CURRENT PRACTICES AND SUPPORT NEEDS OF HEALTHCARE PROVIDERS IN CESPHN IN RELATION TO ADDRESSING PATIENTS' CO-OCCURRING MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ISSUES

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1.   Introduction

A growing literature has documented the high prevalence of co-occurring substance use (alcohol and/or other drug, AOD) and mental health conditions among clients of healthcare services (Marel et al., 2016). It is estimated that more than half of people who present to AOD services also have a co-occurring mental health condition (Kingston et al., 2017). Similarly, approximately half of those with a mental health condition also present with problems relating AOD use. There is also a large literature documenting that people with co-occurring AOD and mental health conditions often present to services with a more severe clinical profile. In addition to their AOD and mental health issues, their care is often further complicated by a range of other medical and social issues (e.g., physical health, housing, employment, education and training, legal issues, and family situations) (Marel et al., 2016).

Given the multitude of issues described above, it is not surprising that people with comorbid disorders frequently come to the attention of a diverse range of services (e.g., health, social welfare, educational, and criminal justice systems) and present a significant challenge to service providers. Little research has been conducted examining the capacity of healthcare providers in responding to clients with AOD and mental health conditions; however, that which does exist suggests that although providers are willing to address these issues, there is a lack of appropriate training and support, and barriers to the implementation of effective care.

As part of a needs assessment conducted in 2016, the Central and Eastern Sydney Primary Health Network (CESPHN) identified comorbidity between AOD and mental health conditions as a priority area, with low levels of service provision. To further inform how best to address this priority area, the CESPHN funded the NHMRC Centre of Research Excellence in Mental Health and Substance Use (CREMS), National Drug and Alcohol Research Centre (NDARC), UNSW to undertake a scoping exercise to evaluate the current practices and support needs of healthcare providers in the CESPHN in working with co-occurring mental health and AOD issues among their clients. The scoping exercise was undertaken to improve understanding of these issues at the network level, with a view to providing recommendations for workforce development and capacity building. By improving the capacity of healthcare providers to identify, intervene, and provide appropriate referral and coordinated care with this population, the standard of care, and the lives of people with co-occurring substance use and mental health conditions may be improved.

Specifically, the scoping exercise aimed to identify:

i)   the knowledge, attitudes, confidence, and capability skills of healthcare providers in relation to the identification and management of co-occurring mental health and AOD use among their patients.

ii) the perceived challenges, difficulties, and rewards associated with working with patients' AOD and mental health issues.

iii) strengths and weaknesses in current practices in relation to identification, intervention, referral and the provision of coordinated care.

2. Methods

The project involved three stages:

Stage 1: An expert panel meeting with invited experts and keystakeholders from CESPHN including general practitioners (GPs), addiction medicine specialists, AOD and mental health service providers, consumers, carers and other identified experts.

Stage 2: A series of focus groups with consumers of mental health and AOD services, families and carers, and interviews with healthcare providers.

Stage 3: An online survey of healthcare providers in the CESPHN.

2.1   Stage 1: Expert panel

Twenty-six experts were approached to provide input on i) the challenges faced by healthcare providers in identifying, managing and addressing AOD issues (including referral and coordinating care with other service providers); and ii) the challenges faced by each of the represented keystakeholder groups in working and/or engaging with healthcare providers in relation to AOD and mental health issues. The discussion was used to identify both strengths and weaknesses in current practice, and potential mechanisms through which practice could be improved.

Fourteen experts agreed to take part. These experts represented a range of occupations including: psychologist, nurse, pharmacist, psychiatrist, addiction medicine specialist, GP, youth worker, Indigenous worker, LGBTI advocate, and consumer representative.

2.2   Stage 2: Focus groups and interviews

Based on feedback obtained from the expert panel in Stage 1, we conducted two focus groups with: i) consumers of healthcare services for mental health and/or AOD issues within the CESPHN region (n = 15); and ii) families or carers of people who access healthcare services for mental health and or/AOD issues within the CESPHN region (n = 5). A third focus group comprising healthcare providers within the CESPHN area was planned; however, a time could not be arranged that was suitable to all those interested in participating. Instead, individual interviews were held at times suitable to the individual

healthcare providers (n = 3). The types of healthcare providers included: occupational therapist, counsellor and care coordinator.

To be eligible to participate participants had to be aged over 18 years, and either access healthcare services located within CESPHN for a mental health and/or AOD use problem; be a family member or carer of someone who access healthcare services within CESPHN for their mental health and/or AOD problems, or; be a healthcare provider located within the CESPHN region.

Advertisements were distributed by CESPHN through their newsletters, distribution lists, and posted online, and expert panel members distributed advertisements via their networks. Eligible participants contacted the research team to express their interest in being involved in the study.

Ethical approval was obtained from the University of New South Wales (UNSW) Human Research Ethics Committee (HC17650). Focus groups were conducted in central Sydney on 22 and 27 November 2017 for consumers and carers respectively. Individual interviews with healthcare providers took place from 25 January 2018 – 6 February 2018. All participants provided written consent and were reimbursed $50.

2.3   Stage 3: Online practitioner survey

Based on feedback obtained in Stage 1, for the purposes of this survey we defined healthcare worker as: GPs, occupational therapists, addiction medicine specialists, caseworkers, counsellors, nurses, psychiatrists, psychologists, residential support workers, social workers, youth workers, and any other healthcare providers. To be eligible to participate in the online survey, participants had to be classified as a healthcare worker according to this definition and be 18 years of age or older.

As with the focus groups, an advertisement for the online survey was distributed through the CESPHN and expert panel networks. Eligible practitioners were directed to a hyperlink for the survey. The survey was made available for completion on the Internet for a period of 3 months (2 Nov 2017 to 12 Feb 2018).

Ethical approval was obtained from the University of New South Wales (UNSW) Human Research Ethics Committee (HC17650). The survey was anonymous (no identifying information was collected), and consent was obtained prior to survey commencement. All participants who completed the survey were invited to enter a draw to win one of three $500 vouchers. This form was accessed via a separate link from the survey so as to ensure that all completed questionnaires were not identifiable.

Online data collection was employed due to the scope, convenience, and cost efficiency of this method. Furthermore, this method is likely to provide participants with greater anonymity, thereby

reducing the likelihood of social desirability bias (Evans & Mathur, 2005; Rhodes, Bowie, & Hergenrather, 2003). The 20-minute survey was developed by the authors and utilised additional items from previous health worker surveys (Mills, Deady, et al., 2012). The survey gathered key demographic information about respondents, their experience in the field, and the service where they were currently employed. A series of questions also asked respondents to what extent they agreed with a series of statements pertaining to the treatment of comorbidity (six-point Likert scale), the utility of a variety of resources (three-point Likert scale), and difficulty and related factors of treating a variety of presentations (five-point Likert scale). There were also a series of questions asking respondents to rate their workplace and career satisfaction (ten-point slider scale), and a range of open-response items. A copy of the survey has been appended to the end of this report (Appendix A).

2.4   Analysis

Key points and themes arising from the expert panel meeting (Stage 1) and focus groups/interviews (Stage 2) were identified and summarised, drawing on previous qualitative and thematic studies in the field (Ross, et al., 2015). Data collected from the online survey (Stage 3) were analysed using PASW Statistics 18 for Windows, release 24.0.0 (PASW Statistics, 2010). Descriptive statistics on the proportion of respondents nominating each response option on the ordinal Likert scales are presented.

3.   Results

3.1   Stage 1: Expert panel

The expert panel discussion highlighted several challenges faced by practitioners working with people with comorbid substance use and mental health conditions, as well as challenges faced by consumers and carers in trying to access healthcare. Major themes were identified across client, family/carer, provider, and health system levels (Ross, et al., 2015).

3.1.1 Client-level issues

Panel members identified one primary client-level factor and spoke of how people with lived experience could impact both consumers and clinicians of mental health and AOD services.

3.1.1.1 Lived experiences

The role of peer workers

The panel identified the need for peers, or people with lived experience, to be better integrated into services. Peers are perceived to be more effective in advocacy roles than clinicians, for example in rolling out Hepatitis C treatment. Panel members perceived that peer workers would be more successful as a respected peer work force but need adequate training, support and accreditation to be recognised as a legitimate part of the workforce, and not merely tokenistic. The development of an accreditation program was suggested as a way of legitimising these roles while at the same time ensuring that peer workers have the skills necessary to undertake the roles. The panel noted that a significant challenge for building a peer workforce are requirements regarding criminal record checks, which were noted to be discriminating against people with lived experience. Although some services (e.g., NGOs) are able to make judgment calls based on the relevancy of an individual's offences, this is often not the case.

3.1.1.2 Lack of awareness regarding AOD and MH comorbidity

The panel raised the need for greater education for consumers, families and carers, and community members regarding AOD use, mental health and their comorbidity. Educational initiatives may improve the recognition of problems and increase help-seeking, and earlier help-seeking. An approach such as mental health first aid that also covered AOD use and comorbidity was suggested as one way to increase awareness among these groups. The importance of oral communication methods among Aboriginal and Torres Strait Islander peoples was noted. It was also suggested that educational messages embedded in mainstream media may be an avenue of communicated education messages, and changing culture and challenging prejudice.

3.1.2 Healthcare provider level issues

Panel members identified three key factors that needed to be considered with respect to providers' capacity to address comorbid mental health and AOD: i) knowledge relating to comorbidity; ii) capacity to address comorbidity; and iii) personal values and attitudes in relation to AOD and mental health.

3.1.2.1 Knowledge relating to comorbidity

Lack of education, training and resources to support practitioners (and associated lack of confidence and capability to respond)
Further education and training in relation to AOD use disorders and comorbid AOD and mental health conditions, and the need to upskill the entire workforce, was identified as a priority. Currently, there are few providers willing to engage with clients presenting with complex comorbidities, and as such,

those that are receive more referrals than they can manage and struggle with caseloads full of severe and complex clients. Capacity needs to increase beyond a small group of providers.

The panel noted that there was a need for education and training across multiple levels – i.e., as part of undergraduate and postgraduate training programs as well as part of continuing professional and workforce development. Education and training was considered key to improving knowledge, confidence and capability. It was suggested that some training should be mandated across professions and there should be minimum standards as suggested in the National Comorbidity Guidelines. For example, that practitioners should be aware of symptoms of AOD and mental health conditions and be able to integrate that information into treatment planning. Particular areas identified as being in need of attention included:

- **Stigma, prejudice, and practitioner approaches:** Described in relation to personal values and attitudes below.

- **Lack of understanding of complex issues surrounding AOD, mental health and their comorbidity:** An inadequate understanding of the complexities surrounding AOD, mental health and their comorbidity was identified as having a considerable impact on health practitioners' capacity to identify and adequately address clients presenting issues. Panel members noted a need for further education and training for health workers to improve their understanding of the complexity surrounding comorbidity (e.g., how AOD use and mental health may be interrelated, the potential role of self-medication, and the harms and implications of comorbid AOD use and mental health), and appreciation of the difficulties individuals with these conditions face across a number of domains including physical health, mental health, social and occupational functioning. Cognitive impairment and foetal alcohol spectrum disorder (FASD) were noted as particular areas in need of attention, which often slip through the cracks. Awareness of different cultural understandings of AOD, mental health and wellbeing are also lacking (e.g., some cultures don't even have a word reflective of mental ill health). In line with this, panel members stressed the importance of providing holistic and multidisciplinary care to clients with AOD and/or mental health conditions. A greater understanding of these issues will also assist practitioners to have realistic expectations and greater awareness of likely outcomes. Despite evidence of effective treatments, practitioners often have a nihilistic view of AOD problems, particularly when a person also has a mental health condition.

- **Provision and principles of trauma-informed care:** A lack of understanding and implementation of trauma-informed care was raised as a significant issue by panel members. Consumers and carers often have experiences which they consider to be retraumatising, not just in the context of the health system, but in relation to emergency

personnel (e.g., police, ambulance). Emergency workers regularly respond in ways suggestive of an inadequate understanding of comorbidity, include the use of restraints, sedation, bright lighting, loud noises, and other re-traumatising practices. There continue to be cases where police respond to the scene of overdose and charge the person with possession (i.e., the criminal issue is prioritised over the health issue).

- **Discomfort and lack of confidence in asking about, and responding to, AOD use, mental health symptoms, suicidal ideation and self-harm**: Guidance on the identification of problematic AOD use disorders (drugs other than alcohol and tobacco in particular), mental health conditions, suicidal ideation and self-harm was identified across the sector. It was noted that many practitioners/services assess only for the conditions they are able to respond to, rather than focussing on the holistic needs of the consumer. In addition to the provision of education and training, using technology to screen and provide feedback and information to clients, was suggested as a mechanism which could assist combat practitioner discomfort.

- **Evidence regarding the effectiveness of various treatment approaches, where and how they can be accessed:** Discussed below in relation to practitioners as well as consumers and carers.

- **Specialist training scholarships:** Were suggested as a means by which to build capacity in responding to complex comorbidity. For example, provision of competitive scholarships to trainees across various sectors that provide for internships/placements in AOD and mental health services.

Lack of awareness and understanding of treatment options and services available
Despite the existence of Health Pathways and other online directories of services available, healthcare providers are largely unaware of services and the types of treatments available. In particular, panel members noted a lack of awareness regarding evidence-based treatments, leading to reduced confidence in terms of assessing and referring comorbid clients.

Consumers and carers also lack an understanding of treatment options and services and have great difficulty trying to work out where they should go for help, what type of help they should be looking or asking for, and where to find out more. Narrow conceptualisations of what constitutes treatment were also identified as barriers. For example, many people continue to think of mental health treatment in terms of involuntary inpatient care ('being locked up') and/or pharmacological therapies with significant adverse side effects, and substance use treatment as inpatient detox or AA/NA. They do not realise that there are a range of traditional and non-traditional interventions that they could potentially choose from.

There is also a lack of understanding on the part of healthcare providers and carers regarding services available to support families and carers. Families and carers feel neglected and are often not considered, despite evidence to suggest that support for the family and/or carer can have direct benefits not only for the family/carer but consumers as well. There is a dearth of funding for these important services and they are not promoted widely by the healthcare system. Many providers do not even know that they exist. It was suggested that one mechanism by which referral to services for families/carers could be increased is to link this to the KPIs and funding of AOD and mental services.

To assist with identifying services where people provide care for AOD and/or mental health conditions, an accreditation process, similar ACONs 'rainbow tick' initiative was suggested (e.g. have undergone discrimination training, have enhanced consumer involvement).

3.1.2.2 Capacity to address comorbidity

Lack of support for practitioners

Professional and personal support for healthcare practitioners is vital to maintaining a skilled workforce and facilitating the delivery of high quality care. Panel members discussed the high levels of burnout among healthcare practitioners working in the AOD and mental health fields, particularly those who work with people with complex comorbidities. Burnout, lack of support and poor remuneration result in high rates of staff turnover. Funding and implementation of initiatives to enhance worker self-care (physical, emotional and professional), including organisational and peer support networks, are needed. Special interest groups may provide a mechanism of professional support and professional development.

3.1.2.3 Personal values and attitudes

Stigma and prejudice

Healthcare providers, consumers and carers identified stigma as a significant barrier to people with AOD and/or mental health conditions seeking and receiving effective care. Stigma toward carers and people working in the AOD sector was also noted. Panel members spoke of healthcare providers believing that people with AOD problems (with or without co-occurring mental health conditions) are not deserving of help or care and behaving/practicing in ways consistent with that belief. Rather, people with AOD problems are perceived to have 'chosen a lifestyle' and are blamed and shamed for their presenting issues. Panel members described the fear of discrimination, from GPs in particular, experienced by consumers in relation to disclosure of injecting drug use. If injecting drug use is disclosed, consumers are labelled as 'addicts' or 'junkies', viewed with suspicion and assumed to be inherently dishonest.

The panel noted that this prejudice creates considerable difficulties for healthcare practitioners when trying to refer AOD patients to non-AOD services; this process was described as 'a constant battle' with services frequently refusing to see clients experiencing AOD problems. Panel members described practitioners being forced to conceal information about the client (or the healthcare provider's workplace) when making referrals so as not to put their client at risk of being refused access to a service.

Challenges were also described in relation to particular organisations that viewed AOD and/or mental health conditions very negatively, particularly those involved in child protection. There is the perception that parents are likely to have their children removed if they are experiencing mental health issues, and will definitely have them removed if they have AOD problems. This makes it very difficult for parents with AOD and/or mental health conditions to ask for help.

Practitioner approaches to care and assessment

Healthcare providers, consumers and carers identified negative, judgemental and confrontational approaches to AOD use (with or without cooccurring mental health conditions) as impediments to help-seeking. This was particularly noted for GP settings as the initial point of contact for many people seeking help. Panel members suggested training for GPs as well as other providers on how to ask about AOD use in a non-confrontational manner that will facilitate information exchange rather than lead to consumers feeling guarded or shut down. Examples given included practitioners responding to disclosure with statements such as 'don't you know the harm you are doing to yourself and your family?' or broaching the topic by saying 'you wouldn't use drugs would you?' or 'you don't look like an addict'. It was suggested practitioners across the health sector, and GPs in particular, be trained in the use of a motivational enhancement and strengths-based approaches to undertaking assessment, case formulation and providing care. Specific mention was also made with regard to the need to change pharmacists' attitudes regarding the provision of substances on which people can become dependent. The current culture was identified as one of policing rather than part of collaborative care. Medication management is, however, a significant challenge for prescribers and other health practitioners.

3.1.3 Health system-level issues

Participants described several system-level issues as significant challenges for consumers, families and carers in trying to access healthcare, as well as healthcare providers working with people with comorbid AOD and mental health conditions.

3.1.3.1 Finding a healthcare provider

Difficulty accessing and navigating services: 'No way in'

The panel identified the difficulties involved in gaining access to appropriate services, both in making referrals for people with comorbidity, and for consumers and carers. Difficulty navigating available services was also highlighted as a significant issue. Panel members described there being 'no way in' to the health system. Particular difficulties identified include:

- **Lack of appropriate services:** In particular, panel members noted a dearth of:

    o GPs that will bulk bill or see AOD clients (consequently, many have no alternative but to seek primary care from hospital emergency departments);

    o Domestic violence and homelessness services; and notably services of this kind that allow pets;

    o Services catering to accommodation and housing that try to proactively keep people in their homes as opposed to responding to needs only once a person has become homeless;

    o One-stop-shop services staffed by multidisciplinary health and social service providers (including dedicated family workers), that proactively collaborate and work within a coordinated care approach;

    o Lack of culturally appropriate services for people of Aboriginal and Torres Strait Islander origin, culturally and linguistically diverse groups, people who identify as LGBTQI;

    o Lack of specialised services for people released from justice settings.

- **Services refusing to accept patients:** Clinical guidelines and both state and federal policy documents across disciplines recommend that services adopt a 'no wrong door' policy. No client should be turned away; rather, healthcare providers should establish where the client will receive the most appropriate care. When a person presents to a provider of a service that is not equipped to provide a particular type of care, he/she should be guided to appropriate facilities, with follow-up by staff to ensure that he/she receives appropriate care. In this way, every door in the health care system should provide access to the services needed.

    The panel described that this principle is rarely adhered to; on the contrary, for many consumers there appears to be 'no right door' policy. The panel noted that even if a consumer and/or carer are able to make contact with a service, they are frequently turned away, or discharged from the service as quickly as possible. The rationale provided often relates to the client being either too severe/symptomatic/complex, or not

severe/symptomatic/complex enough, to meet eligibility criteria for service entry. A label of 'drug-induced psychosis' was also cited as a reason for people not being provided with follow-up mental health care beyond their initial stabilisation in emergency and acute care settings.

The analogy of tennis was used to describe the way consumers and their carers are sent back and forth between services. Healthcare providers noted that they also share this experience when trying to find appropriate services for their clients, and that in some cases they need to withhold information from services they are trying to refer to have the client seen. They described experiences where services lacked the flexibility to adapt their intake processes to accommodate the chaos that often accompanies clients with co-occurring disorders. An example was described of a consumer who presented to a drop-in centre with acute mental health issues in need of urgent help. Drop-in centre staff contacted appropriate services, who asked them to write down the case history, fax it to their number where the case would be discussed at a group meeting next week. Overall the lack of care, let alone co-ordinated care, results in many people falling through the gaps, and not receiving the care they need.

3.1.3.2 Uncoordinated care and lack of appropriate referrals

Several issues were raised by the panel with regards to care coordination and referral.

- **Lack of delineation of roles and responsibilities** of particular services and providers across the government, non-government, and private sector as exists in other areas of medicine (e.g., a patient with cardiovascular disease is initially seen by GP, referred to cardiologist for specialist assessment, cardiac surgeon and rehabilitation if indicated). There is no such delineation in relation to AOD, mental health or comorbidity causing confusion for both practitioners and consumers.

- **Continuity of care for people released from prison:** a need for improved continuity of care with community services pre-release and lack of follow-up in the community.

- **The need for stronger referral pathways:** GP referrals and mental health plans to psychologists are almost always lacking descriptions of complex histories, so an entire Medicare session is needed to try and find this out. The best outcomes for clients are when the majority of the work phoning services has been done before the first session, but few GPs are willing to do this.

- **Communications and collaboration between services** is lacking, including failure to provide feedback to GPs regarding patients' progress.

- **Little to no follow-up for families/carers** following emergency/crisis care or patient discharge from services.

3.1.3.3 Models of care

The panel identified the need for evidence-based models of care such as assertive outreach/case management, and community AOD teams for the management of AOD and mental health comorbidity. They also noted the need to explore other innovative models of care such as virtual communities of care (e.g., supportive online social networks). The need for services adopting a brokerage model such as the Inner City Youth at Risk Project (ICYAR) was also raised.

3.1.3.4 Fragmented, disconnected and siloed service systems

Separation between the mental health and AOD sectors was identified as a barrier to providing care for people with comorbid conditions. Lack of communication and collaboration between fragmented, disconnected and siloed service systems leads to a lack of person-centred care and impedes the provision of integrated care. Suggested mechanisms of improving links across services at multiple levels include:

- **Embedding expert consultants in services** (e.g., having an addiction medicine specialist/psychiatrist consulting in a mental health service, and vice versa, regularly) was suggested as an effective way of improving service level capacity to respond to complexity, and an effective way of increasing other clinicians' capacity through the provision of professional development workshops by the visiting expert. The importance of measuring improvements in capacity and professional development of staff were identified as outcomes associated with the embedding of expert consultants in services (i.e., not merely measuring the number of patients seen by that expert or client outcomes which may be distal, but assessing change in knowledge, confidence, skill in AOD/ mental health)
- **Case management by multidisciplinary teams across services**
- **Clinical supervision across services**
- **Training placements/exchange between services**

3.1.3.5 Funding

The panel identified the short-term nature of service funding as an impediment to the provision of quality care. Reliance of short-term funding from multiple sources requires considerable resources be devoted to continual funding applications, which also encourages competition rather than collaboration between services tendering for the same funding.

3.1.4 Summary

The expert panel identified a range of challenges faced by practitioners working with people with comorbid substance use and mental health conditions, as well as challenges faced by consumers and carers in trying to access healthcare. They also identified a range of possible mechanisms by which some of these challenges can be addressed. One common thread across all of the domains covered was the need for initiatives that were both top down and bottom up. Mechanisms to support practitioners and services to develop local-level responses were considered essential. Furthermore, there was an overall sense of hope, dedication and commitment to improving service responses and the lives of individuals with AOD and mental health conditions, and optimism regarding the potential for PHN funding to allow for new initiatives responding to the region's particular needs.

3.2   Stage 2: Focus groups and interviews

Focus group discussions highlighted a number of challenges faced by: i) consumers of healthcare services for mental health and/or substance use conditions; ii) carers and family members of people accessing healthcare services for mental and/or substance use conditions, and iii) healthcare providers working with people with mental health and/or substance use conditions. As with the expert panel, major themes were identified across client, family/carer, provider, and health system levels (Ross, et al., 2015).

3.2.1 Client-level issues

Two primary issues were identified at the client-level: i) socioeconomic challenges, particularly financial and housing, and ii) those in relation to people with lived experience.

3.2.1.1 Socioeconomic

Both consumer and healthcare provider participants identified socioeconomic challenges as barriers to healthcare, particularly the lack of affordable, accessible, and ongoing services. In particular, focus group members noted:

- **An absence of counsellors or psychologists who will bulk bill or see AOD clients:** Consequently, many have no alternative but to seek counselling from support helplines, who cannot provide any ongoing support. If at immediate risk, they can call Lifeline, but they cannot call the same person back to talk to them for any ongoing help (same with Beyond Blue).
- **Lack of affordable, ongoing services:** Even if consumers are able to find a psychologist that will bulk bill (or not charge the gap above their mental health plan covered by Medicare),

they are still limited to up to a maximum of 10 sessions determined by their Mental Health Care Plan.

Consumer focus group members described the very difficult choice they are often faced with, when needing to decide between paying upfront for psychological support (some of which may come back through Medicare later) or buying a shot and immediately feeling better. In this scenario, group members indicated that their priority was about 'getting through the day', and they were not thinking about the long-term plans for getting well.

- **Dependence on after-hours doctors:** Some family/carers described how their family members were too unwell to leave home to visit their GPs, and had no alternative but to receive care from after-hours doctors who would bulk bill, and make house calls. One participant spoke of numerous issues with the quality of care provided by after-hours GPs, including doctors requesting cash for medication, broken equipment, poor hygiene, and disrespecting their patient and carer (telling patient she had a 'death wish').

3.2.1.2 Lived experiences

Peer workers

Participants in both consumer and family/carer focus groups highlighted the important role of people with lived experience as peer workers, particularly as bridges between healthcare providers and the general public. Consumers indicated that although some clinics have started to use peer workers, most do not. Peer workers were described as potential secondary levels of service delivery. The lack of formal standards and an overarching regulatory body however, were highlighted as challenges to the legitimacy of these roles. In contrast, one of the healthcare providers indicated that although peer workers could be useful, the existence of these roles prevented former AOD users moving on with their lives.

3.2.2 Family/carer-level issues

3.2.2.1 Involvement in care

Family/carer participants spoke extensively of the inadequate level of their inclusion in care, and the impact this had on healthcare providers' ability to adequately address all of the issues that their family member or person they cared for, presented with. The lack of support for family/carers was also identified as an ongoing challenge.

Exclusion of family/carers

The lack of consultation or family/carer involvement in patient care was identified as a barrier to effective care. One participant gave the example of care her daughter received from a youth service, which consisted of a 'weekly chat', when she was experiencing borderline personality disorder (BPD). The practitioner did not involve the client's mother or include her in the treatment plan, and because the client didn't disclose it, the worker was unaware that the she was actively trying to kill herself, and the volatility of her home life. The participant felt that her daughter's BPD led her to provide an inaccurate or incomplete picture of her situation, and she was not given the opportunity to fill in vital information that may have informed her care planning and treatment.

Focus group discussions also identified that staff of hospital emergency departments do not listen to family/carers, and that this was an impediment to the provision of timely and quality care. One participant from the family/carer focus group gave the example of his partner being taken to Emergency while withdrawing from GHB. Although his partner had overdosed from GHB two weeks earlier and been taken to Emergency, on this occasion he had not taken GHB. The participant described how Emergency nurses would not listen or accept that it could not be a GHB overdose; instead, they were telling him that his partner might have hidden GHB and taken it in secret. While these discussions were taking place, his partner was not receiving appropriate medical attention, and was in danger of being provided with the wrong treatment.

Lack of support or referrals for family/carers

Family/carer and healthcare participants spoke of the lack of support for family/or carers of people with AOD and or mental health conditions. The lack of information and resources available for family/carers was also identified as a problem, and one which had the potential to compromise the patient's relationships and care at home. Although family/carers try to educate and resource themselves, it is difficult for them to determine the accuracy and credibility of the information they find. Greater investment in family/carer resources and services is required.

3.2.3 Healthcare provider level issues

As with participants from the expert panel, focus group participants generally identified three key factors when discussing perceptions of healthcare providers' capacity to address comorbid mental health and AOD: i) knowledge relating to comorbidity; ii) capacity to address comorbidity; and iii) personal values and attitudes in relation to AOD and mental health.

3.2.3.1 Knowledge relating to comorbidity

Lack of knowledge and awareness among healthcare providers regarding AOD, mental health and comorbidity

The lack of knowledge and awareness regarding AOD, mental health and comorbidity was also noted by members of both consumer, and family/carer focus groups. In particular, participants raised concerns about the following:

- **Over prescription, medication interaction, and labelling:** Consumers described experiences with healthcare providers, GPs in particular, overprescribing benzodiazepines and recommending their consumption with a glass or two of wine to reduce levels of anxiety. One participant spoke of presenting to her GP with alcohol dependence and anxiety, and her GP told her to have a glass of wine and relax, because she was so anxious.

  Several members of the consumer focus group identified following their GPs instructions as a problem, which had led to them being refused more benzodiazepines or other drugs from their GPs, and labelled as an 'addict'.

  One participant from the family/carer focus group described how one home visit GP prescribed her mother with medication that makes her paranoid and sometimes catatonic, and has refused to listen or adapt the medication based on these reports.

- **Difficulty distinguishing between intoxication and overdose:** Consumer group members also identified the lack of knowledge regarding the distinction between intoxication and overdose on the part of many healthcare providers as a problem. Several group members recounted experiences where healthcare workers had described people who were asleep and snoring as 'overdosed', rather than intoxicated (or asleep).

- **Ageing patients:** Focus group participants, particularly those in the family/carer group, spoke of the lack of awareness, knowledge and understanding about ageing and mental health, as well as comorbidity and ageing people. When any material is available, it is primarily in relation to dementia, but there is no information about AOD – particularly alcohol – and ageing. Self-medication of mental and physical health was identified as a significant issue of concern.

- **Nurses and GPs lacking experience with comorbidity:** Participants of the family/carer member focus group identified the lack of experienced nurses in intensive care as a concern, particularly in relation to dealing with people experiencing substance-induced psychosis. The panel discussed situations where this lack of experience led to an overreliance on containment and the use of security However, group members also described experiences

with empathetic intensive care nurses and registrars, who had offered to keep people in hospital longer, so as to give their family and/or carers a break.

Consumer focus groups participants also felt that GPs needed more training in comorbidity, and it was suggested that as part of their training, GPs could be required to undertake a certain number of 'pro-bono' hours working with AOD and mental health clients at 'street level', similar to the way solicitors complete pro-bono work during training.

- **Healthcare workers lacking understanding of interplay between mental health and AOD:** Consumer group participants spoke of the role of AOD in relation to their mental health, and identified that for many, AOD was used to relieve or help them cope with their mental health symptoms. Although participants indicated that some healthcare workers understood this interplay, many do not.

  Healthcare providers similarly expressed their frustration with the lack of knowledge about AOD/mental health throughout the workforce, which has a wide impact in terms of preventing people seeking help, preventing people engaging in, or returning to services, and coordinating clients' care. Healthcare providers identified the broader assumption held by the wider community and many other health providers that AOD is 'bad' and there is little attempt to understand or appreciate the role AOD plays as a coping mechanism. In particular, healthcare providers did not feel that there was a lot of knowledge about the role trauma plays in AOD use, which can act as a barrier to the effective treatment of these conditions.

  Similarly, those in the healthcare provider group spoke of the divide between mental health and AOD services, and clinicians who primarily work in one area not feeling equipped to treat the other.

- **First responders lacking appropriate training in mental health and AOD:** Both family/carer and consumer participants identified the lack of appropriate mental health and AOD training for police and ambulance officers as a problem. Participants spoke of first responders' assumptions that AOD users are drunk or intoxicated, without consideration being given to their symptoms being due to (or confounded by) mental illness, or complications associated with psychiatric medication (having either not been taken or potential interaction effects). Participants indicated that the prevailing attitude is "we've seen it all before".

  In contrast, one participant from the family/carer group spoke of several positive experiences with police, involving situations where family and friends had gone missing and were at-risk.

Police attending ambulance callouts

Participants of the family/carer group expressed frustration that police attend overdoses when ambulances are requested through emergency services (000). Consequently, many people are afraid of calling an ambulance to an overdose. One group member indicated that the 'unofficial' advice when calling an ambulance for an overdose was to say that people had "passed out", "collapsed", or they "don't know what they've taken" on the phone, so the ambulance arrives by themselves. Then when the ambulance arrives, tell them that they've overdosed and what from.

Healthcare providers lacking adequate support and clinical supervision

Healthcare providers expressed their frustration and disappointment at the lack of lack of adequate clinical supervision and support available, which increased their likelihood of burnout. One participant spoke of how funding for one-on-one clinical supervision had recently been cut to their service, which means that the only available supervision consists of quarterly group supervision, or calling the Employee Assistance Program (EAP). As this clinician works in an assertive outreach, case coordinator role, she felt in need of clinical supervision but was lacking that support.

Another healthcare provider described how all the clinicians at their service were part-time, because the clinical work was too taxing for anyone to be full-time. They suggested that mandatory clinical supervision be made part of services' key performance indicators, encouraging more employees to provide it for their healthcare workers. Healthcare providers also spoke of how a clinical directory or telephone hotline could be established for clinicians to contact an expert in the area, or a clinical supervisor for support.

Confidentiality

Consumers expressed concern that details from their case notes and caseworker sessions were shared among staff within the same service, between units. One participant described a situation where their counselling notes had been used against them by another unit within the same service, to try and get him to comply. Although case conferences provide healthcare workers with the opportunity to consult with other experts and care providers, the inappropriate disclosure of confidential client/patient information can result in patients withdrawing from care altogether.

3.2.3.2 Capacity to address comorbidity within scope of practice

- **Healthcare workers needing to work within their capacity** was highlighted as a critical issue by the consumer and carer focus group members. Participants described situations where clients had been treated by clinicians who were out of their depth, and didn't consult with

appropriate experts. The lasting damage from these experiences can lead to clients becoming concerned about seeking help in the future.

Although focus group members discussed the importance of early intervention, it was acknowledged that this meant little if the healthcare worker did not know what they were doing, or was providing inappropriate treatment/care.

3.2.3 3 Personal values and attitudes

Stigma and discrimination

Consumers were deeply affected by the values and attitudes of healthcare providers they encountered. Provider stigma was described as particularly problematic by consumers and healthcare providers, particularly for those with substance use issues. Although some consumer participants spoke of being well treated, others recounted stories of being turned away from emergency departments of hospitals because they were labelled as 'drug addicts' or 'doctor shopping' by hospital staff. Others spoke of their care being compromised. One consumer gave the example of a friend who had phoned an ambulance because she was in terrible pain. Upon arrival, the ambulance officers' first question was "are you overdosing?" To which she replied, "no". They then assumed she was in withdrawal. She was later found to have gallstones.

Assumptions on the part of healthcare providers act as significant barriers to people with AOD and/or mental health conditions seeking help. Consumers also described previous experiences of being told they would be better suited to seeking care from services such as the Kirketon Road Centre, as opposed to more mainstream healthcare providers.

These sentiments were echoed by healthcare providers, who identified shame and stigma as barriers preventing people seeking help. These attitudes were described as the assumption that people with AOD use having no right to care - or at the very least, are less deserving than others, and 'do not fit anywhere'. Healthcare provider participants identified discriminatory strategies such as drug testing Centrelink recipients and some media campaigns as mechanisms which undercut a lot of the good work being done by many clinicians.

3.2.4 Health system level issues

As with the expert panel, focus group participants described several system-level issues as significant challenges for consumers, families and carers in trying to access healthcare, as well as healthcare providers working with people with comorbid AOD and MH conditions.

3.2.4.1 Difficulty finding a healthcare provider

Finding accessible services

Consumer group participants spoke of difficulties accessing services that would accept and treat them. One participant described an instance where she had presented to a local hospital to join their methadone program, but was told she needed to be Aboriginal, pregnant or recently released from prison to get on the program. She was unable to find information on other services she could attend until sometime later, when she found a 'nice' doctor who advised her that Canterbury hospital were accepting new patients on their program.

Healthcare provider participants also identified the difficulty involved in navigating the system, and the emotional and mental capacity and tenacity required by clients to persevere. Healthcare providers highlighted the intense resources required to follow up many complex clients, who are often the people in most need of help. However, participants felt that these clients are often the ones who are 'written off' by other clinicians, because they are not thought to be worth the effort of following up. Clients perceived to be particularly at risk of being written off were identified as anyone using methamphetamine, and those with a personality disorder.

Lack of specialised services in non-government organisations

Similar to the challenges described in accessing services at the client-level, consumer and healthcare provider participants expressed frustration at the lack of affordable services for people with AOD and/or mental health conditions. Client/consumer participants experienced this as difficulty finding services and/or providers who would bulk bill, finding providers who would not charge above the 'gap' in their mental health plan, and the ongoing struggle to obtain a mental health plan. Healthcare providers expressed profound distress and disappointment at the dearth of 'good' providers, which was attributed to the considerable salary disparity between what healthcare providers (particularly psychologists) would earn in non-government organisations compared to private practice.

3.2.4.2 Lack of continuity in service delivery

Participants of the family/carer and consumer focus groups discussed the lack of continuity of service delivery, particularly in relation to community mental health, as a problem. In particular, participants noted:

- **Difficulties with continuity of care:** Although participants were able to make appointments to see psychiatric registrars, these could only be once every three months. The cycle of rotation means that registrars rotate specialties every six months, so it is not possible to see

one doctor more than twice. The constant rotation makes the formation of relationships between patients and doctors almost impossible.

- **Time and other resource constraints:** The lack of available registrars and time pressure means that doctors are frequently late (increasing levels of anxiety among their psychiatric patients) and do not have time to review the case notes for their next patient prior to their appointment. Consequently, the entire appointment is consumed with going over patient history, which is contained in the case notes – to bring the doctor up to speed. If patients are fortunate enough to have a second appointment, the appointment will be consumed with preparations for handover to the next registrar. Further, appointment times are often too short to be able to discuss the problem.

- **Inappropriate care delivery:** Family/carer group members described the incompatibility and inappropriateness some doctors to patients. Several group members spoke of young (mid-20s) registrars treating their elderly parents (mid-80s). The absence of older doctors from the public health system was noted, and it was also noted that older healthcare providers were likely to be working in private practice, which were unaffordable to participants' family members.

- **Incompatible systems within and between local health districts (LHDs):** Family and carer group members identified the different and incompatible systems within and between LHDs as major problems that prevented them from seeking appropriate care. In particular, the lack of availability of short-stay Psychiatric Emergency Care Centres (PECC: 48-hour short stay units) in all LHDs and hospitals was discussed, . Consequently, many hospitals do not have the capacity or facilities to offer a 48-hour short-stay, which provide patients with the opportunity for stabilisation and discharge to the care of their GP.

3.2.4.3 Collaborative care

Absence of adequate discharge plan or continuing care

The lack of follow-up, assertive outreach, or continuing care for patients was identified by family/carers as an ongoing issue. In particular, the absence of follow-up or discharge plans were noted in:

- **Emergency departments:** Family/carer focus group members described that unless their patient was actively attempting suicide, no comprehensive discharge plan or continuing care would be organised or provided. Rather, a summary letter would be sent to the GP.

- **Community mental health teams:** Participants of the family/carer group described how the local community mental health team is supposed to contact patients within 24 hours following their discharge from short-stay units. In practice however, this rarely happens.

Despite these negative experiences, one participant from the family/carer focus group described a positive experience with one of the PECCs, whereby a doctor had indicated that discharge planning began as soon as the patient arrived at the unit.

3.2.5 Summary

The focus groups identified a range of challenges faced by consumers and carers in trying to access healthcare, as well as challenges faced by practitioners working with people with AOD and comorbid mental health conditions. As with the expert panel, the focus groups identified several means through which some of these challenges can be addressed. Consistent with strategies discussed in the expert panel, the common factor across many initiatives was that they be both top down and bottom up, involving consumers, families and carers and supporting practitioners.

3.3 Stage 3: Practitioner survey

3.3.1 Respondent characteristics

Fifty surveys were completed. The mean age of respondents was 42.2 years (SD 9.4) and 85.1% were female. Respondents represented a range of occupations, most commonly nurses (29.8%), GPs (17.0%), psychologists (10.6%), counsellors (8.5%), case workers (4.3%), and social workers (4.3%). Other occupations included psychiatrist, residential support worker, addiction medicine specialist, health education officer, speech pathologist, support worker, and project officer (25.5%).

In general, morale around work was high with respondents consistently reporting that they enjoyed their work (median 8, range 4–10), would choose the same career again (median 7, range 0–10), and felt stimulated (median 8, range 0–10) and effective in their role (median 8, range 5–10). Surprisingly, provider fatigue was not reported to be an issue by many participants, with relatively few indicating they felt 'burned-out' (median 3, range 0–9).

3.3.2 Service characteristics

The primary focus of respondents' work settings was varied, and included mental health (14%), AOD (18%), GP/family medicine (10%) child advocacy (4%), school/educational (4%), and social work (2.0%), and others (8%).

3.3.3 Education, training and experience

The vast majority of respondents (97.9%) had educational qualifications at the level of university undergraduate degree or higher, and the majority had undergone some level of training across many areas of mental health and AOD (Table 1).

The majority of mental health and AOD use disorder training was via academic coursework. Other forms of training were completed less frequently, with a consistent spread across a range of training sources including external training, workplace training, conferences/seminars, and workshops. All respondents indicated they received training/education regarding depression and anxiety. Lowest levels of training/education were found in relation to comorbid mental health and AOD (72.2%).

Table 1: Training and education courses completed

	Any training/education
Disorder (%)	
Depression	100
Anxiety	100
Trauma or PTSD	86.1
Bipolar	83.3
Psychosis/ schizophrenia	86.1
Eating disorders	88.9
Self-harm	80.6
AOD alone	77.8
Co-occurring MH problems	75.0
Comorbid MH & AOD problems	72.2

In the past 12 months, 56.8% of respondents had completed some form of mental health training, and 37.8% had completed some form of AOD training. Just over one-in-seven (13.5%) respondents reported receiving training on co-occurring mental health and AOD disorders in the last 12 months, with 35.1% having never completed any training of this kind. The majority of the sample (91.9%) indicated they accessed up-to-date, evidence-based research and resources to assist with their work. Attending workshops, seminars, training, and conferences, was the most popular source (44.4%); online resources made up 19.4%, while many used a combination of sources.

The sample had a fair amount of experience in the fields of both MH and AOD problems (Figure 1) with 40.5% reporting over 10-years' experience in AOD, 51.3% in mental health, and 27.7% in comorbid MH and AOD.

Figure 1: Years of experience in the field
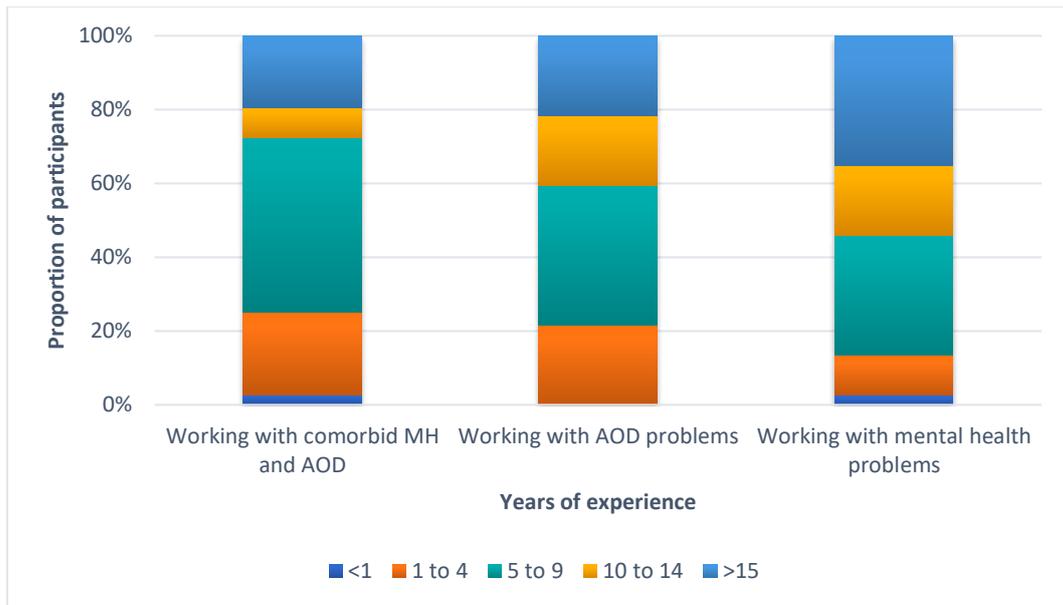
Almost two-thirds of participants (64.3%) reported working with people with co-occurring mental health and AOD problems often or all the time (Figure 2). When respondents were asked to list their three most common roles when responding to comorbidity (Figure 3), the most frequently reported was assessment and screening (51.4%), followed by referral (48.6%), education/information provision (31.4%), early/brief intervention (25.7%), and counselling (25.7%).

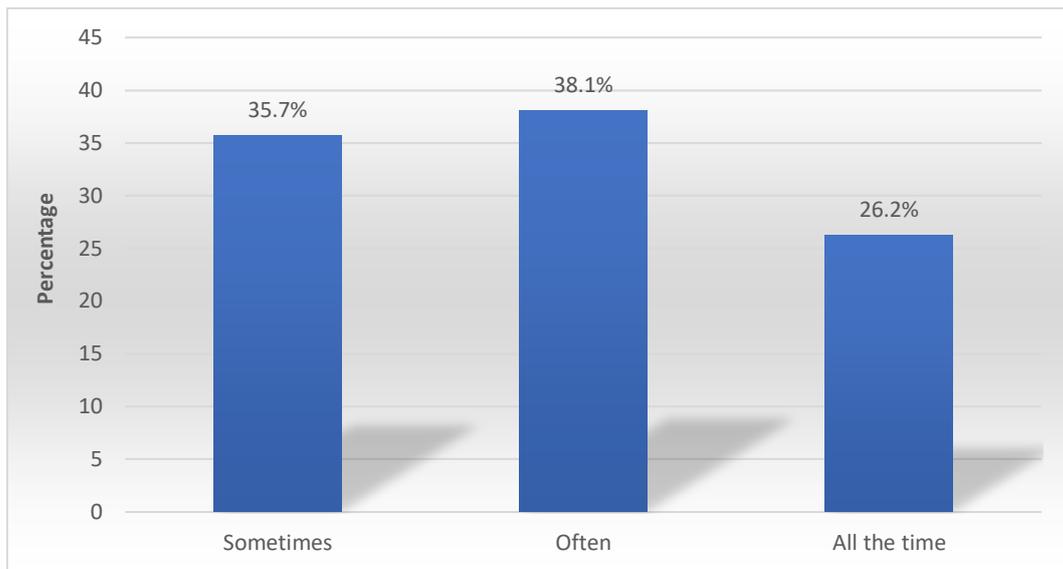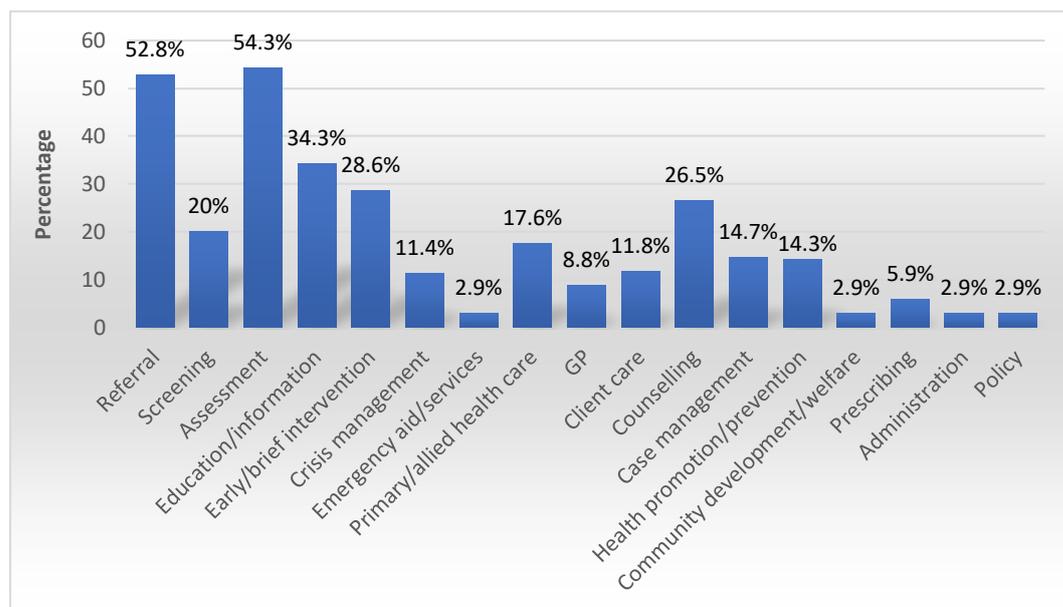**Figure 2: Experience working with people with co-occurring MH and AOD**

Figure 3: Three most common roles when responding to comorbidity

3.3.4 Beliefs around comorbidity treatment

The majority of participants reported that they regularly assessed for mental health symptoms (85.4%) and AOD problems (90.5%) in their practice. Over two-thirds of respondents (70.3%) believed treatments designed for mental health are insufficient for clients who also experience AOD disorders, and a similar proportion believed vice versa (72.9%); that is, treatments designed for AOD disorders are insufficient for clients who also experience mental health disorders. Close to three-quarters (72.2%) believed that two treatment providers/therapists were not required to treat a client with co-occurring mental health and AOD disorders, and 55.2% claimed that, as a general rule, their agency

tended to refer clients with co-occurring mental health and AOD disorders to another provider or agency.

Half of respondents (50.0%) disagreed with the statement, "A client's mental health symptoms must be treated before treatment for their AOD can be effective", while 47.4% disagreed with the statement, "A client's AOD symptoms must be treated before treatment for their mental health can be effective."

The majority of respondents felt that physical activity (89.2%), psychotherapy (84.6%) and pharmacotherapy (86.5%) were moderately or extremely appropriate interventions for treating people with comorbidity (Table 2). Approximately two-thirds of participants indicated that e-health (67.6%) and complementary and alternative therapies (63.9%) were not at all or only a little appropriate.

Table 2: Appropriateness of interventions for people with comorbidity

	Psychotherapy	Pharmacotherapy	E-health	Physical activity	Complementary and alternative therapies
%					
Not at all	2.7	-	16.2	-	13.9
A little	10.8	13.5	51.4	10.8	50.0
Moderately	43.2	64.9	24.3	51.4	22.2
Extremely	43.2	21.6	8.1	37.8	13.9

3.3.5   Working with people with comorbidity

3.3.5.1 Current approach to comorbidity

Clinicians were asked about the first steps they would take with a comorbid client. Almost one-quarter (22.2%) claimed that they would address the mental health condition and connect the client with an AOD service provider for their AOD. Slightly fewer (16.7%) would address both mental health and AOD conditions concurrently, themselves. Approximately one in seven (13.9%) indicated that they would immediately refer on, while 5.6% would address the AOD problem and connect the client with a mental health service provider for their mental health condition. A small proportion (2.8%) indicated they would refer to AOD services. Other responses that participants discussed in the open-ended response section (38.9%) included the suggestion that their actions would depend on factors

such as the severity of the client's presentation, their presenting issues, the recommendations of the treatment team, and the clinician's current case load.

3.3.5.2 Personal experiences of treating comorbidity

As indicated in Table 3, although the majority of respondents felt moderately or extremely confident in treating depression (80%) and anxiety (79.4%) and moderately or extremely prepared in treating depression (77.5%) and anxiety (77.7%), less than half the sample felt confident (30.0%) or prepared (40.0%) with regards to treating eating disorders. Depression alone and anxiety alone were perceived as least challenging with approximately two-thirds of the sample reporting these issues to be not at all challenging or a little challenging. Conversely, almost half of respondents (47.5%) found psychosis/schizophrenia alone extremely challenging, and more than one-third (40.0%) found co-occurring mental health and AOD problems extremely challenging. Self-harm (30.0%) and eating disorders alone (30.0%) were also viewed as extremely challenging. Approximately two-thirds of respondents were moderately or extremely confident in treating co-occurring mental health problems (65.0%), and comorbid mental health and AOD problems (65.0%), but fewer reported feeling prepared to treat these two comorbidities (60.0% and 57.5%, respectively).

Self-harm and eating disorders were not highly viewed as rewarding to treat, while approximately one-third of respondents found working with co-occurring mental health and AOD problems (32.5%) and PTSD alone (32.5%) to be extremely rewarding. With the exception of eating disorders and self-harm, over two-thirds of respondents rated all conditions as moderately or extremely rewarding to treat.

Table 3: Personal experiences of treatment

	Depression alone	Anxiety alone	PTSD alone	Bipolar alone	Psychosis/ schizophrenia alone	Eating disorders alone	Self-harm/ self-injurious behaviours alone	AOD alone	Any co-occurring MH problems	Co-occurring MH & AOD problems
Challenging (%)										
Not at all	22.5	27.5	10.3	7.5	10.0	2.5	5.0	12.5	5.0	2.5
A little	40.0	30.0	28.2	25.0	15.0	15.0	17.5	25.0	27.5	17.5
Moderately	32.5	35.0	41.0	47.5	35.0	37.5	42.5	47.5	40.0	40.0
Extremely	2.5	5.0	15.4	17.5	47.5	30.0	30.0	7.5	25.0	40.0
Not applicable	2.5	2.5	5.1	2.5	2.5	15.0	5.0	7.5	2.5	-
Rewarding (%)										
Not at all	2.5	2.5	2.5	-	-	5.0	7.7	5.0	-	-
A little	22.5	22.5	15.0	25.0	22.5	22.5	30.8	20.0	25.0	20.0
Moderately	47.5	45.0	40.0	45.0	52.5	35.0	25.6	42.5	50.0	47.5
Extremely	25.0	27.5	32.5	25.0	20.0	17.5	28.2	25.0	22.5	32.5
Not applicable	2.5	2.5	10.0	5.0	5.0	20.0	7.7	7.5	2.5	-

Table 3: Personal experiences of treatment (continued)

	Depression alone	Anxiety alone	PTSD alone	Bipolar alone	Psychosis/ schizophrenia alone	Eating disorders alone	Self-harm/ self-injurious behaviours alone	AOD alone	Any co-occurring MH problems	Co-occurring MH & AOD problems
Confident (%)										
Not at all	2.5	-	5.0	10.3	22.5	27.5	10.0	7.5	2.5	10.0
A little	15.0	17.9	32.5	28.2	22.4	30.0	30.0	25.0	30.0	25.0
Moderately	52.5	53.8	45.0	38.5	10.0	25.0	40.0	40.0	52.5	50.0
Extremely	27.5	25.6	12.5	20.5	12.5	5.0	15.0	27.5	12.5	15.0
Not applicable	2.5	2.6	5.0	2.6	2.5	12.5	5.0	-	2.5	-
Prepared (%)										
Not at all	7.5	5.0	15.0	15.0	17.5	25.0	12.5	10.0	12.5	12.5
A little	12.5	17.5	20.0	25.0	35.0	27.5	22.5	22.5	25.0	30.0
Moderately	42.5	42.5	42.5	35.0	30.0	30.0	47.5	37.5	42.5	37.5
Extremely	35.0	32.5	17.5	22.5	15.0	10.0	12.5	30.0	17.5	20.0
Not applicable	2.5	2.5	5.0	2.5	2.5	7.5	5.0	-	2.5	-

3.3.5.3 Client and treatment factors

Approximately three-quarters (73.0%) of respondents reported client anger as a moderately or extremely difficult client-oriented factor when working with comorbid clients (Table 4). Similarly, 70.3% of respondents also rated client emotional dependency as a moderately or extremely difficult factor when working with clients. Close to two-thirds (62.2%) found de-escalation moderately or extremely difficult. Least difficult factors identified by respondents included client crying/sadness, which was rated as not at all difficult or only a little difficult by 70.2%, setting boundaries (62.1%), and hearing about trauma (59.4%).

Table 4: Difficulty of client and treatment factors

	Client anger	Client crying/ sadness	De-escalation	Hearing about trauma	Client self-harm	Client emotional dependency	Setting boundaries	Client relationship problems	AOD
Client-oriented factors (%)									
Not at all	2.7	32.4	10.8	13.5	10.8	2.7	21.6	8.1	22.2
A little	24.3	37.8	27.0	45.9	32.4	27.0	40.5	48.6	27.8
Moderately	56.8	29.7	59.5	37.8	48.6	67.6	35.1	40.5	44.4
Extremely	16.2	-	2.7	2.7	8.1	2.7	2.7	2.7	5.6

	Not knowing what to do	Not wanting to disrupt rapport	Case management	Clients parents/ carers	Prioritising treatment components/goals	Deciding what kind of treatment approach to use	Not feeling knowledgeable about AOD	Not feeling knowledgeable about MH
Treatment-oriented factors (%)								
Not at all	21.6	32.4	16.2	27.0	18.9	18.9	27.0	32.4
A little	45.9	51.4	29.7	45.9	45.9	43.2	35.1	37.8
Moderately	21.6	10.8	43.2	24.3	32.4	32.4	32.4	24.3
Extremely	10.8	5.4	10.8	2.7	2.7	5.4	5.4	5.4

Overall, case management was reported as one of the more difficult treatment-oriented factors. More than half of respondents (54%) reported case management as moderately or extremely difficult when dealing with comorbid mental health and AOD problems. Just over one-third of respondents (37.8%) found deciding what treatment approach to use, and not feeling knowledgeable about AOD as moderately or extremely difficult. Conversely, approximately 65–85% reported "no difficulty" or "little difficulty" in dealing with other treatment-oriented factors.

Approximately one-fifth (22.2%) reported working with the families/parents of clients to be only "a little" rewarding (Table 5). Working with challenging/complex clients also tended to be less rewarding than other factors (approximately 16.2%). However, more than 90% of respondents found other factors (such as "teaching clients new coping skills," "developing expertise," "helping clients achieve AOD goals," and "obtaining insight about yourself") to be moderately or extremely rewarding.

When asked for general comments on their experience working with people with comorbid mental health and AOD problems, participants commented on client complexity, the importance of providing client-oriented care, family support, different treatment approaches, and self-awareness. This section also contained a number of concerns and frustrations around clinician burnout and the need for worker self-care.

Table 5: Rewarding factors

	Helping clients achieve AOD goals	Teaching clients new coping skills	Developing expertise	Obtaining insight about yourself	Working with clients' parents and families	Working with challenging/ complex clients
Comorbid problems (%)						
Not at all	-	-	-	-	-	-
A little	5.4	-	2.7	5.4	22.2	16.2
Moderately	35.1	37.8	40.5	48.6	41.7	45.9
Extremely	59.5	62.2	56.8	45.9	36.1	37.8

3.3.6 Referral practices

Approximately three-quarters of respondents (73.3%) indicated that in general, they preferred to refer clients to services or clinicians they are familiar with, while 69.0% referred to local services (Figure 4). Only 17.4% of participants indicated that they made referrals based on an online search.

Other referral methods that were mentioned by participants included referring clients to the Australian Drug Information Service (ADIS), and basing referrals on client history with services.

**Figure 4: How providers are selected when making referrals for comorbid clients**
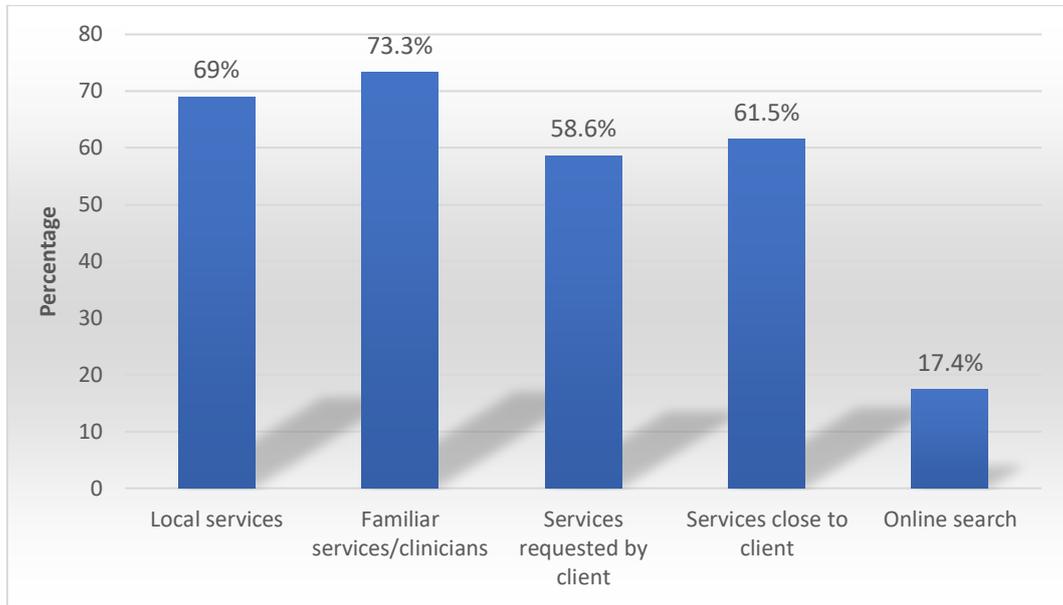
Just under half of respondents (45.9%) indicated that they had a good knowledge of available mental health services within the CESPHN, with a further 51.4% reporting knowledge of some services (Figure 5). In contrast, approximately one-third (32.4%) reported a good knowledge of available AOD services within CESPHN, with a further 59.5% indicating knowledge of some services. In regards to mental health and AOD services available in CESPHN, approximately one-in-six (16.2%) reported a good knowledge, with a further 51.4% having some knowledge. There was considerably less knowledge about services for clients with mental health and AOD comorbidity compared to mental health services and AOD services, with 32.4% of respondents reporting having no knowledge of available services (compared to 2.7% and 8.1% respectively).

Figure 5: Knowledge of MH and AOD services available in CESPHN
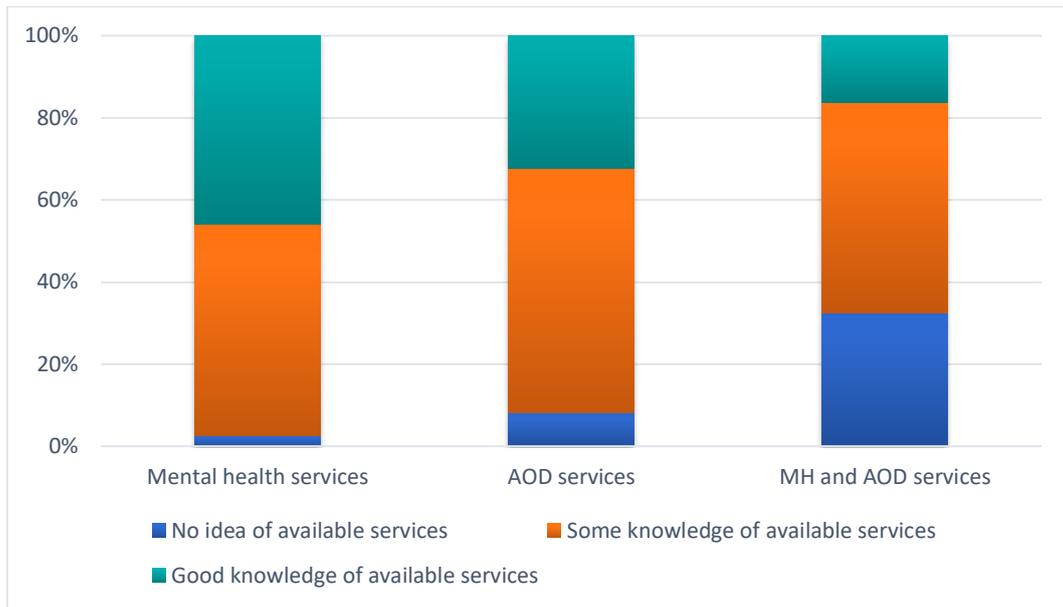
More than one-third (37.1%) of respondents indicated they typically provided passive referrals for clients with comorbidity, whereby they provide clients with details of the service, and let them make their own appointment (Figure 6). Just less than one-quarter (22.9%) reported proving facilitated referrals for clients, by making appointments on their client's behalf. Two-fifths (40%) provided active referrals for clients, by contacting the referral agency in front of their client and making the appointment and providing the service with their professional assessment.

Figure 6: Type of referral provided to clients
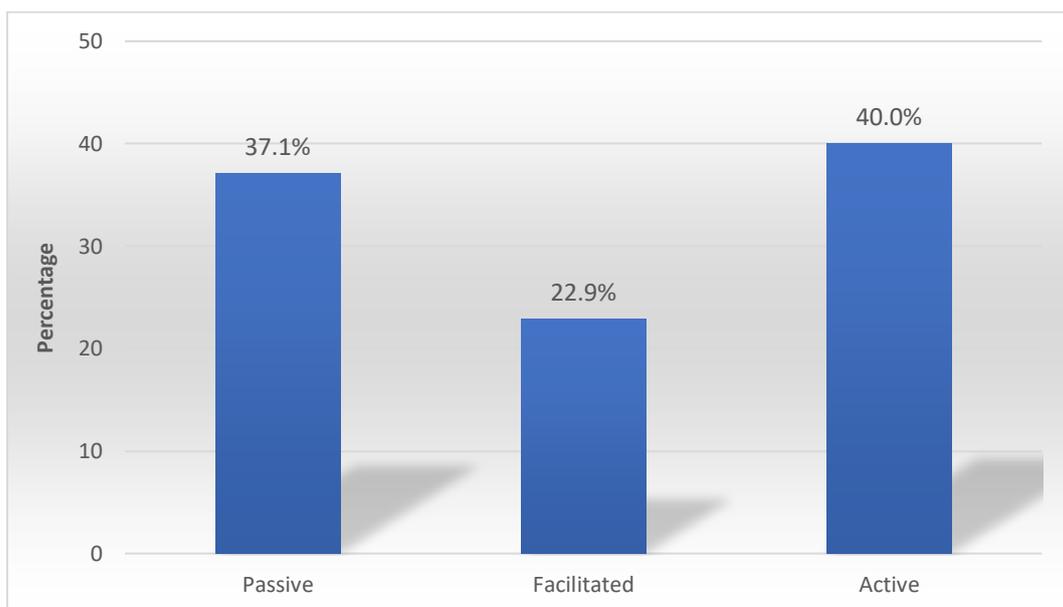
Additional comments made by participants included the difficulty involved in obtaining appointments for clients with comorbidity; the need for more active involvement to assist clients recover; actively following up with clients following a referral being made, assisting with the making of an appointment and accompanying clients to appointments where possible; the need for client consent; the difficulty for clients to access public or bulk billing (affordable) services; previous negative experiences with services leading clients to be more cautious and wary in engaging with subsequent services; necessity of referring to 'trusted' clinicians to avoid clients having negative experiences; and the difficulty and confusion involved in accessing services when referral is for comorbid AOD/mental health.

In terms of who should be responsible for coordinating care for people with comorbid mental health and AOD problems, respondents mentioned several roles. Most commonly mentioned was a case manager, but participants also indicated that coordinated care should be the responsibility of the full treatment team, GPs, nurse coordinators, or whoever the client will engage with. In addition, several participants emphasised the importance of collaborative care, including coordination between and within services.

3.3.7   Utility of resources

The vast majority of respondents (92.9%) felt that access to a treatment manual for co-occurring mental health and AOD would be at least somewhat beneficial (Figure 7), and approximately three quarters (73.8%) indicated that training in evidence-based treatments for co-occurring mental health and AOD disorders would be extremely beneficial. Again, the majority (92.7%) felt that clinical supervision in the area would be at least somewhat beneficial, and more than two-fifths of respondents (40.5%) indicated that it would be extremely beneficial to have more guidance in prioritising treatment goals/objectives (e.g., whether to focus on the AOD or mental health). The majority of respondents (88.1%) felt training in mental health and/or AOD disorders (features, causes, etc.) would be somewhat or extremely beneficial.

More than three-quarters (76.2%) of respondents indicated that a directory of available mental health and AOD services within CESPHN region would be extremely beneficial, and the majority (88.1%) indicated that guidance on referral and treatment pathways for co-occurring mental health and AOD clients would be extremely beneficial. Almost all respondents (95.1%) felt that a clinical network for clinicians interested in comorbidity would be at least somewhat beneficial.

Figure 7: Type of resources that would benefit healthcare providers in their work
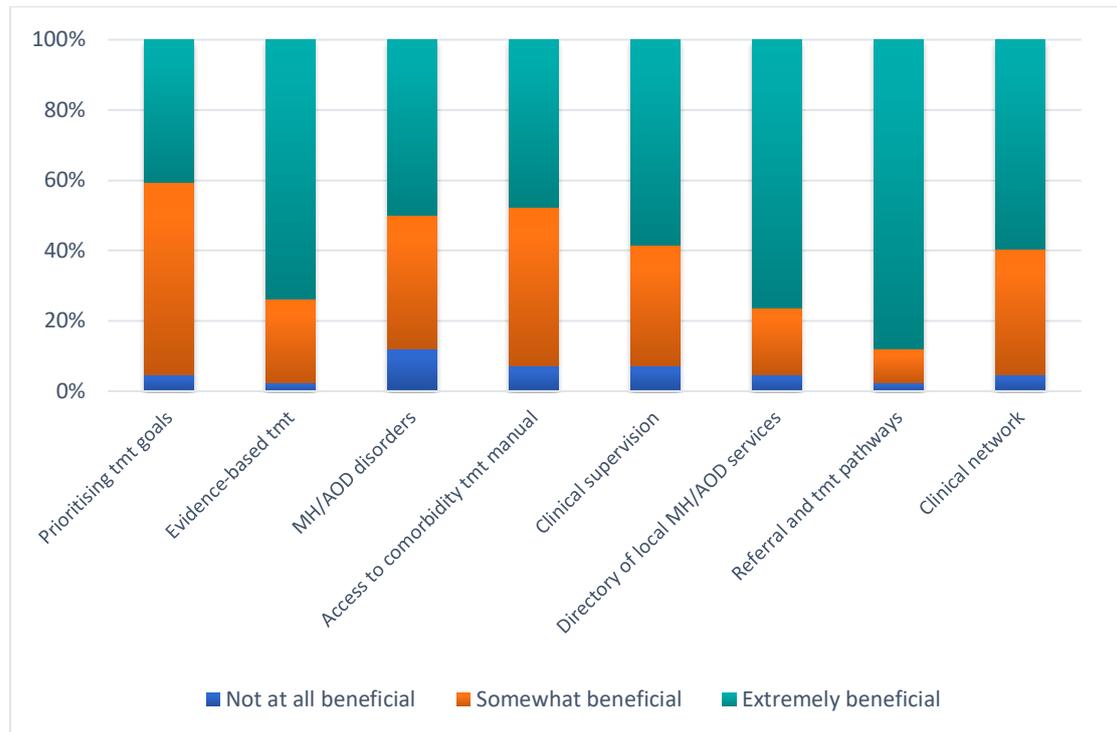
When asked what other resources would be helpful, there was a range of responses. Most consistently, the need for better access to support was mentioned. The need for more (and better access to) relevant experts who can provide expertise, advice, and clinical supervision was discussed, and several participants raised the possibility of a dedicated helpline for clinician support. The need for a service directory, access to evidence-based resources and training, and partnerships between mental health and AOD services was also raised.

4. Discussion

This study represents one of the first attempts to assess the current practices and support needs of healthcare providers working with people who have AOD and mental health conditions in the Central and Eastern Sydney Primary Health Network region. Drawing on previous work in the area (Ross, et al., 2015), this study identified client, family/carer and healthcare provider experiences of working with people who have AOD and mental health conditions, with a view to making recommendations for the development of resources and training for practitioners and services who work with this population.

Specific client factors, including financial barriers and access to peer support, affect the ability of consumers to access healthcare services for their AOD and/or mental health and prioritise their

health over other competing factors. Family/carer factors, including their exclusion from treatment planning, can limit the ability of practitioners to deliver care within a holistic framework, and address clients' needs across multiple levels. Healthcare provider factors, including knowledge about comorbidity, and personal values and attitudes about AOD and mental health, impact the extent to which consumers perceive their healthcare needs are being addressed, and the extent to which they feel able to ask for help. Factors at the health system level, including access and availability of providers, models of care, collaborative and cohesive care, impact the broader context in which consumer, family/carer, and healthcare provider factors interact.

Previous research has found healthcare workers to feel "overwhelmed and fearful" when dealing with people experiencing co-occurring MH and AOD problems (McDermott & Pyett, 1993). Interestingly, this was not supported by the present study's findings. This is likely due to the substantial efforts in recent years to bring this issue to the fore (e.g., National Comorbidity Initiative; Improved Services and Dual Diagnosis initiatives; the Centre of Research for Mental Health and Substance Use; national and state-based comorbidity guidelines). Results from Stage 3 highlighted that although managing comorbidity was still perceived as particularly challenging, confidence and preparedness among practitioners was comparatively high. Furthermore, there was a tendency for the rewarding components to be more pronounced among these populations.

It should be noted however, that while overall confidence was found to be high, this does not necessarily reflect competence. Answers to questions regarding beliefs about the treatment of comorbidity indicated that a significant proportion of respondents were not aware of, or did not practice, in accordance with the evidence-base. This is in spite of the fact that in Stage 3, 92% claimed that they accessed up-to-date, evidence-based, research and resources.

Two-thirds of Stage 3 respondents reported working with comorbid clients often or all the time, lending further support to the assertion that in many treatment services, comorbidity is the rule rather than the exception (Chan, Dennis, & Funk, 2008; van Loo, Romeijn, de Jonge, & Schoevers, 2013). Despite the frequent contact with comorbid clients, only a small proportion (14%) of healthcare providers reported having received comorbidity training in the past year, while a surprisingly considerable proportion (35%) indicated they had never received any comorbidity training. This was in stark contrast to a relatively recent UK study (Schulte et al., 2010), which found 80% of practitioners had received training in comorbidity. It should be noted however, that the job specialisations of the UK study were slightly different than those held by participants in the current study, the most common being psychiatric or general nurses, followed by general and addiction-specific counsellors (Schulte et al., 2010).

Given these findings, it is unsurprising that practitioners reported an overwhelming desire for greater availability, and access to, current evidence-based information and resources (including access to treatment manuals, training in mental health and AOD disorders and comorbidity, guidance in prioritising treatment goals/objectives, referral and treatment pathways), along with more training in evidence-based treatments for comorbidity. Further, participants expressed considerable interest in having access to a directory of available MH and AOD services within the CESPHN region, as well as a clinical network for practitioners interested in comorbidity.

Finally, consistent with the literature in the area (Howard & Holmshaw, 2010; Roche & Pidd, 2010; Roche, White, Duraisingam, & Adams, 2012; Schulte et al., 2010), Stages 2 and 3 revealed the need for more support and supervision around comorbidity.

4.1   Limitations

As with any study of this kind there is the potential for limitations. In particular, while the expert panel, focus group members and interviewees represented a range of health care, consumer and advocacy, and carer and family services within the CESPHN region, their views may not be reflective of other practitioners within CESPHN. Similarly, the relatively small number of respondents to the online survey may not be representative of healthcare providers more broadly, or within the local region. Although attempts were made to obtain all relevant feedback from respondents (e.g., open-response items, preliminary stage to direct survey content) there is always the possibility that some issues were not covered. Similarly, such surveys may be susceptible to self-report bias, in particular, social desirability bias. It has been suggested however, that computer administration of surveys may produce a sense of disinhibition in respondents, and this sense of disinhibition may lead to more accurate reports of certain behaviours (Booth-Kewley et al., 2007).

4.2   Recommendations

Further work is needed to address a number of key issues raised in this scoping exercise. Some of the issues identified require significant shifts in the way in which care is provided at national and state levels, across multiple service sectors; but many can be addressed at the level of the PHN. Based on the synthesis of these findings, we provide the following recommendations for consideration to improve the current practices and capacity of healthcare workers to respond to mental health and AOD comorbidity in CESPHN:

1. Provision of education and training opportunities for healthcare workers in mental health and AOD comorbidity

Consistent with the broader literature, this scoping exercise identified that comorbidity is the norm rather than the exception for people with AOD or mental health conditions who are presenting to services. All three participant groups, across all three stages of this project, identified the need for further education and training in relation to comorbidity and upskilling of the entire workforce, across multiple levels. Education and training was considered key to improving knowledge, confidence and capability with respect to assessment and treatment, and reducing stigma and discrimination. At a minimum, all healthcare workers should be able to competently screen and assess for the presence of possible mental health and AOD problems, and have knowledge of evidence-based prevention, early intervention, and treatment responses. Specific areas in need of attention include understanding the complexities of comorbidity, and the provision of trauma-informed and culturally appropriate care, and the use of motivational enhancement approaches across all areas of health and social service.

Training/education should be provided through academic coursework undertaken through tertiary education, and be maintained through ongoing professional development activities. In addition to face-to-face training, other options may include the development of a series of short training modules for online delivery that could be individually tailored, as this would maximise reach and enhance accessibility.

2. Improved access to up-to-date evidence-based information on mental health and AOD use

a) Development of evidence-based resources for practitioners, clients and carers

As identified in through this scoping exercise, there is a considerable amount of information available on mental health and AOD use, particularly through the internet. However, it is difficult for practitioners, clients and carers to discern the accuracy and credibility of that information. Access to evidence-based information, available in peer reviewed journal articles, is limited. Furthermore, most lack the time and skills needed to be able to accurately interpret and synthesise the evidence base. Resources such as guidelines and treatment manuals provide practical recommendations for practitioners based on a critical evaluation of the existing evidence and are fundamental in translating research findings into practice. The development of resources for clients may also help clients, family and carers identify possible mental health and AOD problems (for themselves and their friends), increase help-seeking, and assist clients in advocating to receive evidence-based interventions.

It is crucial that resources be made available in formats that enhance their use by the target audience. In addition to physical hard-copy resources and electronic documents that can be downloaded from

the Internet, other e-health mechanisms may be utilised. The development and modification of existing resources as applications ('apps') for smartphones and tablets, for example, may enhance implementation by their ease of use, portability, and ability to be used without the need for Internet access (apart from the initial download). Furthermore, apps can easily be updated with new information as necessary, thereby providing a cost-efficient means by which to provide practitioners with the most up-to-date evidence.

b) Communication of evidence-base information via online and social media

It is also vital that practitioners are made aware of new research findings as they become available, in a manner that is useful, relevant, and acceptable to this audience. It is essential that this information be provided by credible organisations. Increasing evidence from multiple disciplines has shown the benefits of social media for increasing the reach and impact of scientific findings.

3. Provision and ongoing support of clinical supervision for healthcare providers in mental health and AOD comorbidity

The benefits of clinical supervision, for both practitioners and clients, have long been recognised. Despite this, healthcare providers identified a lack of supervisory support and clinical supervision available. In order for healthcare workers to be able to successfully implement what they learn through education, training, and access to up-to-date evidence-based information, it is essential that they have access to regular clinical supervision. In addition to reducing burnout, initiatives that aim to facilitate the uptake and ongoing delivery of clinical supervision, such as support of a clinical network of interested practitioners, may promote the greater uptake of evidence-based practice and facilitate collaboration between services.

4. Development and maintenance of an online service directory

Support for the establishment of a service directory for healthcare providers, with information on up-to-date region-specific, multidisciplinary services (e.g., housing, education, employment, domestic and family violence, crime and justice health, sexual health, Aboriginal, trauma-specific, LGBTI, multicultural, NDIS, aged care) to assist workers make referrals and coordinate care.

5. Development and pilot testing of innovative services and enhancement of existing services to address areas of unmet need

The need for increased access to specialised yet affordable care was identified as a priority; in particular, services that are able to provide assertive, proactive and holistic care, and those that can

accommodate a range of long-term needs. Novel programs and services addressing these gaps (e.g.: domestic violence and homelessness services; services that can accommodate pets; incentives for bulk billing providers; culturally appropriate services for a variety of community groups including Aboriginal and Torres Strait Islander peoples and LGBTQI; multidisciplinary services for people leaving custody) could be trialled with a view to upscaling those that prove to be effective. Expansion of programs such as the Psychological Support Service (PSS) could also increase the availability and reach of long-term psychological services. Initiatives to support and facilitate family/carer involvement in care planning, and access to support services need to also be considered.

6. Development and pilot testing of an accreditation program for peer workers to legitimise and ensure that peer workers have the skills necessary to undertake these valuable roles

An accreditation program for peer workers working in AOD could be developed, similar to that which has recently been developed for mental health by the Mental Health Coordinating Council. Alternatively, competitive subsides could be provided for peer workers within the region to undergo the existing peer worker program.

7. Provision of specialist training scholarships and subsidised placements in AOD and mental health services

Competitive scholarships could be provided to encourage those in training to gain experience in AOD and MH. Placement subsidies could be provided to encourage service managers to embed their staff within other services or participate in staff exchange programs. Program such as these may serve to enhance education and training as well as facilitate collaborations between service sectors.

8. Development and pilot testing of a model of coordinated care

The need for a coordinated approach to the management and treatment of AOD and mental health conditions is well recognised but is rarely applied well, resulting in many people falling between the gaps of our health system. A model of coordinated care could be developed and pilot tested in which the roles and responsibilities of healthcare providers and services could be delineation and referral pathways developed.

4.3   Summary

Ultimately, many of these recommendations are largely dependent on funding in an underfunded sector (Roche et al., 2012). Nevertheless, many resources are currently available and simply require better dissemination and translational models in order to address these gaps. This study has

highlighted particular areas of difficulty among practitioners working with comorbid clients, including case management, self-harm, and de-escalation. In addition to comorbidity, specific disorders may also warrant increased attention in regards to training resources (e.g., eating disorders, psychosis, PTSD).

Overall this study highlights both areas of success and a number of key areas for further attention in order to improve the capacity of the workforce to intervene with clinical populations (particularly those with comorbid disorders). It is believed that in addressing some of these shortfalls the standard of care is likely to be improved, and the enduring disability associated with mental health and AOD disorders may be reduced.

5. Acknowledgments

Appendix A: Online survey

SECTION A: ABOUT YOU

1.   How old are you? _____ yrs

2.   Sex:

Female... 0
Male 1
Intersex 2
Transgender... 3
Prefer not to say 4

3.   What is your current occupation**?** *(choose only one)*

Case worker 0
Counsellor...1
Occupational therapist 2
GP...3
Nurse..4
Psychiatrist..5
Psychologist 6
Residential support worker 7
Social worker 8
Youth worker 9
Addiction medicine specialist 10
Other..11 (*specify _____*)

4.   What is the highest formal qualification you have ***completed***? *(choose only one)*

Some secondary school – completed year 9 or less.................0
Secondary school – completed year 10...................................1
Secondary school – completed year 11...................................2
Secondary school – completed year 12...................................3
Certificate I or II 4
Certificate III or IV 5
Diploma Level 6
Advanced Diploma & Associate Degree Level 7
Undergraduate degree (e.g., B.A, B.Sc) 8
Honours degree 9
Graduate Certificate 10
Graduate Diploma..11
Master Degree 12
Doctoral Degree...13
Other...14 (*specify _____*)

5.   Please specify the name of the highest formal qualification you have COMPLETED (e.g., Master in Clinical Psychology; Diploma or Certification in AOD/youth work; MBBS).

_____

SECTION B: EXPOSURE TO PEOPLE EXPERIENCING MENTAL HEALTH AND AOD USE PROBLEMS

This section contains a range of questions asking about your experience working with clients/patients experiencing mental health and AOD problems.

NOTE: "Client" is often used to refer to a person with whom you have been engaged in a therapeutic relationship. You might prefer to use another noun that better represents your work (e.g., "patient").

6.   How often do you work with clients/patients experiencing both mental health and AOD problems?

Never 0
Rarely 1
Sometimes 2
Often 3
All the time 4

7.   Please indicate how much you agree or disagree with each of the following statements:

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Don't Know	Not Applicable
A client/patient's mental health symptoms must be treated before treatment for their AOD can be effective	☐	☐	☐	☐	☐	☐
A client/patient's AOD symptoms must be treated before treatment for mental health can be effective	☐	☐	☐	☐	☐	☐
A client/patient with co-occurring mental health and substance use disorder should have two therapists/providers: one to treat each problem.	☐	☐	☐	☐	☐	☐
Treatments designed for mental health are insufficient for client/patients who also experience AOD problems	☐	☐	☐	☐	☐	☐
Treatments designed for substance use disorders are insufficient for client/patients who also experience mental health disorders	☐	☐	☐	☐	☐	☐

As a general rule, my agency/service tends to refer client/patients experiencing co-occurring mental health disorders and AOD problems to another provider or agency	☐	☐	☐	☐	☐
I regularly assess for mental health symptoms in my practice with clients/patients	☐	☐	☐	☐	☐
I regularly assess for AOD and substance-related problems in my practice with client/patients	☐	☐	☐	☐	☐
It is important to provide holistic care to clients/patients experiencing co-occurring mental health disorders and AOD problems	☐	☐	☐	☐	☐

8. How beneficial would you find the following in assisting you in your work with clients/patients experiencing co-occurring mental health and AOD problems?

	Not at all beneficial	Somewhat beneficial	Extremely beneficial
Guidance in prioritising treatment goals/objectives (e.g., whether to focus on the substance use or mental health)	☐	☐	☐
Training in evidence-based treatments for co-occurring mental health and AOD problems	☐	☐	☐
Training about mental health/AOD disorders (e.g., features, causes, other etc)	☐	☐	☐
Access to a treatment manual for co-occurring mental health and AOD problems	☐	☐	☐
Clinical supervision	☐	☐	☐

9. Are there any other resources that would assist you?

_____

_____

_____

_____

10. How *challenging* is it for you to work with clients/patients who experience:

	Not challenging	A little	Moderately	Extremely	Not applicable
Depression alone	☐	☐	☐	☐	☐
Anxiety alone	☐	☐	☐	☐	☐
PTSD alone	☐	☐	☐	☐	☐
Bipolar alone	☐	☐	☐	☐	☐
Psychosis/schizophrenia alone	☐	☐	☐	☐	☐
Eating disorders alone	☐	☐	☐	☐	☐
Self-harm/self-injurious behaviours (e.g., cutting, burning) alone	☐	☐	☐	☐	☐
AOD alone	☐	☐	☐	☐	☐
Any co-occurring mental health problems	☐	☐	☐	☐	☐
Co-occurring mental health and AOD problems	☐	☐	☐	☐	☐

11. How *rewarding* is it for you to work with clients/patients who experience:

	Not rewarding	A little	Moderately	Extremely	Not applicable
Depression alone	☐	☐	☐	☐	☐
Anxiety alone	☐	☐	☐	☐	☐
PTSD alone	☐	☐	☐	☐	☐
Bipolar alone	☐	☐	☐	☐	☐
Psychosis/schizophrenia alone	☐	☐	☐	☐	☐
Eating disorders alone	☐	☐	☐	☐	☐
Self-harm/self-injurious behaviours (e.g., cutting, burning) alone	☐	☐	☐	☐	☐
AOD alone	☐	☐	☐	☐	☐
Any co-occurring mental health problems	☐	☐	☐	☐	☐
Co-occurring mental health and AOD problems	☐	☐	☐	☐	☐

12. How *confident* are you in working with clients/patients who experience:

	Not confident	A little	Moderately	Extremely	Not applicable
Depression alone	☐	☐	☐	☐	☐
Anxiety alone	☐	☐	☐	☐	☐
PTSD alone	☐	☐	☐	☐	☐
Bipolar alone	☐	☐	☐	☐	☐
Psychosis/schizophrenia alone	☐	☐	☐	☐	☐
Eating disorders alone	☐	☐	☐	☐	☐

Self-harm/self-injurious behaviours (e.g., cutting, burning) alone	☐	☐	☐	☐	☐
AOD alone	☐	☐	☐	☐	☐
Any co-occurring mental health problems	☐	☐	☐	☐	☐
Co-occurring mental health and AOD problems	☐	☐	☐	☐	☐

13. How *prepared* do you feel in treating clients/patients who experience:

	Not prepared	A little	Moderately	Extremely	Not applicable
Depression alone	☐	☐	☐	☐	☐
Anxiety alone	☐	☐	☐	☐	☐
PTSD alone	☐	☐	☐	☐	☐
Bipolar alone	☐	☐	☐	☐	☐
Psychosis/schizophrenia alone	☐	☐	☐	☐	☐
Eating disorders alone	☐	☐	☐	☐	☐
Self-harm/self-injurious behaviours (e.g., cutting, burning) alone	☐	☐	☐	☐	☐
AOD alone	☐	☐	☐	☐	☐
Any co-occurring mental health problems	☐	☐	☐	☐	☐
Co-occurring mental health and AOD problems	☐	☐	☐	☐	☐

14. How *difficult* are each of the following *client-oriented* factors for you in working with your clients/patients who experience co-occurring mental health and AOD problems:

	Not at all	A little	Moderately	Extremely
Clients/patients' anger	☐	☐	☐	☐
Clients/patients' crying/sadness	☐	☐	☐	☐
Trying to de-escalate clients/patients (e.g., when clients/patients are agitated or upset)	☐	☐	☐	☐
Hearing painful details of trauma	☐	☐	☐	☐
Clients/patients' self-harm (e.g., cutting, burning, suicidal thinking)	☐	☐	☐	
Clients/patients' dependency (e.g., needing a lot of care)	☐	☐	☐	☐
Setting boundaries with clients/patients	☐	☐	☐	☐
Relationship problems (e.g., peer problems, intimate partner violence)	☐	☐	☐	☐
AOD problems	☐	☐	☐	☐

15. How *difficult* are each of the following *treatment-oriented* factors for you in working with your clients/patients who experience co-occurring mental health and AOD problems:

	Not at all	A little	Moderately	Extremely
Not knowing how to work with them	☐	☐	☐	☐
Not wanting to disrupt rapport	☐	☐	☐	☐
Case management (e.g., finding services, referrals, etc.)	☐	☐	☐	☐
Working with clients/patients' parents/caregivers	☐	☐	☐	☐
Prioritising treatment components/goals	☐	☐	☐	☐
Deciding what kind of treatment approach to use	☐	☐	☐	☐
Not feeling knowledgeable about AOD problems	☐	☐	☐	☐
Not feeling knowledgeable about mental health	☐	☐	☐	☐

16. How *rewarding* are each of the following for you in working with your clients/patients who experience co-occurring mental health and AOD problems:

	Not at all	A little	Moderately	Extremely
Helping clients achieve their AOD goals	☐	☐	☐	☐
Teaching clients/patients new coping skills	☐	☐	☐	☐
Developing expertise in working with these clients/patients	☐	☐	☐	☐
Obtaining insight about yourself through working with these clients/patients	☐	☐	☐	☐
Working with clients/patients' parents and families	☐	☐	☐	☐
Working with challenging/complex clients/patients	☐	☐	☐	☐

17. Do you have any additional comments?

_____

_____

_____

_____

18. When one of your clients/patients experiencing both mental health and AOD problems presents to your service, what are the next steps?

Refer them to mental health services 0
Refer them to drug and alcohol services.. 1
Address their mental health condition (and connect them with an AOD service provider for their substance use) 2
Address their AOD problem (and connect them with a mental health service provider for their mental health condition) 3
Address both their mental health and substance use conditions concurrently, yourself 4
Other.. 5
(*specify*_____)

19. How knowledgeable are you of the mental health and AOD services available in CESPHN?

	I have no idea what services are available	I know of some services	I have good knowledge of what services are available
Mental health	☐	☐	☐
AOD problems	☐	☐	☐
Mental health and AOD problems	☐	☐	☐

20. When referring clients/patients experiencing mental health and AOD problems to another service provider, in general, how do you select which provider to refer to? *(choose all that apply)*

Refer to local services.. 0
Refer to services where I know the clinicians/providers, and know they will do a good job
.... 1
Refer to services that the client/patient requests 2
Refer to services that are close to the client/patient 3
Do a quick online search, and choose one that looks ok 4
Other (specify) 5
(specify_____)

21. What type of referral do you typically provide for clients/patients experiencing mental health and AOD problems?

Passive (provide the client/patient with details of the referral agency, and let them make their own appointment) 0
Facilitated (make the appointment for the client/patient on their behalf)........................ 1
Active (contact referral agency/service in front of client/patient and make appointment, provide referral agency/service with professional assessment of client/patient's needs) .. 2

22. Do you have any comments on challenges faced when referring clients/patients, or things that have worked well?

_____

23. Who do you think should be responsible for coordinating care for people who experience both a mental health and AOD problem? (e.g., GP, dedicated case manager, AOD services etc)?

_____

_____

24. How appropriate do you think the following interventions are for people experiencing co-occurring mental health and AOD problems?

	Not at all	A little	Moderately	Extremely
Psychotherapy	☐	☐	☐	☐
Pharmacotherapy	☐	☐	☐	☐
E-health	☐	☐	☐	☐
Physical activity	☐	☐	☐	☐
Complementary and alternative therapies (e.g., dietary supplements)	☐	☐	☐	☐

25. Please place any comments you would like to make below:

_____

_____

_____

_____

26. Do you access up-to-date evidence-based research and resources to assist with your work?

No 0
Yes...1

27. How do you access these resources?

Word of mouth 0
Supervision 1
Library 2
Online (e.g., RACGP, APS websites)...3
Journal databases (e.g., ProQuest, MedLine)............................4
Attending workshops, seminars, conferences 5
Other (please specify)..6 (*specify_____*)

28. What are the main issues you face when working with clients/patients who experience both mental health and AOD problems (e.g., lack of resources or support, not sure how to approach the problem or what to do next)?

_____

_____

_____

_____

29. What would you like to receive further training in?

Identification of mental health disorders...0
Identification of AOD problems...1
Management of mental health disorders 2
Management of mental health disorders 3
Referral practices..4

SECTION C: ABOUT YOUR EXPERIENCE AND TRAINING

This section asks about your background and training.

30. Please check the boxes in the table below to indicate whether you have ever ***completed*** the following types of education or training courses for the following problems.

Type of training	Academic coursework	External training (not provided by employer)	Workplace training (provided by employer)	Conferences /seminars	Workshops	Other (please specify)
Depression	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	
Trauma or PTSD	☐	☐	☐	☐	☐	
Bipolar	☐	☐	☐	☐	☐	
Psychotic/ Schizophrenia	☐	☐	☐	☐	☐	
Eating disorders	☐	☐	☐	☐	☐	
Self-harm/self-injurious behaviours	☐	☐	☐	☐	☐	
AOD problems alone	☐	☐	☐	☐	☐	
Any co-occurring mental health problems	☐	☐	☐	☐	☐	
Co-occurring mental health and AOD problems	☐	☐	☐	☐	☐	

31. Have you ***completed*** any mental health training in the last 12 months?

No, never completed any mental health training 0
No, completed more than 12-months ago...............................1
Yes, completed in the past 12-months....................................2

32. In the context of your entire professional working life, how much experience do you have working with mental health related issues?

Less than 1 year 0
More than 1 year but less than 5 years...................................1
More than 5 years but less than 10 years 2
More than 10 years but less than 15 years 3
More than 15 years 4
Not applicable..5

33. Have you *completed* any AOD training in the last 12 months?

No, never completed any AOD training 0
No, completed more than 12-months ago..............................1
Yes, completed in the past 12-months....................................2

34. In the context of your entire professional working life, how much experience do you have working with AOD-related issues?

Less than 1 year 0
More than 1 year but less than 5 years...................................1
More than 5 years but less than 10 years 2
More than 10 years but less than 15 years 3
More than 15 years 4
Not applicable..5

35. Have you completed any training on co-occurring mental health and AOD conditions in the last 12 months?

No, never completed any co-occurring mental health and AOD training 0
No, completed more than 12-months ago..1
Yes, completed in the past 12-months..2

36. In the context of your entire professional working life, how much experience do you have working with co-occurring mental health and AOD-related issues?

Less than 1 year 0
More than 1 year but less than 5 years...................................1
More than 5 years but less than 10 years 2
More than 10 years but less than 15 years 3
More than 15 years 4
Not applicable..5

37. From the list of activities, what are your *three* main roles when responding to comorbidity (i.e., substance use and mental health related issues) in your workplace? (*Mark up to three responses*)

Referral 0
Screening 1
Assessment 2
Education and/or information provision................................3
Early/brief intervention 4
Crisis management 5
Emergency aid/services..6
Primary or allied health care service delivery 7

Medicine/general practice 8
Client care/support activities 9
Counselling/therapy 10
Case management 11
Health promotion/prevention..12
Community development and/or welfare activities 13
Medication prescribing..14
Withdrawal management...15
Administration 16
Service/program management 17
Training, policy..18
Research 19
Other (please specify)...20 (*specify_____*)

Please choose a number between 1-10 (1=not at all, 10 = completely), to indicate how much you agree with the following:

38.   I enjoy carrying out my work:

39.   I would choose the same career again, knowing then what I know now:

40.   I feel stimulated (energised/gratified/rewarded) by my work:

41.   I feel "burned out" (drained/exhausted) by my work:

42.   I feel effective in my role:

43.   Do you have any other general comments on your experience working with young people with co-occurring mental health and AOD problems?

_____

_____

_____

_____

SECTION D: ABOUT YOUR SERVICE

This section contains a range of questions asking about the service you are CURRENTLY working for.

44.   How would you describe the focus of your primary work setting? *(select as many as apply)*

Mental Health 0
Drug and alcohol/substance abuse 1
Child advocacy/child welfare...2
Juvenile justice...3
School/educational..4
GP/Family medicine...5
Social work...6
Other (please specify)...7 (*specify____*)

You have now reached the end of the survey - thank you very much for taking the time to complete it. If you have any questions or comments, please contact Dr Christina Marel (c.marel@unsw.edu.au).

Thank you again for taking the time to complete this survey.

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