SUBMISSION ON THE NATIONAL MENTAL HEALTH COMMISSION'S NATIONAL STIGMA AND DISCRIMINATION REDUCTION STRATEGY

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About

Turning Point is Australia's leading addiction treatment, research, and education centre. Turning Point is auspiced by one of Victoria's largest public health services, Eastern Health, and conducts world-leading, policy- and practice-relevant research and education through its affiliation with Monash University. Dedicated to delivering high-quality, best practice treatment, care and support for people affected by alcohol, other drug, and gambling harms, Turning Point also operates national helplines (Counselling Online and Gambling Help Online), supports health professionals nationally and internationally through education, training and expert clinical advice, and draws on its clinical, research and policy expertise to provide government with evidence-based advice to drive change.

The **Monash Addiction Research Centre (MARC)** brings together world-leading expertise from across Monash University and the sector to provide solutions to the challenges of addiction. MARC draws on the multidisciplinary strengths and capabilities of researchers across the University to develop and test novel, scalable prevention and treatment approaches. MARC's mission is to provide national solutions to addiction, leveraging expertise in basic and social science, clinical, and epidemiological research to develop new knowledge to shape government policy and evidence-based approaches.

1. Summary of recommendations

Turning Point and the Monash Addiction Research Centre welcome the opportunity to provide feedback on the draft *National Stigma and Discrimination Reduction Strategy* (the Strategy). Our recommendations are as follows:

1. Ensure the Strategy includes concrete actions, informed by further targeted consultation, to address alcohol-, other drug-, and gambling-related stigma and discrimination alongside mental health.
2. Scale successful strengths-based anti-stigma campaigns such as Rethink Addiction's *Real Stories of Addiction* to tackle stigma, promote help-seeking, and reduce addiction-related suicide.
3. Invest in research to develop and evaluate a best practice model of integrated care to address structural stigma.
4. Improve alcohol and other drug screening and delivery of brief interventions in non-alcohol and other drug specialist services through investment to improve workforce capability and promote a multidisciplinary, collaborative approach to care.
5. Include targeted measures to support the alcohol and other drug peer workforce in all relevant strategy and planning documents.
6. Prioritise responding to addiction with governance and policy settings that adequately support a coordinated national response to addiction-related stigma and discrimination:
   a. Reinstate a national governance framework for the alcohol and other drug sector.
   b. Develop a national strategy to reduce gambling harms and associated stigma.

2. Background

People experiencing substance use disorders are at an increased risk of suicidal ideation, suicide attempts, and suicide,[1] with an estimated 23 to 46 per cent of suicide deaths associated with a substance use disorder.[2] Alcohol dependence is the second most common psychiatric diagnosis after depression,[3] with one quarter to one third of people who die by suicide meeting diagnostic criteria for *alcohol* use disorder.[4] Indeed, alcohol use and related harm is a significant risk factor for suicide, with a 26-year longitudinal study finding people with alcohol use disorder died by suicide at 8 times the rate of those who had not been diagnosed.[5] People experiencing a drug use disorder alongside a major depressive episode are also 16 times more likely to consider suicide than those with no diagnosis.[6]

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[1] Jalal Poorolajal et al, 'Substance Use Disorder and Risk of Suicidal Ideation, Suicide Attempt and Suicide Death: A Meta-Analysis' (2016) 38(3) *Journal of Public Health* 282, 286.

[2] Jonathan Cavanagh et al, 'Psychological Autopsy Studies of Suicide: A Systematic Review' (2003) 33(3) *Psychological Medicine* 395, 400.

[3] Katrina Witt and Dan Lubman, 'Effective Suicide Prevention: Where is the Discussion on Alcohol?' (2018) 52(6) *Australian & New Zealand Journal of Psychiatry* 507, 507.

[4] Ibid.

[5] Trine Flensborg-Madsen et al, 'Alcohol Use Disorders Increase the Risk of Completed Suicide — Irrespective of Other Psychiatric Disorders. A Longitudinal Cohort Study' (2009) 167(1-2) *Psychiatry Research* 123, 127.

[6] Vivian Onaemo, Timothy Fawehinmi and Carl D'Arcy, 'Risk of Suicide Ideation in Comorbid Substance Use Disorder and Major Depression' (2022) 17(12) *PLoS ONE* 1, 6-7.

In addition to the human cost of lives lost to addiction-related suicide, there are also significant social and economic costs of addiction. For example, alcohol and other drug use is associated with family violence, with alcohol involved in 23 to 54 per cent of all family violence incidents in New South Wales, Western Australia, and Victoria.[7] As for the substantial economic burden of addiction, a joint report written by Rethink Addiction and KPMG and launched by Assistant Minister for Mental Health the Hon Emma McBride MP estimated the tangible cost of addiction to Australia was $80 billion in 2021. It also estimated the value of life lost to be $174 billion when considering lives lost in 2021 and their potential contributions in the future.[8] These enormous costs are in part underpinned by stigma and discrimination causing people to avoid or delay help-seeking, or tragically contributing to their dying by suicide.

While it is welcome that the draft Strategy recognises the impact and associated stigma of alcohol, other drugs, and gambling harms, there are few proposed actions that specifically address these issues. Given addiction is one of the most stigmatised health conditions and is associated with enormous social, health and economic costs, it is imperative that the Strategy includes concrete actions to address addiction-related stigma and discrimination. These should be developed through further, targeted consultation with the alcohol and other drug sector and advocacy organisations working to reduce gambling harms.

3. Scale anti-stigma campaigns

"I tried to stop. I hated myself. I looked in the mirror and was disgusted with myself. I was lying about where I was, I was lying about what I was doing… It was a complete secret. Nobody knew. You can hide gambling." – Anna Bardsley, lived experience of gambling addiction (Rethink Addiction Convention, 2022)

Stigma can be conceptualised in three interacting ways:

- Structural or institutional stigma occurs at the macro level and is experienced through the enactment of rules, policies, and practices that negatively affect or constrain the opportunities and resources of the stigmatised person or group.[9] For example, structural stigma can be thought of in relation to 'tough on crime' drug laws that place people in jail for drug use rather than helping them access healthcare and treatment.[10]
- Public stigma describes stereotypes and negative attitudes held by others that lead to prejudice and discrimination towards a stigmatised person or group.

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[7] Anne-Marie Laslett et al, *The Hidden Harm: Alcohol's Impact on Children and Families* (Report, February 2015) 71-73 <https://fare.org.au/the-hidden-harm-alcohols-impact-on-children-and-families/>.

[8] Rethink Addiction and KPMG, *Understanding the Cost of Addiction in Australia* (Report, 2022) 7 <https://www.rethinkaddiction.org.au/the-cost-of-addiction>.

[9] Ali Cheetham et al, 'The Impact of Stigma on People with Opioid Use Disorder, Opioid Treatment, and Policy' (2022) 13 (January) *Substance Abuse and Rehabilitation* 1, 2.

[10] Mark Hatzenbuehler, 'Structural Stigma and Health' in Brenda Major, John Dovidio and Bruce Link (eds), *The Oxford Handbook of Stigma, Discrimination, and Health* (Oxford University Press, 2018) 105, 106.

● Self-stigma refers to the negative thoughts and feelings people have about themselves when they identify with a stigmatised group, which can manifest in feelings of unworthiness or embarrassment.[11]

The draft Strategy notes that people's experience of mental health-related stigma and discrimination is often amplified by other forms of stigma and discrimination, including that related to people experiencing alcohol, other drug, or gambling harms.[12]

The inclusion of addiction-related stigma and discrimination is important because we know it causes people to hide their addiction from others due to fear of judgement, which delays help-seeking.[13] For example, the median time to first treatment for alcohol dependence is a staggering 18 years.[14] Stigma can also negatively impact people's mental health and wellbeing, which can further exacerbate alcohol, other drug or gambling related harms.[15] For example, there is an association between experiences of discrimination, self-stigma and non-fatal overdose among people who use drugs.[16]

We also know alcohol and other drug and mental health problems often co-occur and have a bidirectional relationship. For example, people experiencing alcohol dependence are 3 times more likely to experience major depression, and 2.5 times more likely to experience anxiety disorders.[17]

Healthcare professionals are not immune from holding stigmatising views, which can impair their ability to accurately identify and respond to patients experiencing alcohol, other drug or gambling related harm or addiction and co-occurring mental health conditions. For example, in a study we conducted with a national sample of paramedics, less than half were able to recognise affective disorders like depression among their patients, and only 1 in 5 could do so when alcohol and other drug use was also involved.[18] Patients presenting for ambulance care have also reported feeling that they were not always treated with professionalism, empathy, and compassion by paramedics when their mental health conditions involved substance use.[19] Negative experiences like these discourage future help-seeking. Indeed, one bad encounter can put someone off seeking help for years.[20]

To tackle entrenched stigma and discrimination associated with alcohol, other drug, and gambling harms, we must develop nuanced public health campaigns that seek to change the

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[11] Cheetham et al (n 9).

[12] National Mental Health Commission, *National Stigma and Discrimination Reduction Strategy* (Draft for Consultation, 9 November 2022) 11 <https://haveyoursay.mentalhealthcommission.gov.au/hub-page/national-stigma-and-discrimination-reduction-strategy-draft-for-consultation>.

[13] Sarah Clement et al, 'What is the Impact of Mental Health-Related Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies' (2015) 45(1) *Psychological Medicine* 11, 15.

[14] Chapman et al, 'Delay to First Treatment Contact for Alcohol Use Disorder' (2015) 147 (February) *Drug and Alcohol Dependence* 116, 118.

[15] Elena Cama et al, 'Internalized Stigma Among People Who Inject Drugs' (2016) 51(12) *Substance Use & Misuse* 1664, 1666.

[16] Carl Latkin et al, 'Stigma and Drug Use Settings as Correlates of Self-Reported, Non-Fatal Overdose Among People Who Use Drugs in Baltimore, Maryland' (2019) 68 (June) *International Journal of Drug Policy* 86, 90.

[17] Harry Man Xiong Lai et al, 'Prevalence of Comorbid Substance Use, Anxiety and Mood Disorders in Epidemiological Surveys, 1990–2014: A Systematic Review and Meta-Analysis' (2015) 154 (September) *Drug and Alcohol Dependence* 1, 7.

[18] Terence McCann et al, 'Recognition of, and Attitudes Towards, People With Depression and Psychosis With/Without Alcohol and Other Drug Problems: Results From a National Survey of Australian Paramedics' (2018) 8(12) *BMJ Open* 1, 5.

[19] Nyssa Ferguson et al, '"I Was Worried if I Don't Have a Broken Leg They Might Not Take It Seriously": Experiences of Men Accessing Ambulance Services For Mental Health and/or Alcohol and Other Drug Problems' (2019) 22(3) *Health Expectations* 565, 569.

[20] Suzanne Nielsen et al, 'Mapping the Alcohol and Other Drug Patient Journey to Improve Treatment Access and Engagement in Care', *Monash Addiction Research Centre* (Resource, 2022) <https://www.monash.edu/medicine/ehcs/marc/research/current/AOD-PJ>.

conversation and humanise addiction.[21] The Strategy is a timely opportunity to prioritise responding to addiction-related stigma and discrimination. This can be achieved by supporting successful anti-stigma campaigns, such as those led by Beyond Blue for depression and anxiety, or the Rethink Addiction campaign, which provides a platform for real stories of addiction to inspire hope for recovery and challenge negative stereotypes that limit help-seeking. Rethink Addiction's *Real Stories of Addiction* was informed by people with lived experience and uses a strengths-based narrative that emphasises hope and recovery, as well as the many varied ways people living with addiction contribute to the community. By prioritising and scaling successful anti-stigma campaigns, we can tackle stigma, promote help-seeking, and reduce costly treatment delays.

4. Develop a best practice model of integrated care for addiction and mental health conditions

"We can actually work together in a collaborative way if we can unify around some common goals… We need to think very carefully about what that might look like." – A/Prof Shalini Arunogiri, Clinical Director, Turning Point (Rethink Addiction Convention, 2022)

The draft Strategy states that the separation of mental health and alcohol and other drug services from other health services is indicative of structural stigma,[22] and proposes that equity of access could be improved by "strengthening the integration and coordination of care across mental health, physical health, and alcohol and other drug sectors, along with cultural care services, so that the provision of care considers a person's holistic needs and is health-promoting."[23]

Integrated care is promoted as a solution to the problem of fragmented and poorly coordinated care for people with co-occurring addiction and mental health conditions who are often bounced between services. There are many different understandings of integrated care, with one study finding at least 175 definitions,[24] while some models of integrated care work better than others.

As was noted in a recent review of integrated care approaches in Australia, differences in the scope of practice between alcohol and other drug and mental health practitioners, coupled with a lack of understanding about different models of care and service constraints between these two specialties, represents a key challenge to the provision of integrated addiction and mental health care.[25] To promote a multidisciplinary, collaborative approach to care, we need to improve alcohol and other drug screening and delivery of brief

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[21] Guy Boysen et al, 'Evidence for Blatant Dehumanization of Mental Illness and its Relation to Stigma' (2019) 160(3) *The Journal of Social Psychology* 346, 347.

[22] *National Stigma and Discrimination Reduction Strategy* (n 12) 37.

[23] Ibid 38.

[24] Gail Armitage et al, 'Health Systems Integration: State of the Evidence' (2009) 9(2) *International Journal of Integrated Care* 1, 4.

[25] Ali Cheetham, Shalini Arunogiri and Dan Lubman, 'Integrated Care - Panacea or White Elephant? A Review of Integrated Care Approaches in Australia Over the Past Two Decades' (2023) *Advances in Dual Diagnosis* (forthcoming).

interventions in non-alcohol and other drug specialist services and increase investment in workforce capability.

A key barrier is that we still do not have a shared understanding of what integration or integrated care would look like at the individual, service, or system levels. Indeed, the lack of integrated care has been identified by governments for over two decades, yet little has changed. This is indicative of the inherent challenges in addressing segregated service delivery across multiple health systems and jurisdictions. To overcome this barrier, we need to involve alcohol and other drug treatment providers in a dedicated research agenda—one that develops a more sophisticated approach and builds the evidence base for a best practice model of integrated care.

Of concern then is that the draft Strategy includes the following proposed action 2.2c: "Ensure minimum standards/clinical guidelines are in place for the care of co-occurring alcohol and other drug problems among people with personal lived experience, including for healthcare providers to collaborate with other relevant service providers to deliver holistic care."[26] This raises questions around the feasibility of this proposed action, and how the Australian Commission on Safety and Quality in Health Care intends to consult closely with different alcohol and other drug and mental health services across jurisdictions, as well as state and territory health departments, to clarify and operationalise clinical governance and quality frameworks for service delivery.

Recommendation 35 of the Royal Commission into Victoria's Mental Health System recommended that "all mental health and wellbeing services, across all age-based systems, including crisis services, community-based services and bed-based services provide integrated treatment, care and support to people living with mental illness and substance use or addiction."[27]

Turning Point has since been appointed by the Victorian Government to operate a new statewide service for people living with addiction and mental illness. The service has several roles, including primary consultation for consumers, secondary consultation for health practitioners, workforce education and training, and interdisciplinary research into addiction and mental illness. A key role of the statewide service's research agenda is to develop innovative, evidence-based models of integrated care that will support the service system to realise its vision of a more integrated and responsive mental health and wellbeing system.

Importantly, the development of a best practice model of integrated care that helps to address structural stigma across health service systems will require an iterative approach over time as investment in integrated care research becomes available.

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[26] *National Stigma and Discrimination Reduction Strategy* (n 12) 40.
[27] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Summary and Recommendations, 71 <https://finalreport.rcvmhs.vic.gov.au/download-report/>.

5. Recognise the alcohol and other drug peer workforce

"Peers are the ones that can reach somebody when no one else can. The role of peers isn't just in reaching other people who use drugs, but in reaching health professionals and broader members of the community." – Mary Harrod, CEO, NSW Users & AIDS Association (Rethink Addiction Convention, 2022)

In the Australian Patient Pathways study, people who attended mutual aid or other peer support meetings (such as Alcoholics Anonymous and SMART recovery) after alcohol and other drug treatment were 72 per cent more likely to achieve treatment success (measured by abstinence or a reduction in use in the last month). When a person's primary drug of concern was alcohol only and they attended mutual aid, the effect was even more pronounced: treatment success was 2.5 times more likely. Frequency of meeting attendance also led to higher rates of treatment success, with each additional meeting attended in the last 12 months increasing the likelihood of treatment success.[28] Ensuring people have access to peer support/mutual aid as a form of aftercare is essential given their ability to improve treatment outcomes.[29]

The draft Strategy includes proposed action 1g: "Develop guidelines for Lived Experience workforce roles in sectors outside the mental health system, leveraging guidelines in development in some sectors."[30] These Guidelines should be considerate of the important role and distinct expertise of the alcohol and other drug peer workforce.

6. Prioritise responding to addiction

"We have no national governance structure for the alcohol and other drug sector anymore… It's not just about funding. It's being able to have that coordinated approach at the national level." - Melanie Walker, CEO of Australian Alcohol and other Drugs Council (Rethink Addiction Convention, 2022)

The governance structure for the alcohol and other drug sector was disbanded along with the Council of Australian Governments (COAG) in 2020. Prior to this, national governance structures such as the Ministerial Council on Drug Strategy, the Intergovernmental Committee on Drugs, and the National Indigenous Drug and Alcohol Committee played an important role in the development and implementation of National Drug Strategies.

As mentioned above, a recent report jointly authored by Rethink Addiction and KPMG estimated the tangible cost of addiction to Australia was $80 billion in 2021.[31] To address the enormous social, health, and economic burden posed by addiction, the report recommended that "responding to addiction should be a national priority that receives the

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[28] Victoria Manning et al, 'Substance Use Outcomes Following Treatment: Findings from the Australian Patient Pathways Study' (2017) 51(2) *Australian & New Zealand Journal of Psychiatry* 177, 183-184.

[29] Dan Lubman, Victoria Manning and Ali Cheetham, *Informing Alcohol and Other Drug Service Planning in Victoria* (Final Report, 2 May 2017) 29 <https://www.turningpoint.org.au/research/impact/service-planning>.

[30] *National Stigma and Discrimination Reduction Strategy* (n 12) 29.

[31] *Understanding the Cost of Addiction* (n 8) 4.

same level of attention as any other highly prevalent health condition," including by "re-establish[ing] a national governance framework to prioritise investment, promote collaboration across levels of government, and improve the coordination of our approach to all forms of addiction." It also noted that "this must include gambling, which deserves its own national strategy to reduce gambling harm."[32]

7. Conclusion

The National Mental Health Commission's first of its kind *National Stigma and Discrimination Reduction Strategy* is a fantastic opportunity to prioritise responding to addiction at the federal level. This could be achieved by scaling successful, strengths-based anti-stigma campaigns such as Rethink Addiction, supporting a program of research to develop a best practice model of integrated care that improves service responses and health outcomes for people with co-occurring addiction and mental health conditions, and re-establishing a national governance framework to respond to alcohol, other drug, and gambling harms. In addition, efforts to build workforce capacity and capability must recognise the importance of the alcohol and other drug peer workforce, and investment is needed to support alcohol and other drug screening and brief interventions in non-alcohol and other drug specialist services to promote a multidisciplinary, collaborative approach to care.

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[32] *Understanding the Cost of Addiction* (n 8) 21.