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Royal Commission into Victoria's Mental Health System.

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Thank you for the opportunity to make a submission to the Royal Commission into Victoria's Mental Health System. In this submission I have identified a number of contemporary priority policy and law reform issues focusing on the interaction of alcohol and other drug (AOD) issue and mental health issues. My submission is based on many years' experience working in both systems as well as the best available research. I'd like to focus the Royal Commission on a possibly slightly different perspective to the typical discussion around the interface of the mental health and alcohol and other drugs sectors.

Alcohol and drug dependence as a mental health issue.

As a health issue, alcohol and drug problems have historically been treated as separate and distinct from mental health disorders. This is probably in part because alcohol and other drugs has previously been viewed as a moral deficit, and then a criminal issue. The shift to truly viewing it as a health issue is relatively recent.

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The US led push to view alcohol and other drug problems as a 'brain disease' was in part to try to provide a counter to the prevailing moral view at the time. However, although the use of alcohol and other drugs clearly has a (mostly temporary) impact on the structure and function of the brain, there is no evidence that alcohol or other drug problems are a brain disease in the same way that Huntington's or Parkinson's are diseases of the brain, for example. The fact that relatively few people who use drugs develop a problem with them is also evidence that it is not a brain disease. We still can't distinguish between the brain of someone who is dependent on alcohol or other drugs and someone who is not.

The social consequence of viewing alcohol and other drug dependence as primarily a function of an 'addictive brain' and a specific drug is prohibition. We either need to eliminate drugs from society (and hence more law enforcement is needed) or we need protect the brain from drugs (and hence abstinence is required). The research shows that a prohibition approach is not effective in reducing harms or use. The reality is there are many factors that impact on the development of alcohol and other drug issues, including family history; socio-demographic factors and broader social determinants of health, such as low socio-economic status, lack of education, homelessness, and unemployment; as well as early trauma and mental health issues.

Alcohol and other drug problems are more aligned to the definition of a mental health issue, with multiple factors in both their development and maintenance. We don't typically refer to mental health disorders as a 'disease', even though there is evidence that there is associated impact on the structure and function of the brain.

But there is a further complication in understanding where alcohol and other drug problems fit in. Not all drug use is problematic. Very few people go on to develop long term problems with alcohol and other drugs (overall the estimate is around 10%),[1] so our understanding of alcohol and other drugs as a mental health issue

[1] https://theconversation.com/health-check-what-makes-it-so-hard-to-quit-drugs-69896

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only applies to the end of the use spectrum where people are experiencing problems.

For this reason, while considering alcohol and other drugs as a mental health condition, we also need to take a broader view that encompasses a general health view and a human rights perspective.

In my nearly 30 years working in the alcohol and other drug and mental health sectors, I have seen the two sectors 'integrated' several times. The broader issues around alcohol and other drugs makes this an uncomfortable fit, and in my view impacts negatively on the alcohol and other drug sector. The sectors are then necessarily separated again. It's a cycle I have seen many times.

Therefore, while alcohol and other drug problems should be viewed from mental health perspective, the issues are much broader and should not be intrinsically linked with, or integrated into, the mental health system.

It is imperative to both reducing stigma and improving the application of effective responses that we do some deep thinking about how to frame alcohol and other drug problems in the context of mental health without it losing its separate identity.

Why we need to address both alcohol and other drugs and mental health problems.

Co-occurring mental health and AOD problems are common among people attending treatment in both services. The most common mental health disorders among people in AOD treatment are depression, anxiety, PTSD and personality disorders.[2] People in public mental health services are most likely to be diagnosed with a psychotic disorder.

[2] Marel C, Mills KL, Kingston R, Gournay K, Deady M, Kay-Lambkin F, Baker A, Teesson M (2016). 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.

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There are a number of ways in which alcohol and other drug use problems interact with other mental health disorders, primarily: [3]

- The use of drugs may change the structure and function of the brain that leads to symptoms of other mental health disorders. For example, neuroscience studies have shown that long term methamphetamine use depletes the dopamine and serotonin systems, both required for the regulation of mood, potentially leading to symptoms of depression.
- Alcohol and other drugs may be used to relieve distress of mental health symptoms, sometimes referred to as 'self medication'
- Comorbidity may emerge from shared genetic or socio-economic predisposing factors, such as poverty or trauma.

The presence of more than one disorder can complicate treatment significantly.[4] There is evidence that relapse from one disorder can trigger relapse from the other so there is general agreement among professionals that both disorders need to be addressed.

For many conditions, just providing good alcohol and other drug treatment reduces symptoms disorders.[5][6] So it is critical that treatment providers outside the specialist alcohol and other drug sector are well trained in assessment, brief intervention and effective referral of alcohol and other drug problems.

Why 'integrating' the alcohol and other drug and mental health systems is not the solution.

'Horizontal integration' links components within a system, such as movement between inpatient and outpatient alcohol and other drug

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[3] Lai, H. M. X., Cleary, M., Sitharthan, T., & Hunt, G. E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990–2014: A systematic review and meta-analysis. Drug and Alcohol Dependence, 154, 1–13.

[4] VicHealth (2017). Dual diagnosis. Melbourne: Victoria State Government.

[5] https://pubs.niaaa.nih.gov/publications/arh26-2/130-135.htm

[6] http://www.atoda.org.au/wp-content/uploads/2018/04/PracticeGuide_Online.pdf

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treatment, which may improve continuity of care within a system.[7] 'Vertical integration' attempts to link up different types of care. Despite many decades of debate and many calls and attempts to vertically integrate alcohol and other drug services with mental health services, we have not been able to achieve this.

There is, in fact, very little evidence for the effectiveness of vertical integration on client outcomes such as AOD use.[8] [9] Systematic reviews show no benefit of integrated care over non-integrated care.[10] [11] For example, a 2018 Australian systematic review found no evidence to support the superiority of integrated dual-focused treatment for co-occurring depression and alcohol problems; psychosocial treatment for alcohol use *or* depression was sufficient in reducing symptoms for both.[12]

The reason potentially lies within the different services. The *types* of mental health disorders 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 disorders differs between the two types of services.

Public mental health services primarily support people with low prevalence disorders such as schizophrenia[13], while mental health problems among people in alcohol and other drug services are primarily the higher prevalence disorders, anxiety (up to 70%) and

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[7] Lubman D, Manning V, Cheetham A. Informing alcohol and other drug service planning in Victoria: Final Report. Melbourne: Turning Point, 2017.

[8] Lubman D, Manning V, Cheetham A. Informing alcohol and other drug service planning in Victoria: Final Report. Melbourne: Turning Point, 2017.

[9] Savic M, Best D, Manning V, Lubman DI. 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.

[10] 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. 2005;60(6):1371-83

[11] Lubman D, Manning V, Cheetham A. Informing alcohol and other drug service planning in Victoria. Final report. Melbourne: Turning Point; 2017.

[12] Hobden, B., et al. (2018). Finding the optimal treatment model: A systematic review of treatment for co-occurring alcohol misuse and depression. Australian & New Zealand Journal of Psychiatry, 52(8), 737–750.

[13] aihw.gov.au/getmedia/0e102c2f-694b-4949-84fb-e5db1c941a58/aihw-hse-211.pdf.aspx?inline=true

depression (up to 60%), and personality disorders (up to 70%).[14] Prevalence of psychotic disorders among people in drug treatment is elevated but still relatively low at up to 10%, and are typically chronic and stable, rather than acute.

The range of alcohol and other drug problems in mental health services may span from non-problematic use to severe problems, while those is specialist alcohol and other drug treatment (aside from harm reduction services) are typically moderate to severe.

Therefore, while there is significant comorbidity among people with both alcohol and other drug problems and mental health problems, the two sectors have quite distinct client groups, with little overlap. Calls for service and systems integration are neither evidence based or rational. They are a blunt instrument to respond to a nuanced problem.

A rational, evidence-based approach to comorbidity.

Although the evidence for integrated care is limited, there is evidence that meeting the diverse needs of clients improves retention and program outcomes. We can address a person's holistic needs without integration.

One series of case studies,[15] found that having behavioural health providers co-located in community health centres increased the likelihood that primary care providers would screen for AOD and other behavioural health care needs and facilitated clients' transition from primary care to specialist behavioural health care. Colocation is an easier system to implement than full integration.

Another study designed to identify associations between specific wrap around services and indicators of treatment retention and posttreatment outcome found that there was a strong association

[14] comorbidityguidelines.org.au/pdf/comorbidity-guideline.pdf

[15] Gurewich D, Prottas, J., & Sirkin, J. T. Managing care for patients with substance abuse disorders at community health centers. Journal of substance abuse treatment. 2014;46(2):227-31.

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between providing medical, educational, and mental health services and several indicators of retention. Meeting child care, educational, family, and medical needs was associated with improvements in alcohol and other drug outcomes. The study supports the need to address broader biopsychosocial needs within alcohol and other drug use treatment.

Holistic, wraparound client care should be routine in both mental health and alcohol and other drug settings. Providing this kind of holistic care wherever the client has made first contact seems to be more effective than service integration, but requires deliberate systems to ensure that the different services have the means to cooperate and collaborate.

Health professionals in each sector need to understand the types of co-occurring problems they may each face and what is within their capacity to respond to, as well as where, at what point and how they should refer for additional support.

This starts with routine and comprehensive assessment of a range of health and social domains within each service. Improving relationships between agencies and encouraging cooperation and collaboration in the form of structured case conferencing, agreements on co-location of services or professionals.

A potential framework for coordinated care

There appears to be no benefit of integration in service delivery, which is complex and expensive to achieve. Truly integrated mainstream dual diagnosis services are not, in my view, likely to achieve the client outcomes expected by those calling for an integrated system. There may be some justification for a limited number of these services to support severe and complex cases that cannot be managed in the mainstream system.

Currently the alcohol and other drug sector works primarily on a loose coordination approach in which individual practitioners work together from different sectors to get the best outcomes for clients. The downside to this approach is that people often fall through the

gaps, as it relies on the good will of individuals to engage in shared care arrangements.

Alternative options, which are probably more cost effective and do not require major disruption to sector or organisational culture poor processes include **collaboration** in which formal service level systems are in place that facilitate shared care, referral and communication about clients; or **colocation** in which multiple services are geographically located together, which has been shown to facilitate working relationships and referral pathways, and therefore client outcomes.

In my view, given the lack of evidence for integration, we should put more effort and funding into linking up services more effectively and more formally.

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Other issues

Because alcohol and other drug treatment clients have different mental health problems to clients in the public mental health sector, there is likely to be little benefit in placing mental health workers in alcohol and other drug services, providing joint training between the sectors, or for mental health workers to provide training to alcohol and other drug workers.

In my view, over the past two decades, the alcohol and other drug sector has enthusiastically taken up workforce and professional development in relation to comorbidity. To their credit, the sector understands that it is routine practice to assess and manage a range of mental health issue within the alcohol and other drug setting. They have extended this from common mental health problems to more recently responding to people who have experienced trauma and to domestic and family violence.

The key comorbidity related skills alcohol and other drug workers need are skills in mental health assessment; brief mental health intervention; management and monitoring of mental health problems while treating alcohol and other drug issues. One of the biggest gaps for alcohol and other drug workers is the lack of referral options. For the types of mental health problems presenting to alcohol and other drug services, the main treatment occurs in the private sector. People in alcohol and other drug treatment may not be able to afford private health care.

The mental health sector has less enthusiastically taken up formal alcohol and other drug measures, but there has been some gains in that area as well.

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drug intervention; effective referral to alcohol and other drug services (for example when to refer to different treatment types).

Good alcohol and other drug treatment improves both alcohol and other drug and mental health outcomes, so continuing to improve the application of evidence based alcohol and other drug practice, and continuing to improve workforce education and skills, will improve outcomes in the sector. Targeted training and workforce measures to meet each sectors needs is required to ensure they are working within, and to their full, capacity with people with co-occurring alcohol and other drug and mental health problems.

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