1).
25. Poorolajal J, Haghtalab T, Farhadi M, et al. Substance use disorder and risk of suicidal ideation, suicide attempt and suicide death: a meta-analysis. Journal of Public Health. 2016;38(3):e282-e91.
26. Esang M, Ahmed S. A Closer Look at Substance Use and Suicide. American Journal of Psychiatry Residents' Journal. 2018;13(6):6-8.
27. Rontziokos H, Deane F. Systematic Review of Suicidal Behaviour in Individuals Who Have Attended Substance Abuse Treatment. International Journal of Mental Health and Addiction. 2019;17(6):1580-98.
28. Too LS, Spittal MJ, Bugeja L, et al. The association between mental disorders and suicide: A systematic review and meta-analysis of record linkage studies. Journal of Affective Disorders. 2019;259:302-13.
29. Holmstrand C, Bogren M, Mattisson C, et al. Long-term suicide risk in no, one or more mental disorders: the Lundby Study 1947-1997. Acta Psychiatr Scand. 2015;132(6):459-69.
30. Zubin J, Spring B. Vulnerability: A new view of schizophrenia. Journal of Abnormal Psychology. 1977;86(2):103-26.
31. Clancy R. Chapter 10: Substance use disorders. In: Hungerford C, editor. Mental health care, 3rd Edition. 3rd ed. Milton, QLD: John Wiley & Sons Australia Ltd; 2018.
32. Mueser K, Noordsy D, Drake R, et al. Integrated treatment for dual disorders: a guide to effective practice. New York, NY: Guilford Press; 2003.
33. Australian Government Department of Health. Harmful Alcohol and Other Drug Use. 2006.
34. Bjorkquist C, Hansen GV. Coordination of services for dual diagnosis clients in the interface between specialist and community care. J Multidiscip Healthc. 2018;11:233-43.

35. Vujanovic AA, Meyer TD, Heads AM, et al. Cognitive-behavioral therapies for depression and substance use disorders: An overview of traditional, third-wave, and transdiagnostic approaches. Am J Drug Alcohol Abuse. 2017;43(4):402-15.
36. Flanagan JC, Korte KJ, Killeen TK, et al. Concurrent Treatment of Substance Use and PTSD. Curr Psychiatry Rep. 2016;18(8):70.
37. Croton G. Better Outcomes: Towards a Victorian Complexity-Capable Service System. Submission to the Royal Commission into Victoria's Mental Health System. Victorian Dual Diagnosis Initiative; 2019.
38. Armitage GD, Suter E, Oelke ND, et al. Health systems integration: state of the evidence. Int J Integr Care. 2009.
39. Flatau P, Conroy E, Thielking M, et al. How integrated are homelessness, mental health and drug and alcohol services in Australia? Melbourne: Australian Housing and Urban Research Institute; 2013.
40. Kodner DL, Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications--a discussion paper. Int J Integr Care. 2002;2:e12.
41. Lubman D, Manning V, Cheetham A. Informing Alcohol and other Drug Service Planning in Victoria. Turning Point; 2017.
42. Savic M, Best D, Manning V, et al. Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review. Substance abuse treatment, prevention, and policy. 2017;12(1):19.
43. Mental Health Stepped Care Model Victoria: South Eastern Melbourne PHN; [Available from semphn.org.au/images/downloads/commissioning/mental-health/SEMPHN_Mental_Health_Stepped_Care_Model.pdf.
44. Drake RE, O'Neal EL, Wallach MA. A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. J Subst Abuse Treat. 2008;34(1):123-38.
45. Alcohol Tobacco and other Drugs Council Tasmania Inc. ATDC submission responding to: Reform Agenda for Alcohol and Drug Services in Tasmania: Consultation Draft. Hobart: ATDC; 2018.
46. VAADA. VAADA Submission to the Royal Commission into Victoria's Mental Health System. 2019.
47. De Hert M, Correll CU, Bobes J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry. 2011;10:52-77.
48. Keaney F, Gossop M, Dimech A, et al. Physical health problems among patients seeking treatment for substance use disorders: A comparison of drug dependent and alcohol dependent patients. Journal of Substance Use. 2011;16(1):27-37.
49. Australian Institute of Health and Welfare 2018. Mental health services - in brief 2018. Canberra: AIHW; 2018. Report No.: HSE 211.
50. Report identifies NDIS gaps for people living with mental illness [press release]. Sydney: The University Of Sydney 2018.

51. Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia: 2018–19. Drug treatment series no. 34. Cat. no. HSE 243. Canberra: AIHW; 2020 25 July 2019.
52. Skinner N, McEntee A, Roche A. Australia's Alcohol and Other Drug Workforce: National Survey Results 2019-2020. Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University; 2020.
53. Australian Institute of Health and Welfare. Mental health services. In brief 2019. (Web report) 2020 [updated 21 Jul 2020. Available from: aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia.
54. Ahern J, Stuber J, Galea S. Stigma, discrimination and the health of illicit drug users. Drug and Alcohol Dependence. 2007;88(2-3):188-96.
55. Anstice S, Strike CJ, Brands B. Supervised Methadone Consumption: Client Issues and Stigma. Substance Use & Misuse. 2009;44(6):794-808.
56. Van Boekel LC, Brouwers EPM, Van Weeghel J, et al. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug and Alcohol Dependence. 2013;131(1-2):23-35.
57. Van Boekel LC, Brouwers EP, Van Weeghel J, et al. Comparing stigmatising attitudes towards people with substance use disorders between the general public, GPs, mental health and addiction specialists and clients. International Journal of Social Psychiatry. 2015;61(6):539-49.
58. Hunt GE, Siegfried N, Morley K, et al. Psychosocial interventions for people with both severe mental illness and substance misuse. Cochrane Database of Systematic Reviews. 2019(12).
59. Donald M, Dower J, Kavanagh D. Integrated versus non-integrated management and care for clients with co-occurring mental health and substance use disorders: a qualitative systematic review of randomised controlled trials. Social science & medicine (1982). 2005;60(6):1371-83.
60. Leung J, Stockings E, Wong I, et al. Co-morbid mental and substance use disorders – a meta-review of treatment effectiveness. Technical Report Number 336. Sydney: National Drug and Alcohol Research Centre, University of New South Wales; 2016.
61. Watkins KE, Hunter SB, Hepner KA, et al. An effectiveness trial of group cognitive behavioral therapy for patients with persistent depressive symptoms in substance abuse treatment. Arch Gen Psychiatry. 2011;68(6):577-84.
62. The Department of Health. Comorbid mental disorders and substance use disorders: Epidemiology, prevention and treatment. Treatment Services.: Australian Government; 2003 [updated 2003. Available from: www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-comorbid-toc~drugtreat-pubs-comorbid-6~drugtreat-pubs-comorbid-6-4.
63. Boden JM, Fergusson DM. Alcohol and depression. Addiction. 2011;106(5):906-14.
64. Schuckit MA. Comorbidity between substance use disorders and psychiatric conditions. Addiction. 2006;101 Suppl 1:76-88.
65. Shaw GK, Waller S, Latham CJ, et al. The detoxification experience of alcoholic in-patients and predictors of outcome. Alcohol Alcohol. 1998;33(3):291-303.

66. Charlet K, Heinz A. Harm reduction-a systematic review on effects of alcohol reduction on physical and mental symptoms. Addict Biol. 2017;22(5):1119-59.
67. Baker AL, Kavanagh DJ, Kay-Lambkin FJ, et al. Randomized controlled trial of MICBT for co-existing alcohol misuse and depression: outcomes to 36-months. J Subst Abuse Treat. 2014;46(3):281-90.
68. Nunes EV, Liu X, Samet S, et al. Independent versus substance-induced major depressive disorder in substance-dependent patients: observational study of course during follow-up. J Clin Psychiatry. 2006;67(10):1561-7.
69. Hobbs JD, Kushner MG, Lee SS, et al. Meta-analysis of supplemental treatment for depressive and anxiety disorders in patients being treated for alcohol dependence. Am J Addict. 2011;20(4):319-29.
70. Vogel EA, Ly K, Ramo DE, et al. Strategies to improve treatment utilization for substance use disorders: A systematic review of intervention studies. Drug and Alcohol Dependence. 2020;212.
71. Goldsmith RJ, Garlapati V. Behavioral interventions for dual-diagnosis patients. Psychiatr Clin North Am. 2004;27(4):709-25.
72. Horsfall J, Cleary M, Hunt GE, et al. Psychosocial Treatments for People with Co-occurring Severe Mental Illnesses and Substance Use Disorders (Dual Diagnosis): A Review of Empirical Evidence. Harvard Review of Psychiatry. 2009;17(1):24-34.
73. Gurewich D, Prottas J, Sirkin JT. Managing care for patients with substance abuse disorders at community health centers. J Subst Abuse Treat. 2014;46(2):227-31.
74. Sterling S, Weisner C. Chemical Dependency and Psychiatric Services for Adolescents in Private Managed Care: Implications for Outcomes. Alcoholism: Clinical & Experimental Research. 2005;29(5):801-9.
75. Sterling S, Hinman A, Kohn CS, et al. Pathways to Substance Abuse Treatment for Adolescents: Implications for Policy. Summary of Provider Interviews (Report to Robert Wood Johnson Foundation). Oakland, CA: Division of research, Kaiser Permanente Northern California; 2002.
76. Friedmann PD, D'Aunno TA, Jin L, et al. Medical and psychosocial services in drug abuse treatment: do stronger linkages promote client utilization? Health services research. 2000;35(2):443-65.
77. Substance Abuse and Mental Health Services Administration. Dual Diagnosis Capability In Mental-Health Treatment (DDCMHT) Index. Version 4.0. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2011.
78. Boyle P. IDDT-Inpatient: Final Report. HNE - Mental Health Substance Use Unit. NSW, Australia: Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence 2016.
79. Victorian Government. Dual Diagnosis Residential Rehabilitation. Melbourne: State of Victoria, Department of Health and Human Services; 2018.
80. Butler K, Reeve R, Viney R, et al. Estimating prevalence of drug and alcohol presentations to hospital emergency departments in NSW, Australia: impact of hospital consultation liaison services. Public health research & practice. 2016;26(4).

81. Australian Healthcare Associates. Evaluation of the Victorian Dual Diagnosis Initiative. Melbourne, Victoria: Department of Health; 2011.
82. Mills KL, Deady M, Teesson M, et al. Guidelines on the management of co-occurring mental health conditions in alcohol and other drug treatment settings: how useful are they? Mental Health and Substance Use. 2012;5(2):160-72.
83. Australian Public Service Commission. Tackling wicked problems: A public policy perspective. Canberra: Australian Government - Australian Public Service Commission; 2007.
84. Australian Government. Western Victoria HealthPathways Victoria: PHN Western Victoria; 2020 [Available from westvicphn.com.au/health-professionals/general-practice-support/healthpathways
85. Cook L. Mental health in Australia: a quick guide. Australia: Department of Parliamentary Services; 2019.

360edge.

360edge.com.au