THE UNIVERSITY OF SYDNEY
Matilda Centre

The Matilda Centre for Research in
Mental Health and Substance Use
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Submission to the Australian Government Productivity Commission
Mental Health Inquiry

Lessening the Burden of Comorbid Substance Use and Mental Disorders Through Evidence-Based Care: The Case for a National Minimum Qualifications Strategy

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Topics addressed from issues paper:

1. Mental health identification and prevention (preventing relapse)
2. Suicide prevention
3. Comorbidities
4. Health workforce
5. Towards coordinated care and a fully integrated system

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IN A NUTSHELL: EXECUTIVE SUMMARY

The co-occurrence of substance use disorders and mental health disorders have a high prevalence in Australia and come with substantiated disability; 1 in 2 Australians will develop a substance use, anxiety or mood disorder in their lifetime[1-3], and 1 in 5 Australian adults meet criteria for a substance use, anxiety or mood disorder annually[3]. Furthermore, findings from the most recent Australian National Survey of Mental Health and Wellbeing (NSMHWB) show that these disorders frequently co-occur with 35% of individuals with a substance use disorder (31% of men and 44% of women) also meeting diagnostic criteria for at least one co-occurring mood or anxiety disorder[1]. Prevalence is even higher among individuals entering alcohol and other drug (AOD) treatment programs, with estimates indicating between 50–76% of Australian clients of AOD treatment services meet diagnostic criteria for at least one comorbid mental disorder[4-7].

Co-occurring substance use and mental disorders are also extremely costly. The economic burden that substance use adds to this inquiry is highlighted in a 2016 report commissioned by The Royal Australian & New Zealand College of Psychiatrists (RANZCP) and the Australian Health Policy Collaboration at Victoria University (AHPC)[24]. These estimates show that in Australia, the annual cost of premature death due to co-occurring mental and physical health conditions in people with serious mental illness is $15 billion, yet this increases dramatically when substance abuse is considered; climbing to an astounding $45.4 billion. Furthermore, 75% people who develop a substance use or mental disorder do so before the age of 25, with peak disability occurring in those aged 15-25. It is for these reasons that substance use and mental disorders have been described as chronic diseases of the young[20].

In our submission we emphasise the importance of substance use as a crucial compounding factor when considering the social and economic costs of mental ill health. These costs may be reduced, and productivity improved, by effective early intervention and treatment. To achieve this, we recommend improving the capabilities of AOD workers to respond to comorbidity. Such strategies have already been executed through the Minimum Qualification Framework (MQF) currently operating in Victoria and the Australian Capital Territory[40,41]. This strategy has been well received by AOD workers[42], yet co-occurring substance use and mental disorders remain the most frequently requested area for further training[42,43].

From this, The Matilda Centre suggests two key solutions to the commission for the issue of co-occurring substance use and mental disorders with regards to productivity and participation;

1. A national rollout of the MQF for AOD workers;
2. A greater emphasis within the four key competencies of the MQF on identifying and responding to co-occurring substance use and mental disorders.

We offer our best-practice Guidelines, accompanying website and Online Training Program as an evidence-based resource that may be implemented into the reviewed key competencies[27]. Through upscaling our evidence-based training program into practice as part of a national minimum qualification strategy, we believe treatment outcomes for those experiencing co-occurring substance use and mental disorders will be improved, and the burden on productivity and participation lessened.

Our submission and suggested solutions are pertinent to several specific issues the issues paper has requested feedback and suggestions for, as outlined below.

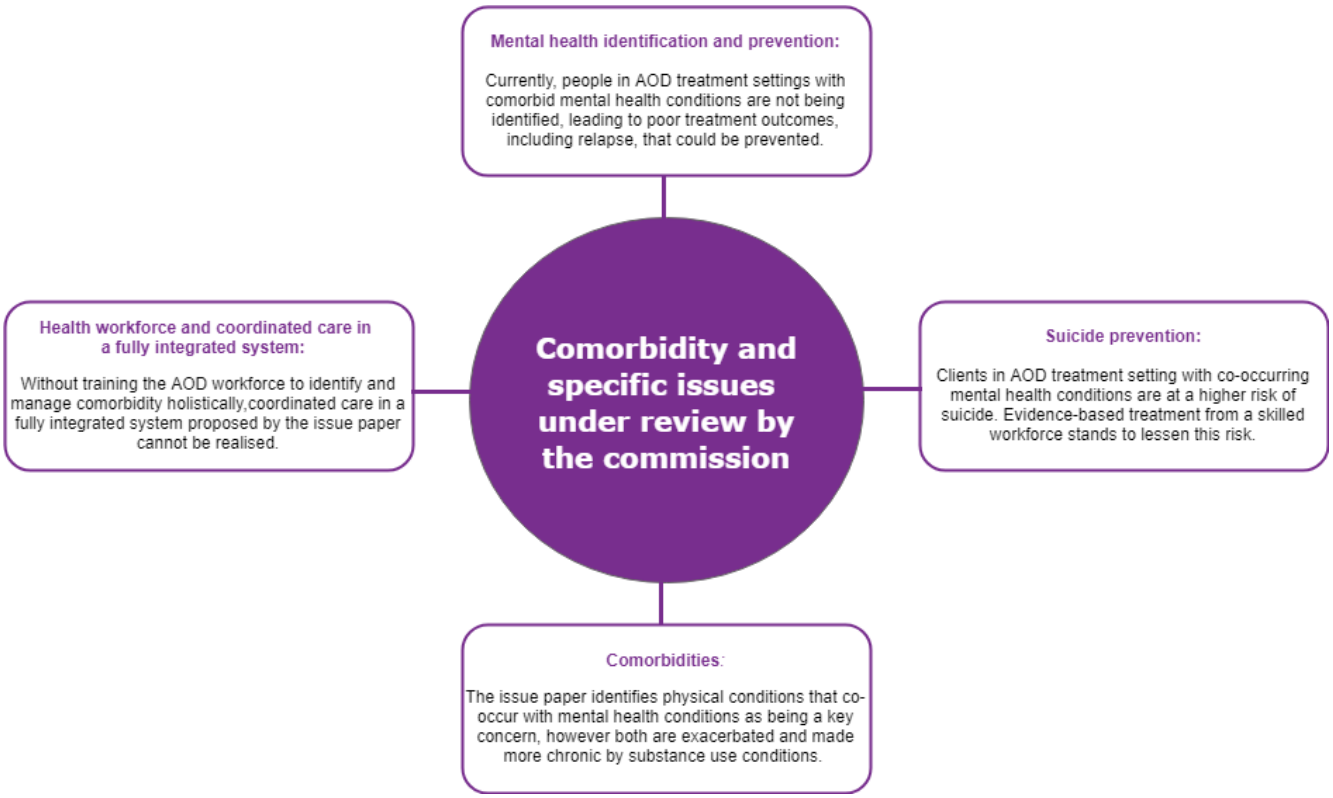

Figure 1. *Comorbidity and specific issues under review by the commission*

ABOUT THE MATILDA CENTRE

The Matilda Centre for Research in Mental Health and Substance Use (the Matilda Centre) delivers research programs to prevent, treat and reduce substance use and mental disorders. The work of the Matilda Centre is built upon the success of the formerly-known NHMRC Centre of Research Excellence in Mental Health and Substance Use (CREMS).

Our mission is to improve health and wellbeing through research conducted in collaboration with multi-disciplinary international experts, consumers, carers, policy makers, and other key-stakeholders. We will achieve this by:

- bringing together globally recognised national and international researchers with a shared commitment to the prevention, early intervention and treatment of mental and substance use disorders;
- building the evidence base for a thriving and empowered youth; and
- engaging with decision makers and lived experience to enact real change.

With a focus on prevention, treatment and epidemiology, our research streams facilitate knowledge exchange and develop strategic partnerships with the aim of increasing the knowledge base around the effective prevention and treatment of mental and substance use disorders.

THE PROBLEM

CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS ARE CHRONIC, COMMON AND COSTLY DISEASES OF THE YOUNG

Research conducted on the general population indicates that approximately one in two Australians will develop a substance use, anxiety, or mood disorder at some point in their life[1-3]. Approximately one in five Australian adults (18% of men and 22% of women) meet diagnostic criteria for a substance use, anxiety, or mood disorder in a given year, representing close to 3.2 million Australian adults[3]. Furthermore, findings from the most recent Australian National Survey of Mental Health and Wellbeing (NSMHWB) show that these disorders frequently co-occur with 35% of individuals with a substance use disorder (31% of men and 44% of women) also meeting diagnostic criteria for at least one co-occurring mood or anxiety disorder[1].

As summarised in a recent systematic review, the prevalence of comorbidity is even higher among individuals entering alcohol and other drug (AOD) treatment programs: between 50–76% of Australian clients of AOD treatment services meet diagnostic criteria for at least one comorbid mental disorder[4-7]. The most common mental health conditions observed are those listed as a key focus for the current inquiry: anxiety disorders (45–70%), most commonly Generalised Anxiety Disorder (GAD)[4-5,8-9], depression (26–60%)[4-6,9-13] Post Traumatic Stress Disorder (PTSD, 7–51%)[4-5,11,13]. In addition to those who meet diagnostic criteria for mental disorders, there are a large number of people who present to AOD treatment services who display symptoms of disorders, while not meeting full criteria for a diagnosis of a disorder[14]. Individuals who display a number of symptoms of a disorder but do not meet criteria for a diagnosis are sometimes referred to as having a 'subsyndromal' or 'partial' disorder. Although these individuals may not meet full diagnostic criteria, their symptoms may nonetheless impact significantly on their functioning and treatment outcomes[15-19].

A key summary of the incidence and prevalence of co-occurring substance use and mental disorders can be found in Figure 2.

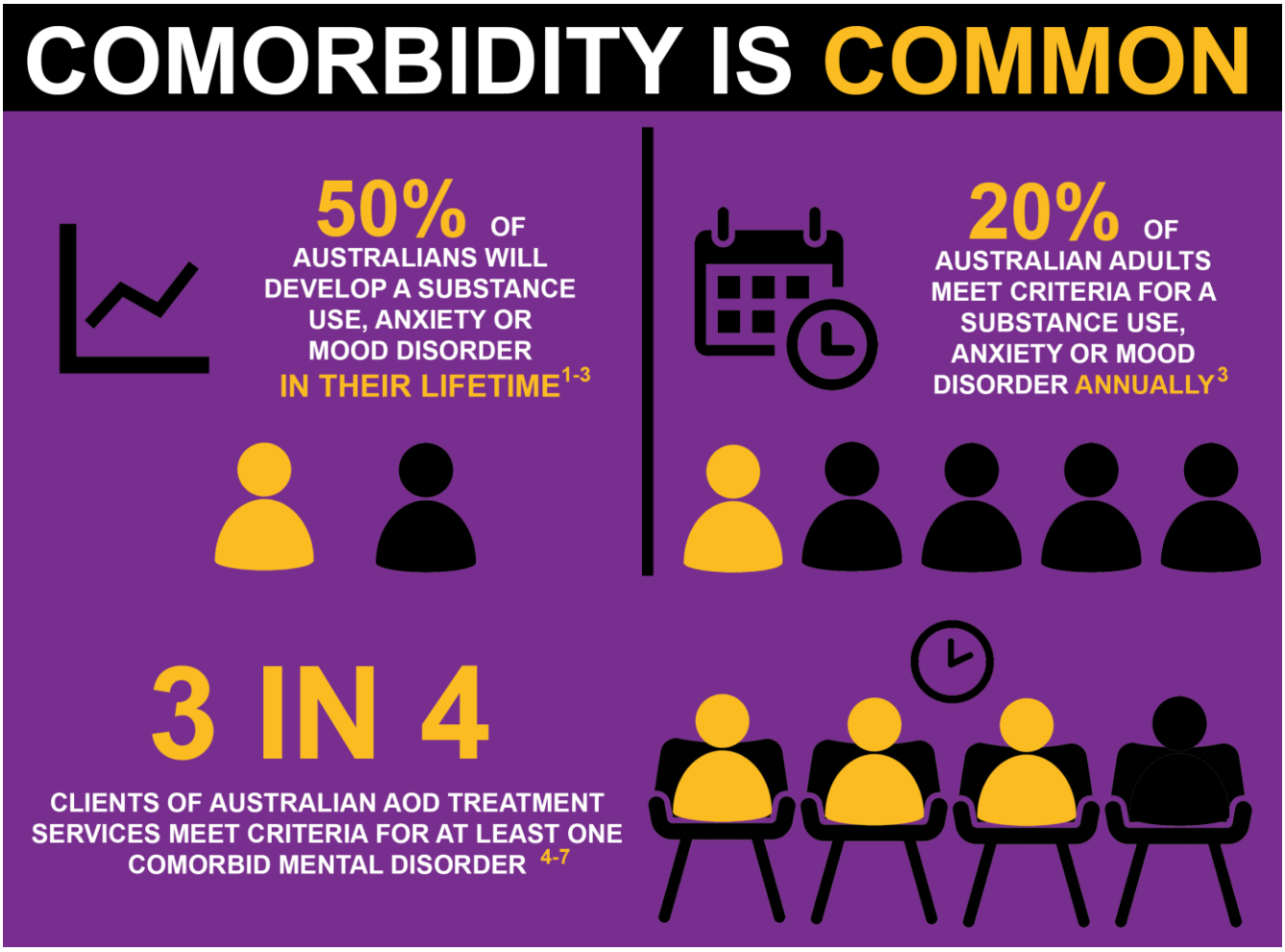

Figure 2. *Summary of key statistics outlining the incidence and prevalence of co-occurring substance use and mental disorders.*

THE IMPACT OF COMORBID SUBSTANCE USE AND MENTAL DISORDERS ON PRODUCTIVITY AND PARTICIPATION ARE CONSIDERABLE

Substance use and mental health conditions can place an enormous strain on individuals, families and communities, both emotionally and financially. Substance use and mental disorders are among the leading cause of non-fatal burden of disease globally in terms of years lived with disability (YLD)[20] and substance use disorders are among the top five most burdensome mental health conditions to the individual in terms of illness severity and quality of life lost[20]. Twenty-three percent of all YLD are attributable to substance use and mental disorders. By way of comparison, the corresponding figures for cardiovascular disease and cancer are 2.8% and 0.6% respectively[20]. The peak of this disability, and the associated productivity costs, occurs in those aged 15-24 years, corresponding with the typical period of onset of these problems[20-22]. **75% of people who develop a substance use or mental disorder do so before the age of 25 years**[23]. Without effective early intervention

and treatment, these conditions may persist with lasting consequences on a person's participation and productivity. It is for these reasons that substance use and mental disorders have been described as chronic diseases of the young[20].

The social and economic impacts of substance use and mental disorders are compounded when they co-occur. People experiencing comorbid substance use and mental disorders experience considerable disadvantage, presenting to treatment with a more complex and severe clinical profile, including poorer general physical and mental health, greater drug use severity, poorer functioning, and increased risk of suicide (Figure 3)[5,16-19]. Estimates highlighted in a 2016 report commissioned by The Royal Australian & New Zealand College of Psychiatrists (RANZCP) and the Australian Health Policy Collaboration at Victoria University (AHPC)[24] show that the annual cost of premature death due to co-occurring mental and physical health conditions in people with serious mental illness in Australia is $15 billion, yet this increases dramatically when substance abuse is considered; climbing to an astounding $45.4 billion. The significant social and economic costs of may be reduced, and productivity improved, by effective early intervention and treatment.

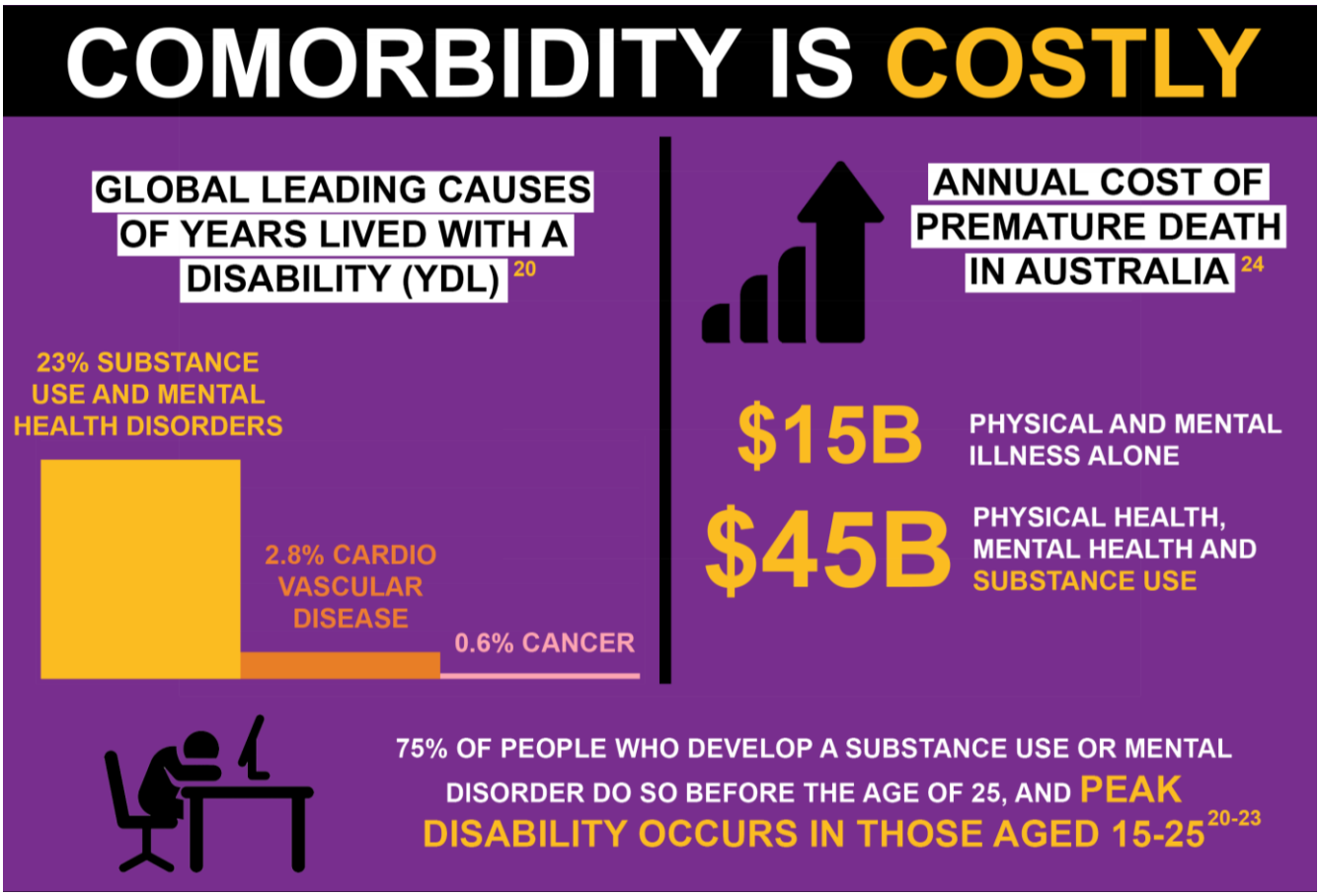

Figure 3. *Summary of key statistics outlining the burden and costs of comorbidity.*

Sizeable barriers exist for people with comorbid substance use and mental disorders in terms of accessing and receiving effective treatment. Clinical and academic experts have long advocated for reform of our current systems that lead many with comorbid disorders to 'fall through the gaps" of our service silos. Research has shown that while people entering substance use treatment who have a comorbid condition demonstrate improvements, people with comorbid conditions continue to drink or use more, be in poorer physical and mental health, and display poorer functioning following treatment, when compared to people without comorbid mental disorders[5-6,25-26]. It is therefore not surprising that comorbid disorders have also been associated with higher rates of readmission and health service utilisation[14,19]. Collectively, these findings suggest that despite the best efforts of clinicians, clients with comorbidity are not receiving all the support they need. One mechanism by which support may be enhanced (and participation and productivity increased), is through improving the capabilities of AOD workers to respond to comorbidity.

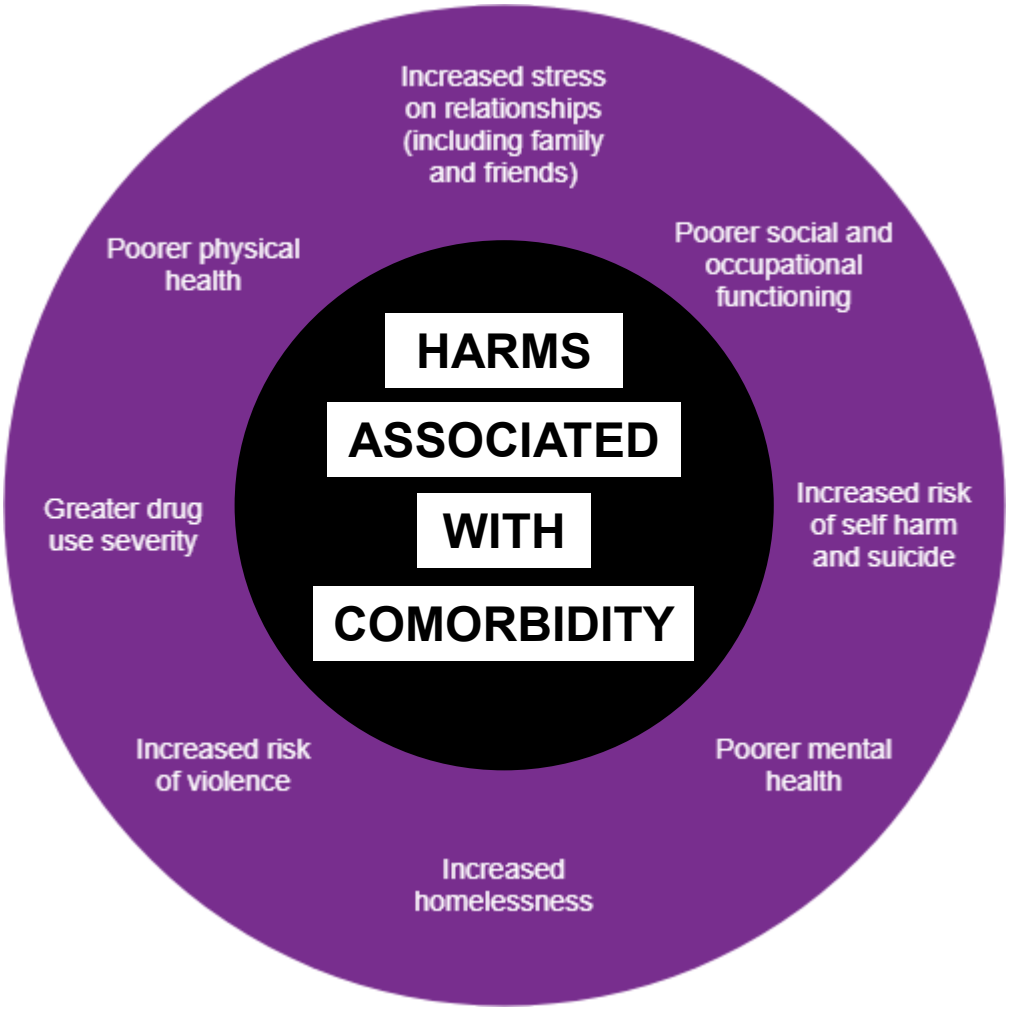

Figure 4. *The harms associated with comorbidity[27]*

PRODUCTIVITY AND PARTICIPATION MAY BE IMPROVED BY ENHANCING AOD WORKER TRAINING TO RESPOND TO COMORBIDITY

Studies have reported that AOD workers feel overwhelmed and fearful when treating people with comorbid mental disorders, as their knowledge and the resources available to them are inadequate[28]. Unsurprisingly, high levels of stress, burnout and turnover are common in the AOD workforce, lessening productivity and participation for the workers as well as the clients they treat[29,30]. Improving workforce capacity may serve to improve client outcomes as well as reduce this turnover.

The need for improved training and support of AOD workers in responding to comorbid mental disorders has been identified as priority by numerous reviews and policy documents[31-36], as well as by AOD workers themselves[37]. Within the AOD workforce, the management of co-occurring mental health conditions has been described as *'the single most important issue… a matter akin to blood-borne viruses in the 1980s.'*[15]

By improving capacity of the AOD workforce to respond to mental health we may actualise the commission's goal to *"…realise benefits from increased social and economic participation and contribution to the wider community in both the near and long term".*[38]

THE SOLUTION:

We suggest two key solutions to the commission to improve the capacity of the AOD workforce to respond to co-occurring substance use and mental disorders, as outlined in Figure 5 below.

Figure 5. *Suggested solutions for lessening the burden of co-occurring substance use and mental disorders from The Matilda Centre.*

1. A NATIONAL ROLLOUT OF THE MQF FOR AOD WORKERS

The National Alcohol and other Drug Workforce Development Strategy (2015–2018) outlines an overarching plan for enhancing the capacity of Australian AOD workers to respond to comorbidity[39]. Here, key goals within the Strategy offer solutions that might be adopted by the commission for an integrated approach to increasing participation and productivity. These include;

1. Enhancing the capacity of AOD workers to care for AOD clients with comorbid mental health conditions;
2. Enhancing the capacity of generalist health, community, welfare and support services workers to prevent and reduce harm related to AOD and mental health conditions;
3. Promoting the ability of the education sector to prevent and reduce harm related to substance use and mental disorders.

Key principles guiding the strategy stress that "*…the reduction of AOD harm in Australia will be optimised by having a workforce engaged in evidence-based practice*" and that "*…in recognition of the often complex needs of individuals experiencing AOD-related harm and their families, the Strategy should foster enhanced cooperation between sectors and agencies*."[39]

But how should this be executed? The Strategy discusses building minimum capability requirements for generalist health, community, welfare and support services workers to prevent and reduce AOD harm. This less specialised section of the AOD workforce is classified as Tier 1 and Tier 2 in the Strategy's workforce model (Figure 6)[39]. However, the need for Tier 3 and Tier 4 to have minimum qualifications regarding co-occurring mental health conditions in an AOD setting is not mentioned.

A national approach to qualify AOD workers to respond to comorbid mental health conditions may greatly enhance the effectiveness of AOD treatment and lessen the estimated $45 billion-dollar annual cost of comorbidity in Australia[24]. Without holistic care, the healthcare journey of clients with comorbidity will likely continue to be cyclical, ineffective, and costly.

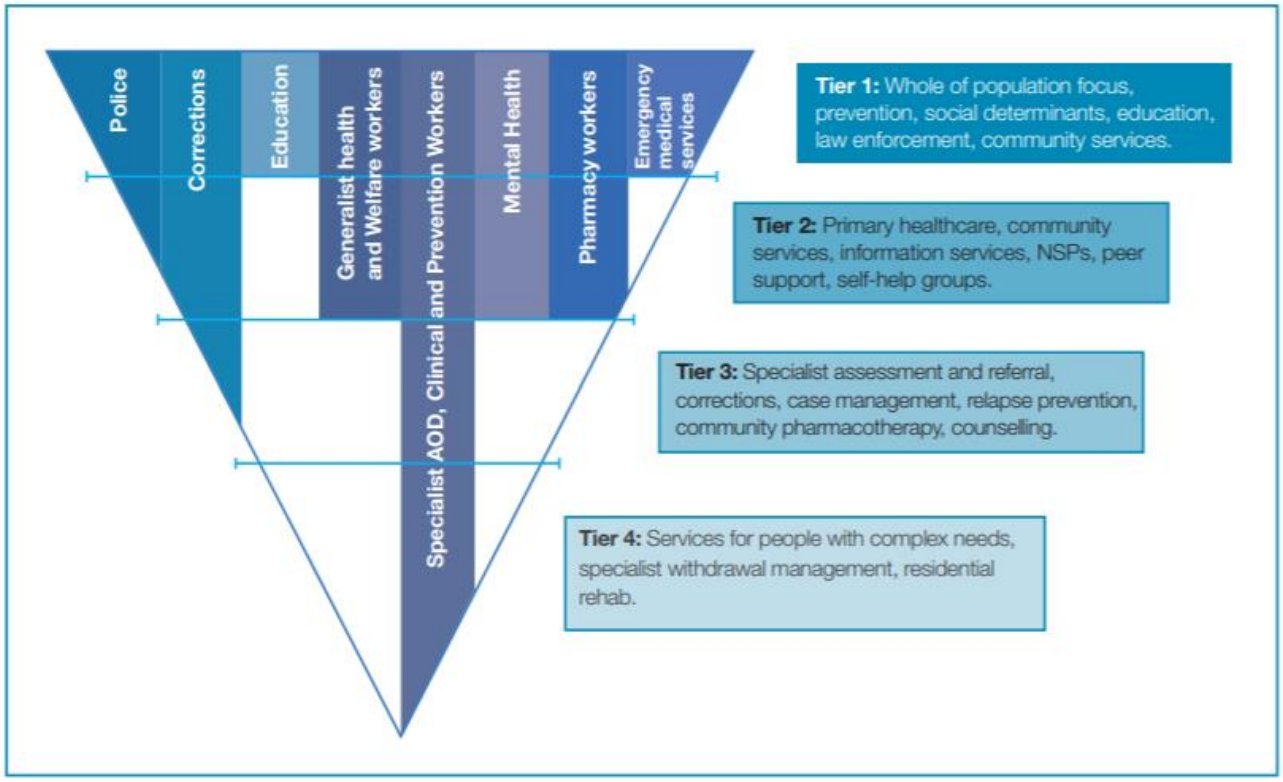

Figure 6. *The National Alcohol and other Drug Workforce Development Strategy (2015–2018) tiered model of the AOD workforce*[39].

In recognition of this, from 2006 two states have implemented a Minimum Qualifications Framework (MQF) for the AOD workforce; Victoria (VIC) and the Australian Capital Territory (ACT)[40,41]. These strategies require AOD agencies to ensure employees complete four key competencies designed to better identify issues and respond to the need of clients accessing AOD services. These four competencies are also built into the vocational AOD courses in these states[40,41].

These competencies include;

1. CHCAOD001: Work in an AOD context;
2. CHCAOD004: Assess needs of clients with AOD issues;
3. CHCAOD006: Provide interventions for people with AOD issues;
4. CHCAOD009: Develop and review individual AOD treatment plans.

In 2008 the reception of the MQF in VIC was reviewed by Turning Point; a key AOD centre and registered training provider[42]. AOD workers from across Victoria were surveyed (n=492), and findings showed that AOD workers meeting MQS requirements had risen from 64% in 2006 to 70% in 2008, and that support for the MQS

was high at 78% of surveyed workers[42]. Despite this, 67% of workers reported they required training beyond the MQS – and **dual diagnosis (comorbidity) was at the most frequently requested topic for further training**[42].

At a national level, support for a minimum qualification requirement within the AOD sector is also high. In 2010, the National Centre for Education and Training on Addiction (NCETA) conducted a nation-wide survey of 186 AOD treatment service managers. Eighty-two percent of respondents supported a minimum qualification requirement for AOD workers and again, the **importance of further training to identify and respond to co-occurring mental health and AOD issues was recognised as a high priority**[43].

2. GREATER EMPHASIS WITHIN FOUR KEY COMPETENCIES ON EVIDENCE-BASED IDENTIFICATION, MANAGEMENT AND TREATMENT OF CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

The potential for upscaling the National Comorbidity Guidelines Online Training Program

We propose integrating existing evidence-based training and educational resources into core training as part of the MQF to ensure the four competencies include evidence-based training for comorbidity. One such resource may be the Australian Government Department of Health (AGDoH) funded National Comorbidity Guidelines Online Training Program.

In 2007, the Australian Government Department of Health and Ageing funded the development of *'Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings'*[44] as part of the National Comorbidity Initiative to improve the capacity of AOD workers to respond to comorbidity. The resource was a huge success. Since their publication in 2009, over 12,000 hard- and electronic-copies were distributed to clinicians and treatment services across Australia, training was rolled out nationally, and the resource became a recommended text for students studying tertiary courses in AOD and mental health. An evaluation also found that AOD workers from a range of occupations and service types across Australia perceived the Guidelines to be relevant and useful to their clinical practice and enabled them to respond to comorbidity with greater confidence[45].

The scientific evidence regarding the management and treatment of comorbid disorders has, however, grown considerably since the Guidelines were first published. Building on the success of the first edition, in 2014 the Australian Government Department of Health (AGDoH) funded the update and revision of the Guidelines to bring them up to date with the most current evidence. Like the first edition, the second edition of the Guidelines were based on the best available research evidence, developed in consultation with a panel of experts, and drew upon the experience and knowledge of clinicians, researchers, consumers, and carers. The Guidelines provide AOD workers with a range of evidence-based options for identifying, managing and treating mental health symptoms within a holistic health care approach, involving multiple services, and integrated care coordination.

This second edition was officially launched in September 2016[27]. To date, more than 7,000 electronic and hard-copies of the Guidelines have been distributed to services across Australia including AOD, mental health, and disability services. Copies have also been distributed to all educational institutions providing tertiary training in AOD and mental health across Australia, and demand remains high.

A dissemination and translational strategy was developed based on extensive consultation with key stakeholders and experts about the most effective methods of translating the evidence-based Guidelines into clinical practice. To provide clinicians working across all sectors and stages of workforce development Australia-wide with easy and user-friendly access to the Guidelines, and to facilitate their uptake into clinical practice, the AGDoH provided further funding in 2016 for the national dissemination of the Guidelines and the development of an accompanying website and online training program.

In November 2017, our innovative and interactive online training program was developed in line with best practice e-learning principles in consultation with clinicians and consumers (www.comorbidityguidelines.org.au/training-modules).

The program has three key aims, and has been developed to assist AOD workers:

1. Increase their knowledge and awareness of comorbidity.
2. Improve the confidence of those working with clients with comorbidity.
3. Improve AOD workers' ability to identify mental health conditions.

Our online training program is hosted on a highly responsive web-based platform that also provides users with downloadable resources and links, online videos, as well as a customised "build your own guidelines" module where clinicians can personalise the Guidelines to suit their clinical needs. In addition, visitors can order free hard copies of the Guidelines to Australian addresses.

The Online Training Program was launched at the conference of the World Psychiatric Association in Melbourne 2018, Over 900 hard copies have been ordered through the Guidelines website, over 1,600+ users have registered for online training and average page views have remained over 31,000+ per month. Preliminary results from our online training evaluation study indicate that >90% of program completers agreed/strongly agreed that the program improved their confidence, skills, and capacity to respond to comorbidity.

In recognition of the clinical utility and impact of the Guidelines and Online Training Program, the developers were awarded the *Australian Rotary Health Knowledge Dissemination Award* in December 2016; and the *Australian Drug Foundation Excellence and Innovation Award in Research* in June 2017.

The National Comorbidity Guidelines Online Training Program holds enormous potential for upscaling at a national level, and by being incorporated into a national MQF rollout, would greatly enhance AOD workforce capacity to identify and manage comorbidity in healthcare settings throughout Australia. While the program has been designed for AOD workers, our training registration data reflects the broad diversity of occupations that comprise the AOD workforce. Those signing up for training range from peer support counsellors to domestic violence workers to correctional officers. Not only is our training being utilised by the more specialised AOD workforce (Tiers 3 and 4 under the National Strategy) but also the more general sector that the National Strategy seeks to upskill (Tiers 1 and 2). Our online delivery method for training also stands to greatly benefit regional healthcare workers in a cost-effective, accessible way.

SUMMARY

The commission is tasked with investigating how mental ill health impacts the ability of Australians to participate in our community, and the effects this has on our economy and productivity as a nation. In our submission we have emphasised the importance of expanding upon a pivotal issue the commission seeks input on; comorbidity. The burden of co-occurring substance use and mental disorders, both to the individual, the health workforce, and the Australian community, cannot be understated.

Despite the high co-occurrence of these conditions, training to support AOD workers in addressing mental health disorders among their clients is lacking. We offer a solution to this issue by suggesting a national rollout of existing minimum qualification strategies adopted by Victoria and the Australia Capital Territory for the AOD workforce. In doing so, the capacity of the AOD workforce to identify and respond to comorbidity will be greatly enhanced, and the burden on participation and productivity lessened.

In addition, we recommend a review of the four key competencies under the current minimum qualification strategies to place a greater emphasis on co-occurring substance use and mental disorders, as requested by the AOD workforce. We offer our best-practice Guidelines, accompanying website and Online Training Program as an evidence-based resource to be implemented into the reviewed key competencies.

Through upscaling our evidence-based training program into practice as part of a national minimum qualification strategy, we believe treatment outcomes for those experiencing co-occurring substance use and mental disorders will be improved, and the burden on productivity and participation lessened.

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