Submission

Whole-of-government Victorian alcohol and drug strategy

September 2011

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beyondblue, the national depression and anxiety initiative, is pleased to present this submission on the whole-of-government Victorian alcohol and drug strategy to the Department of Health. In making this submission, *beyondblue* has focussed on the **high prevalence mental health disorders of depression and anxiety**, the impact on consumers and carers, and areas that are most relevant to our work and research findings. This submission is also informed by the *beyondblue*-sponsored Medical Journal of Australia supplement, *Depression, anxiety and substance use*, published in August 2011 (see Attachment A).

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related disorders in Australia. Established in 2000, initially by the Commonwealth and Victorian Governments, *beyondblue* is a bipartisan initiative of the Australian, State and Territory Governments, with the key goals of raising community awareness about depression and anxiety and reducing stigma associated with the illnesses. *beyondblue* works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression and anxiety, to bring together their expertise. Our **five priorities** are:

1. Increasing community awareness of depression, anxiety and related disorders and addressing associated stigma.
2. Providing people living with depression and anxiety and their carers with information on these illnesses and effective treatment options and promoting their needs and experiences with policy makers and healthcare service providers.
3. Developing depression and anxiety prevention and early intervention programs.
4. Improving training and support for GPs and other healthcare professionals on depression and anxiety.
5. Initiating and supporting depression and anxiety-related research.

Specific population groups that *beyondblue* targets include young people, Indigenous peoples, people from culturally and linguistically diverse backgrounds, people living in rural areas, and older people.

Prevalence and impact of depression and anxiety disorders

Depression, anxiety and substance use conditions are the most prevalent mental health disorders in Australia.[i] One in three Australians will experience depression and/or anxiety at some point in their lifetime and approximately 20 per cent of all Australians will have experienced depression, anxiety or a substance use disorder in the last year.[ii] **The 2007 National Survey of Mental Health and Wellbeing reported on the prevalence of comorbid 12-month affective, anxiety and substance use disorders.**[iii] As demonstrated in Figures 1 and 2, males are more likely to experience substance use disorders than females.

Figure 1: Prevalence of comorbid 12-month affective, anxiety and substance use disorders in males[iv]

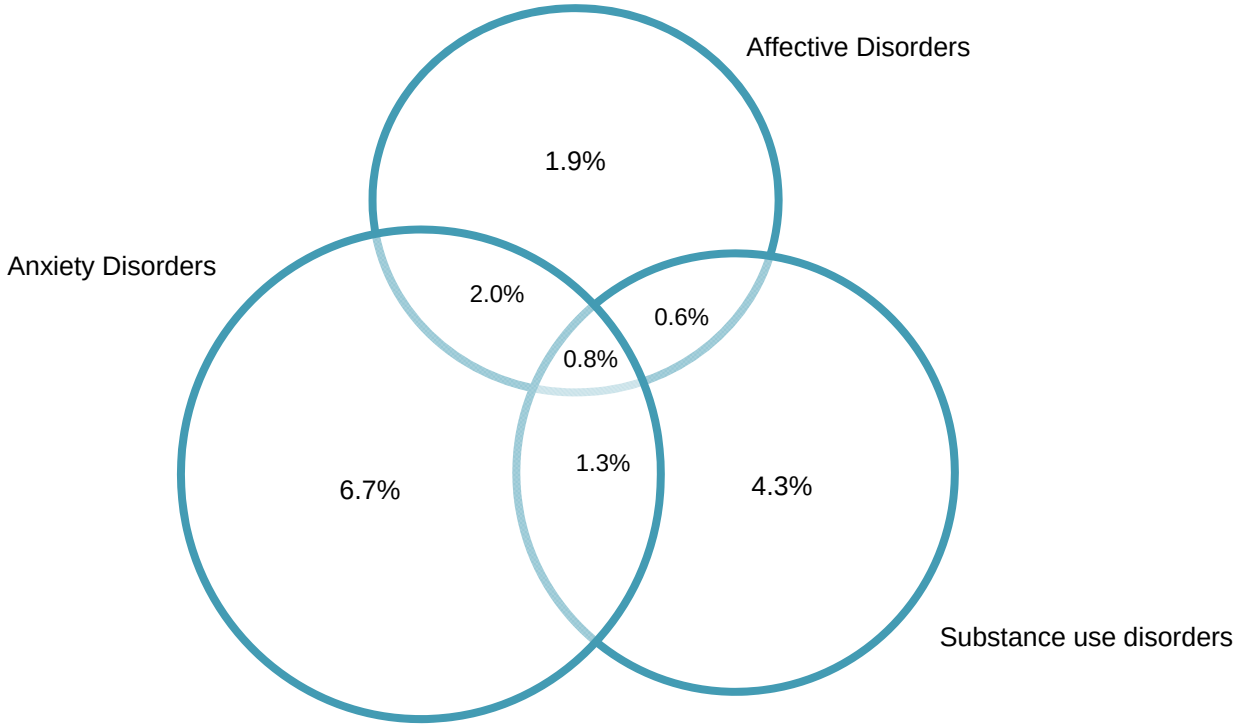
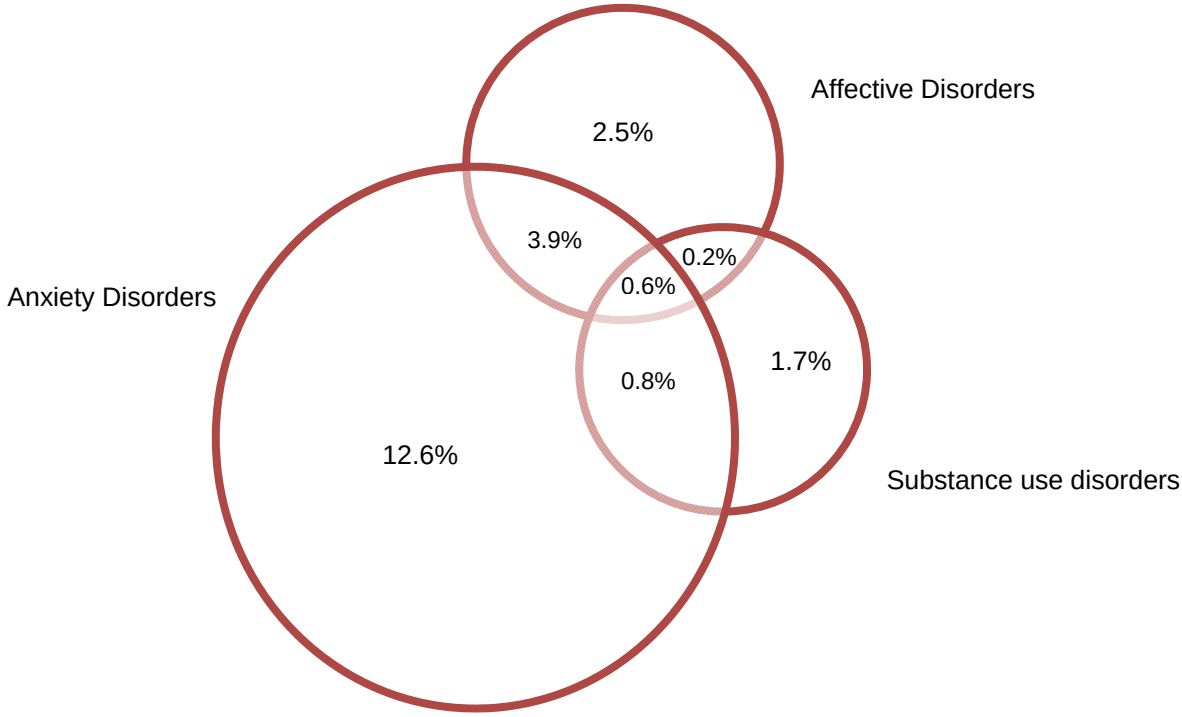


Figure 2: Prevalence of comorbid 12-month affective, anxiety and substance use disorders in females[v]



Mental illness is the leading cause of non-fatal disability in Australia, and it is important to note that depression and anxiety accounts for over half of this burden.[vi] Globally, the World Health Organisation predicts depression to become the **leading cause of burden of disease by the year 2030**, surpassing ischaemic heart disease.[vii]

Mental illness costs the community in many different ways. There are social and service costs in terms of time and productivity lost to disability or death, and the stresses that mental illnesses place upon the people experiencing mental illness, their carers and the community generally. There are financial costs to the economy which results from the loss of productivity brought on by the illness, as well as expenditure by governments, health funds, and individuals associated with mental health care. These costs are not just to the health sector but include direct and indirect costs on other portfolio areas, for example welfare and disability support costs. **It is estimated that depression in the workforce costs the Australian society $12.6 billion over one year, with the majority of these costs related to lost productivity and job turnover**.[viii] The individual financial costs are of course not exclusively borne by those with mental illness. It is often their carers who experience financial hardship due to lost earnings, as well as increased living and medical expenses.[ix] It is also important to recognise the differences in mental and physical disabilities, and the impact on workforce participation. In 2003 **28.3 per cent of people with a mental illness participated in the labour force, compared to 48.3 per cent of people with a physical disability**.[x]

beyondblue's response to the *whole-of-government Victorian alcohol and drug strategy* consultation

Demand Reduction (Question 7) – What can be done to better respond to the health needs of people who have a mental illness and misuse alcohol and drugs?

Harm Reduction (Questions 22 – 24) – How can we improve the assessment and treatment for alcohol and other drugs?

The **prevalence of comorbid depression, anxiety, and drug and alcohol misuse is common**. An Australian study has suggested that having an alcohol use disorder increases the odds of reporting depression or anxiety by two to five times.[xi] Among Victorian adolescents, research also suggests that persistent depression and anxiety symptoms almost double the risk of alcohol use disorders.[xii] Strategies to both reduce the demand and harm of alcohol and other drugs should therefore incorporate a strong focus on the issues and needs of people that experience comorbid depression and anxiety disorders.

The **relationship between mental illness and alcohol and drug misuse is complex and interrelated**. This relationship is explored by Frei and Clarke (2011),[xiii] who indicate that:

- addictive substances exacerbate psychiatric symptoms;
- people experiencing depression and anxiety may use psychoactive drugs to manage symptoms;
- active substances may induce psychiatric disorders; and

- substances may substantially impact the effectiveness of psychiatric pharmacotherapies.

The complexity and interdependencies between depression, anxiety and alcohol and drug misuse contribute to the difficulties in providing effective treatment and care for these conditions. **Services often treat depression, anxiety, and alcohol and substance use issues as single problems, rather than comorbid conditions**.[xiv] This issue was identified in *beyondblue*-commissioned focus groups, which explored the needs and experiences of people with depression and anxiety and their carers[xv]:

- *"...they're not dealing with the two issues together. It's 'oh sorry, you have drug problems. That's not our problem. That's somebody else's problem'."* Mental health carer
- *"...[these] people are falling between the cracks."* Mental health carer
- *"For me, drug effects have been a massive side effect of mental illness..."* Mental health consumer
- *"Someone in his [son] dropkick friends gives him some methamphetamines. Then dope cigarettes. Plus the fact that he cannot live without booze. He regards all these sorts of things as harmless, helpful, temporary cure. But all these things are part of the problem. They're not the cure."* Mental health carer

To improve the treatment and services available for people with depression, anxiety and drug and alcohol misuse problems, an **integrated and coordinated approach to care is needed**.[xvi] Baker and colleagues (2010)[xvii] provide an example of an integrated model, which addresses depression and alcohol use. This treatment approach included providing nine weekly one-hour sessions which addressed the way in which depression and alcohol use impacted on each other, as well as addressing the two conditions in parallel. This research indicated that integrated treatment was associated with a greater reduction in drinking days and levels of depression, compared to a single-focused intervention.

To support integrated approaches, it is also important that **effective screening and assessment tools** are used. These tools should identify comorbidities, and be used in primary care settings, specialist mental health, drug, and alcohol treatment services.[xviii] Screening and assessment tools may support the development of comprehensive treatment plans, and improved linkages between service providers. [xix] The implementation of this integrated and holistic model of care is needed to improve both mental health and drug and alcohol outcomes.

Despite the effectiveness and evidence-base on integrated treatments, **there is a substantial gap between treatment needs and accessibility**.[xx] Effective treatments are often high-intensity and require specialist training, which limits the number of people who can access services.[xxi] It is also difficult to recruit and train health professionals to work within the field of addiction medicine. [xxii] Strategies are therefore needed to both invest in different models of care, and support and strengthen the workforce.

There are significant opportunities to improve the quality and availability of services by investing in **innovative treatment options that can be delivered through information and communication technologies**.[xxiii] Research indicates that clinician-assisted computer

therapy can deliver clinical improvements that are at least equivalent to that achieved by therapist-delivered treatment.[xxiv] In addition to achieving positive clinical outcomes, this treatment modality is potentially more cost and time effective than face-to-face treatment.[xxv] Computer-assisted treatments may also address issues of access, potentially improve the structure and consistency of treatments, and help to address workforce shortages.[xxvi]

In addition to investing in different models of care, it is important that the **workforce is appropriately skilled and experienced to effectively treat comorbid conditions**. Frei and Clare (2011) suggest that workforce challenges are *"fed by the perception of clinical complexity."*[xxvii] While there is a need to recruit and strengthen the skills of specialists to manage the complexities of comorbid conditions, there is also a need to increase the rates of screening for comorbid conditions in primary care, and develop links and referral networks between service providers. Implementing team-based approaches to care will help to foster integrated treatment and care plans for depression, anxiety and substance misuse problems, which recognise the relationships between the conditions. This should be supported by an increase in the number and availability of specialist, integrated mental health and substance use treatment services.

Recommendations

1. Consider the needs of people with comorbid depression/anxiety in all strategies and policies aimed to reduce the demand, supply and harm of alcohol and other drugs.
2. Support the development and implementation of integrated and coordinated mental health, alcohol and drug treatment services.
3. Develop resources and incentives to encourage the identification of comorbid depression, anxiety and substance misuse in primary care and specialist mental health and drug and alcohol treatment services.
4. Conduct research on the effectiveness and feasibility of implementing computer-based treatment services for comorbid depression, anxiety and substance misuse.
5. Develop incentives to attract health professionals to specialise in addiction medicine.
6. Develop training programs to increase the skills of health professionals to identify and treat comorbid depression/anxiety and substance misuse problems.
7. Facilitate the development of improved networks between primary care and specialist mental health, drug and alcohol services.

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