Directions Health Services submission to the ACT Government's Budget Consultation 2018-19

Integrated Mental Health and Alcohol and Other Drug Treatment Services

Identified Service Gap and Proposed Response

Directions Health Services has identified a service gap in the support of people who are struggling with co-occurring mental health and substance use issues.

It has been noted that, where co-occurring substance use and mental health issues are present, it is often "difficult to differentiate psychopathological symptoms, which represent an independent (primary) mental disorder, from symptoms of acute or chronic substance intoxication or withdrawal."[1] The distinct, reflexive relationship between substance use and mental health was articulated in a 2014 study by Vella *et al*, where participants noted that change in one domain resulted in causal symptomology in the other. There are increased risks of chronicity and criminality for people with coexisting substance use and mental disorders and poor prognoses for both disorders[2] if treatment does not address both issues concurrently. Both conditions may serve to maintain or exacerbate the other.[3]

It is to this distinct relationship of mutual influence that this submission speaks. Directions Health Services proposes the need for an innovative, integrated and multi-disciplinary service model, incorporating AOD, mental health and primary care specialists. This model should be underpinned by a recovery-oriented, stepped care approach that supports responsive, holistic and appropriate service provision, customised to individual client need.

Context

The comorbidity of mental health and substance use has been well recognised and documented[4], with 63% of Australians who have issues with alcohol and other drugs (AOD) also experiencing a mental health disorder[5]. This compares to approximately 20% of the general population. Significantly, however, the rate of comorbidity is even higher within the cohort of people seeking treatment from AOD support programs, with up to 75% of AOD

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[1] Torrens, Mestre-Pinto & Domingo-Salvany (2015) *Comorbidity of substance use and mental disorders in Europe 2015:17,* European Monitoring Centre for Drugs and Drug Addiction

[2] Ibid (2015:20)

[3] Marel C, Mills KL, Kingston R, Gournay K, Deady M, KayLambkin 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.

[4] NSW Ministry of Health (2015); Marel C, Mills KL, *et al* (2016); Torrens, Mestre-Pinto & Domingo-Salvany (2015)

[5] ABS 2007, cited Vella V E *et al Comorbidity in detoxification: symptom interaction and treatment intentions, Journal of Substance Abuse Treatment* (2014)

program participants experiencing lifetime mental health disorders[6]. A significant deficit in life expectancy has also been noted for people with co-occurring mental health and substance use issues, with an estimated reduction in life expectancy of up 30 years suggested[7]. This deficit is frequently attributable to lack of health care; untreated, serious chronic illnesses; and late diagnosis of potentially terminal illnesses.

People with co-occurring substance use and mental health concerns struggle with multiple and compounded issues[8]. This often has profound and debilitating impacts. These may include any or all of the following, which not only significantly affect the individual, but also resonate through family and community, and generate significant economic costs to society[9]:

- homelessness
- poverty
- inconsistent and often incomplete education
- poor labour force participation
- poor physical health
- criminal behaviour
- increased risky behaviours
- a high level of other co-occurring conditions
- stigma and discrimination
- family breakdown
- social isolation

Treatment of co-occurring mental health and substance use issues presents as one of the critical challenges facing the Australian health system[10]. Although best practice evidence identifies an integrated treatment approach as ideal for optimal client outcomes, single disorder treatment models remain the dominant approach[11]. Services are often provided either sequentially, based on identification of the primary issue, or in parallel, with separate, specialist service providers.

Despite recognition that the siloed structure of the health system and the differing treatment approaches of mental health and AOD services pose considerable access barriers to those experiencing co-occurring substance use and mental health, the system remains fragmented and difficult for clients to navigate. This inevitably leads to poor outcomes for people with coexisting disorders and their families, and all too frequently preventable, early death through poor health, suicide or misadventure.

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6 Centre for Substance Use Treatment (2007)

7 Lawrence, Holman & Jablensky (2001), *Duty to care: Physical illness in people with mental illness*, cited O'Halloran P (2014)

8 Bower Place

9 Torrens, Mestre-Pinto & Domingo-Salvany (2015) European Monitoring Centre for Drugs and Drug Addiction, *Comorbidity of substance use and mental disorders in Europe p13*

10 NSW Ministry of Health (2015)

11 Ibid

Outcomes and Benefits

In line with recommendations from Marel et al[12], the aim of such an integrated program is to improve clients' health and quality of life across all life domains - including health, social welfare and housing, relationships, employment, criminal justice, and of course, AOD and mental health. This would be best achieved through a co-ordinated and multi-disciplinary approach, supported by intensive case management. The aim would be to also build the participant's capacity, over time, to advocate for themselves, enabling them to increase their personal agency and improve their access to mainstream services.

This submission posits that the combination of intensive mental health and AOD support, in addition to primary health care, will scaffold service participants across all domains of significant vulnerability. This will enable more holistic engagement, with service participants able to access supportive from health practitioners who are familiar with the implications of, and best practice response to, coexisting mental health and substance use.

The objective, then, is to ensure that the ACT's most vulnerable sub-populations - those experiencing co-existing AOD and mental health issues - are able to access appropriate services and are supported to:

(a) minimise the harm resulting from their substance use, and
(b) positively manage their mental health.

Directions anticipates that participants will:

- have the information that they need to make informed decisions
- be better equipped to manage their needs
- be connected to services
- reduce the harms associated with their substance use
- be better able to manage their comorbid mental health & AOD issues
- experience improved mental health
- experience improved physical health
- experience improved life outcomes and quality of life

It is to these challenges that Directions Health Services speaks with this proposal, recognising that the ACT has long been recognised as an adaptable jurisdiction, with an emphasis on maximising best practice opportunities13. Such practices also offer the potential for significant, long term, social cost benefits to the ACT community, as well as to the public health and welfare systems.

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[12] Marel C, Mills KL, Kingston R, Gournay K, Deady M, KayLambkin F, Baker A, Teesson M (2016). ibid

[13] Hughes & Ritter 2008, cited Hughes, Shanahan et al 2013 *2013 Evaluation of the Australian Capital Territory Drug Diversion Programs p78*

The estimated cost of such a program in the ACT, with a team of primary health care, allied health, specialist mental health and AOD clinicians (approximately 8.5 FTE) working intensively with the identified cohort, would be in the vicinity of $1.1 million per annum.

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