Select Committee Hearing 17 June 2019 – Questions on Notice and Additional Questions
MENTAL HEALTH COMMISSION RESPONSES

Questions on Notice

1. **Evaluation of UCC at RPH (Page 5)**
   The Mental Health Commission (MHC) does not fund the urgent care clinic (UCC) at RPH. We suggest that the question be redirected to East Metropolitan Health Service (EMHS).

2. **Cannabis information session – cost per session for taxpayer, government (Page 6)**
   A review of activity data for CIS provision indicates the cost per session for 2017/18 was $916.00
   *MHC maintains a state-wide network of CIS Treatment Providers to ensure CIS capacity in the form of set appointment times is available ongoing. In addition to set appointment times per Providers, regional Providers are also contracted to provide outreach based capacity either regularly or as required. The MHC Booking Service uses these allocations to directly book people in for their required CIS. The amount of available allocated CIS times is greater than the amount of actual sessions delivered. This is because actual activity is dependent on WA Police CIR issue, and recipient uptake. The cost per session takes into account MHC expenditure for the Booking Systems and MHC purchased Treatment Provider capacity to maintain the state-wide CIS provision, noting the majority of CIRs issued by WA Police are in the Perth Metropolitan area. An increase in CIRs issued by WA Police would reduce the cost per CIS to the taxpayer/government.

3. **Access to AOD Services – wait times (Page 13)**
   The Western Australian Network of Alcohol and Drug Agencies provide to the MHC, on a fortnightly basis, the Western Australian Bed Management Tool for government funded Western Australian AOD residential rehabilitation services, which covers both metropolitan and regional areas.

   For the week commencing 10 June 2019, there were 8 unallocated* beds available within the Perth Metropolitan area. The average wait time between being assessed as ready to enter a residential service and being admitted was between 1 to 31 days.

   Within the regions, there were 35 unallocated beds available, with the average wait time for admission being 3 to 12 days.

   For Community Alcohol and Drug Services (CADS), usually there is a short wait time for day time appointments. If a client wants an evening appointment, there is usually a longer wait time, sometimes up to 4 weeks.

   * Unallocated: The term unallocated is used to describe a bed that is available. Within services, beds may be vacant, but have been allocated to a client. The client may be completing a detoxification program and the allocated bed will be maintained for them until their discharge from detoxification and their admission to the residential rehabilitation service.

4. Drug Intervention sessions (Page 14) – attendance numbers/data

Attendance at all three sessions satisfies the requirement for the Police ODIR issued. While MHC Treatment databases record treatment expiation as 'planned' or 'unplanned', these fields are not specific to the ODIR Scheme and partial attendance of all three required ODISs may on occasion be recorded as 'completed as planned' when the Treatment Provider has not administered all three required ODISs, e.g. in the case of transfer from one to another Provider (generally for geographical reasons).

MHC data for 2017/18 indicates there were 294 Episodes[1] (Treatments) under ODIR referral of which 97% are recorded as completed as 'planned'. Final attendance data, including partial, is held by WA Police systems and clarification can be sought from WA Police. MHC understands from WA Police that the overall expiation for ODIRs issued in 2018 was expected to be 67%.

5. Intervention sessions – Evaluation – (Page 15)

As part of the monitoring of the legislated CIR Scheme, those who attend a CIS are offered a voluntary feedback survey as part of session provision. From 1 Aug 2011 (Scheme onset) – 31 July 2018, 82.6% (n=6459) of CIS participants surveyed indicated they thought a little or a lot about cutting down their cannabis use following their CIS, and of the same participants 73.5% indicated they thought a little or a lot about not using cannabis anymore.

While no such dedicated ODIS feedback survey exists, routine treatment pre and post data for ODIS participants from 2016/17 and 2017/18 indicates that following the last session of ODIS treatment undertaken, for those participants who completed the evaluation[2], an average of:

- 26% of ODIS participants stated they had reduced use of the primary drug of concern
- 30% of ODIS participants stated they had improved physical health
- 37.5% of ODIS participants stated they had improved mental health
- 31% of ODIS participants stated they had improved relationships (social health)
- 35% of ODIS participants stated they had increased confidence to stop or reduce AOD use
- 82.5% of ODIS participants stated they were satisfied with the service provided

[1] Treatment data was extracted from databases held at MHC on 21 June 2018. Whilst the data is considered to be true and correct at the date of publication, changes in circumstances after the time of publication may impact upon the accuracy of the data. The databases are active databases and therefore the data may change without notice. Changes may relate to a number of issues, including amendments made to the databases and variations in syntax used to perform the individual queries. MHC is not in any way liable for the accuracy or repeat reliability of any information printed and/or stored by a user.

[2] Treatment data was extracted from databases held at MHC on 24 June 2018. Whilst the data is considered to be true and correct at the date of publication, changes in circumstances after the time of publication may impact upon the accuracy of the data. The databases are active databases and therefore the data may change without notice. Changes may relate to a number of issues, including amendments made to the databases and variations in syntax used to perform the individual queries. MHC is not in any way liable for the accuracy or repeat reliability of any information printed and/or stored by a user.

No further post treatment attendance evaluation follow-ups are undertaken by MHC or MHC contracted Treatment Providers for CIR or ODIS. Any recidivist or broader evaluation of the CIR/ODIR is a matter for WA Police as the lead agency for the CIR and ODIR Schemes.

Additional Questions

1. **Noting the 10 year Plan update released recently, could you give us a summary of the status of implementation?**
   - The Plan Update 2018 is the first scheduled remodelling of the optimal level and mix of services for Western Australian mental health and AOD services as outlined in the Plan. The Plan Update 2018 is supported by an Infographic (**Attachment 1**) and an At a Glance Summary (**Attachment 2**). This suite of documents is provided as a means of providing a summary of implementation, achievements and changes to the modelling framework in the Plan.
   - The MHC's intention to lead a continuous implementation and review process will be further supported by the mid-term review of the Plan, scheduled to commence in 2020. The mid-term review will be a more comprehensive evaluation, including broader community consultation as well as providing a further update of the modelling framework for all service streams. Additionally there will be further refinement of future priority areas and actions for service development as part of the mid-term review process.

2. **Could you provide an update on the WA Police Force Mental Health Co-Response expansion?**
   - The expansion of the Mental Health Co-Response (MHCR) Program was one of the six Immediate Actions to the Methamphetamine Action Plan (MAP) Taskforce Report (the Taskforce Report). This has since been delivered with a doubling of the mobile teams to expand to a full metropolitan service.
   - On 11 March 2019, the phased expansion of the MHCR Program commenced, where the two new mobile teams in the South (Cockburn; South Metropolitan Health Service) and East (Midland; East Metropolitan Health Service) commenced; and previously established mobile teams in the North (Warwick; North Metropolitan Health Service) and South East (Cannington; East Metropolitan Health Service) increased and adjusted their hours of operation.
   - In addition, the Police Operations Centre and the Perth Watch house have adjusted shift patterns to 10-hour shifts.
   - The Government has allocated $0.2 million funding in 2019-20 to plan for the expansion of the existing MHCR Program to regional areas and to develop a plan for the inclusion of AOD expertise within the program as part of the Full Government Response to the Taskforce Report.
   - Planning for the expansion into regional areas and to also address AOD-related issues would respond to key issues raised throughout the MAP Taskforce Report.

- In May 2019, the Mental Health Co-Response Regional WA Steering Group was established with the purpose of researching relevant data and consulting with relevant stakeholders to assess the potential expansion of MHCR into Regional Western Australia and for the provision of responses to AOD-related cases.

3. **Going forward, will the co-response teams be able to service very regional and remote areas as well as regional hubs?**
   - The specific locations of future MHCR program teams are yet to be determined.
   - The recently established Mental Health Co-Response Regional WA Steering Group aims to plan for the expansion of the MHCR model to regional areas and to include support for AOD issues. The work of this group will provide guidance for regional and/or remote locations and rollout out of co-response teams going forward.

4. **Have the co-response teams been able to avoid trips to either lock-up or the emergency room for people experiencing meth-induced psychosis?**
   - A trial period for the MHCR program ran from January 2016 to January 2018, and a formal evaluation of the trial was completed by Edith Cowan University in April 2018. The evaluation of the trial indicated positive results including reducing the need for consumers to be transported to hospital by Police from 70% to 25%, within the program area, resulting in 1,300 fewer attendances to Emergency Departments.
   - It is noted that the evaluation of the trial did not provide detail of presentations specifically relating to methamphetamine psychosis. However, going forward, it is anticipated that the reporting regarding both mental health and AOD would occur, once the MHCR is expanded to include AOD –related responses.

5. **Have recent legislative changes been effective in dealing with new psychoactive substances, or is further work required?**

   New psychoactive substances (NPS) are variously defined. A popular definition is that they are a range of drugs that have been designed to mimic established illicit drugs, such as cannabis, cocaine, ecstasy and LSD. A psychoactive substance means any substance that, when consumed by a person, has the capacity to induce a psychoactive effect on the person.

   The Western Australian Misuse of Drugs Amendment (Psychoactive Substances) Act 2015 (the Misuse of Drugs Act) contains a definition for the purposes of the Misuse of Drugs Act.

   The Misuse of Drugs Act was proclaimed on 18 November 2015.

   The Misuse of Drugs Act prohibits the sale, supply, manufacture, advertising and promotion of any psychoactive substance, or a substance purported to have a psychoactive effect, unless it is approved through existing legislation or regulation. There are no personal possession offences.

   Complementary legislation was also enacted by the Commonwealth to regulate importation of NPS.

Prior to the Misuse of Drugs Act being proclaimed, the sale, manufacture, advertising and promotion of NPS in Western Australia were unregulated, unless scheduled in the Medicines and Poisons Act 2014 (the MP Act).

Monitoring prevalence and related harm takes time to establish. As harm related to use is established, consideration can then be given to whether the substance warrants scheduling in the MP Act.

In 2011, monitoring systems incorporating harm, treatment and other surveillance indicators were established with the emergence of NPS in Western Australia. This involved the cooperation of different Government agencies including the MHC (the then Drug and Alcohol Office), Health, Police, Consumer Protection and Chem Centre. Coordination activity included:

- State action;
- National action;
- Prevalence and harm;
- Critical Actions Review;
- Identification and harm assessment;
- Monitoring/surveillance system;
- Legislative/regulatory control options:
  - The MP Act;
  - The Misuse of Drugs Act;
  - Consumer law;
  - Other; and
- Communication.

Following proclamation of the Misuse of Drugs Act, a decrease in a number of indicators was observed. This decrease was attributed to:

- The decreased availability and promotion of NPS in the Western Australian market;
- Communication with retailers and the public regarding the Misuse of Drugs Act;
- Some highly publicised enforcement actions by Police regarding sale and supply provisions of the Misuse of Drugs Act; and
- Complementary Commonwealth action targeting importation.

The WA Police Force may be able to provide further information regarding effectiveness when enforcing and investigating the Misuse of Drugs Act.

Whilst the prevalence of NPS use and related harm appears to be significantly reduced, ongoing monitoring and action is required. A need to identify NPS as they emerge still exists. This requires ongoing coordination between agencies and the development of an early warning surveillance system that provides timely and reliable information about NPS availability, use and related harm.

6. **This Committee has heard that despite its focus in the 10 year Plan, there is still little service integration between mental health and alcohol and other drug services.**
   a. **What is the Commission doing to address the cultural and systemic barriers to service integration?**

The MHC works to integrate services to increase the ease of access for consumers, families, carers and the broader community, where they would otherwise have trouble seeking appropriate support, have to seek services from a range of agencies or providers independently or have been unable to have services that meet their needs along the service continuum. Some examples of where the MHC has contributed to reducing the cultural and systemic barriers to service integration are provided below:

- Courses developed and provided by the Western Australian Recovery College will address both mental health and AOD-related topics, and will be made available to the community. The Recovery College will address cultural barriers to service integration, and strengthen integration between the mental health and AOD services, consumers, families and carers.
- As part of funding provided for additional Methamphetamine Action Plan (MAP) initiatives, $0.2 million was allocated to plan for the expansion of the Mental Health Police Co-Response model to regional areas and to include support for AOD issues, enhancing service integration. A Mental Health Co-Response Regional WA Steering Group has been established, and contains representatives from WA Police, the WA Country Health Service (WACHS) and the MHC.
- Stabilisation Assessment and Referral Areas (SARA) – The MHC is planning to enable the development of new SARAs to complement the current continuum of mental health and AOD services, across Western Australia. SARA's are similar to Mental Health Observation Areas and would provide assessments to manage behavioural emergencies amongst individuals experiencing mental health and/or AOD related crisis.
- One-Stop Shop – Making help easier to find with the development of a One-Stop Shop (OSS) to better support individuals and families was one of the six Immediate Actions to the MAP Taskforce Report (the Taskforce Report). The OSS project will oversee the development of a complementary online service directory of AOD and mental health services that are available across Western Australia and contribute to improved service integration and access to mental health and AOD support.
- The MHC has developed, and is in the process of developing, a number of statewide strategic documents guiding the current and future development of the mental health and AOD sectors which aim to address and support service integration between mental health and AOD services. This includes the Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (complete), the Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2019-2025 (due for release mid-2019), and the draft Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025 (due be released in the second half of 2019).

- Included in the Full Government Response to the Western Australian Methamphetamine Taskforce Report, are a number of initiatives to support the workforce in responding to people impacted by methamphetamine use and their families. This includes:
    - $914,000 for AOD training for Aboriginal workers through the Strong Spirit Strong Mind program;
    - $614,000 towards AOD training for frontline workers such as psychologists, social workers and counsellors; and
    - $457,000 for the Meth Peer Education Program which focuses on harm reduction and health promotion.

These initiatives can contribute to improved service integration amongst the mental health and AOD sectors and can build the capacity of the workforce to respond to changing environments and emerging issues being faced by the mental health and AOD sectors.

Additionally, people with co-occurring mental health and AOD issues are identified as a priority group for the AOD services funded by the MHC. All funded AOD services are required to provide appropriate programs for people experiencing co-occurring AOD and mental health problems. Services are required to demonstrate that their service model addresses the needs of this group and that they have appropriate partnership arrangements with the providers of mental health services to ensure that clients receive coordinated care.

The MHC will be developing a shared Outcomes Framework across the mental health and AOD sectors. The intention is to ensure that individuals with mental health, AOD and co-occurring issues will gain better access to services and have their needs met. It is the intention of the MHC to undertake this work in collaboration with the AOD and mental health sectors in developing these outcomes.

Specific examples to develop the capacity of the mental health and AOD sectors to provide services for people with co-occurring problems are included below:

- Co-location of Wheatbelt Community Alcohol and Drug Service and Wheatbelt Mental Health Service

  The Wheatbelt CADS is provided by Holyoake and has its main office in Northam. Smaller offices in Merredin and Narrogin are co-located with the Wheatbelt Mental Health Service teams. The key benefit of co-location has been the building of collaborative working relationships which has contributed to effective referral pathways, opportunities for professional informal consultation in relation to AOD and mental health issues, integrated care arrangements and shared training opportunities.

- South Metropolitan – Memorandum of Understanding between AOD services and Mental Health Services

  The longstanding South Metropolitan Memorandum of Understanding (MOU) which was reviewed and re-signed in 2018 is between the following services:

    - South Metropolitan Community Alcohol & Drug Service (Palmerston and Next Step); South East Metropolitan CADS (Palmerston and Next Step), Next Step In-patient Withdrawal Unit (East Perth) and Palmerston Residential Service;

- Peel and Rockingham and Kwinana Mental Health Services of South Metropolitan Health Services; and
- Fiona Stanley Fremantle Hospital Group.

The purpose of the MOU is to support liaison, communication, consultation and shared practices between local AOD services and mental health agencies and to assist in building the capacity of these services to manage co-occurring problems to a high standard.

The presence of dual diagnosis clinical nurse specialists (DDCNS) in the South Metropolitan Mental Health Services is highly supportive of the MOU. The DDCNS positions provide a specialist link between AOD and mental health services, and are frequently called upon for consultation and shared care of consumers presenting with co-occurring issues.

- Kimberley Mental Health and Drug Service

  Kimberley Mental Health and Drug Service is composed of mental health staff from the public mental health service and AOD staff from the Kimberley Community Alcohol and Drug Service (KCADS). All clients aged 14 years and older are initially referred through the mental health triage service. This is in recognition of very high rates of comorbidity and as such, provides opportunity for a mental health as well as AOD assessment. Those clients assessed as having both mental health and AOD issues are jointly case managed by mental health and KCADS workers, including regular shared care meetings. Mental health and KCADS staff travel together on outreach visits on a monthly basis to co-manage clients and respond to community issues in regional towns and remote communities. A similar model is being implemented in the Midwest where WACHS are the providers of the Midwest CADS.

- Service Level Agreement between Richmond Wellbeing and the Holyoake North East Community Drug Service (NEMCDS)

  The Service Level Agreement between Richmond Wellbeing (RW) and the Holyoake North East Community Drug Service (NEMCDS) establishes collaborative working arrangements to address the needs of the large number of clients of both agencies who experience co-occurring mental health and drug and alcohol problems. Collaborative arrangements include outreach from NEMCDS to RW in Bassendean and Queens Park. The visiting counsellor provides one to one counselling and group sessions and participates in case management planning and review. Workers from NEMCDS and RW Bassendean liaise with the partner service regarding relevant referrals, and support referrals between the two services at site level meetings, communicating bi-monthly at the RW staff meeting to promote the relationship between the services.

- Albany Step up and Step down (Neami National)

  The Albany Community mental health step up/step down service will include in their staffing profile a dedicated AOD worker to support and liaise with local AOD groups. Neami National will use evidence-based techniques such as the Alcohol, Smoking and Substance Involvement Screening Test. This tool was developed for the World Health Organisation by an international group of addiction specialists as a tool that is easy to use to identify substance use and related problems.

- Services in the Midwest

  Midwest Mental Health & Community Alcohol & Drug Service (MMH&CADS) merged in 2016/17 and has undergone a comprehensive reform process implementing a new model that assists Midwest consumers of mental health and alcohol and drug services by providing a 'no wrong door' approach. The community team works closely together to provide a single point of entry and early assessment, and appropriate ongoing treatment and referrals.

  MHC purchases the provision of mental health and drug and alcohol services from WACHS in the Midwest region. In 2017/18 MHC provided an additional $1.8 million. In 2018/19 and 2019/20 $2.5 million was invested in each of the financial years for these improvements.

b. We have heard that the number of people with co-occurring substance use disorder and mental illness is increasing over time. Does the Commission collect this data?

If so, can you please provide it to the Committee? Note: please refer to SHIP study in OCP transcript for more information. Please see attached link http://www.parliament.wa.gov.au/Parliament/Chief Psychiatrist transcript

- The MHC does not collect data on co-occurring substance use disorders and mental illness. National data is available from the Australian Survey of High Impact Psychosis and the National Drug Strategy Household Survey.
- The 2010 Australian Survey of High Impact Psychosis was a national survey of 1,825 adults aged 18-64 years with a psychotic illness published by the Commonwealth.
- The 2016 National Drug Strategy Household Survey is an ongoing population-based survey of alcohol, tobacco and illicit drug use in Australia coordinated by the Australian Institute for Health and Welfare.
- Both surveys show a rise in the co-occurrence of substance use and mental illness in Australia over their respective time periods.
- The 2010 Australian Survey of High Impact Psychosis reports increases between 1997-98 and 2010 in:
- The proportion of people with psychosis who report lifetime alcohol abuse/dependence (1997-98: 29.0%, 2010: 50.5%).
- The proportion of people with psychosis who report lifetime drug abuse/dependence (1997-98: 30.4%, 2010: 56.4%).
- A smaller Survey of High Impact Psychosis was conducted in North Metropolitan Area Health Service in 2012.
- The sample included 250 adults aged 18-64 years with a psychotic illness.
- The proportion of lifetime drug abuse/dependence and lifetime cannabis abuse/dependence in the North Metropolitan Area Health Service in 2012 were comparable with estimates provided in the 2010 Australian Survey of High Impact Psychosis.

- The 2016 National Drug Strategy Household Survey reports increases between 2010 and 2016 in the proportion of people diagnosed or treated for select types of mental illness amongst those who have used an illicit drug.
- Of people aged 18+ years who report having used an illicit substance in the last month, the proportion diagnosed or treated for a mental illness has increased from 20.4% to 29.2%.
- Of people aged 18+ years who report having used marijuana/cannabis in the last month, the proportion diagnosed or treated for a mental illness has increased from 20.5% to 30.5%.
- Of people aged 18+ years who report having used meth/amphetamine in the last month (for non-medical purposes), the proportion diagnosed or treated for a mental illness has increased from 25.4% to 46.1%.
- Updated NDSHS estimates for 2019 are expected to be available in 2020.

7. The Mental Health Commission oversees the delivery of Cannabis Intervention Sessions and Other Drug Intervention Sessions.

a. What is the rationale for having one session for cannabis possession and three sessions for other drug possession?

Both Cannabis Intervention Requirement (CIR) and Other Drug Intervention Requirement (ODIR) are Police led Diversion schemes. Their primary purpose is to act as a gateway to direct the offender to a health response for simple illicit drug use offending. The intent of diversionary initiatives is to offer specialist assistance to individuals that explores their drug using behaviour, and provides the opportunity for further engagement as a self-referral following completion of the mandated session/s.

The rationale for the intervention length for both CIR and ODIR was determined by WA Police and the former Drug and Alcohol Office (pre merge with the MHC). It is likely that the longer intervention for other drug possession was determined based on the presenting needs of people with amphetamine and opioid use being more complex.

b. Are the sessions used as an opportunity to ascertain if the person requires additional support or treatment?

As with all diversionary initiatives and programs managed by the MHC, CIS and ODIS Treatment Providers offer the opportunity for the participant to engage in further treatment. Referral to other services for support with needs beyond the scope of specialist AOD treatment services also features. Any further engagement subsequent to the CIS, whether immediately following the CIS/ODIS or at a later date, is non-mandated and captured as a self-referral.

8. **Has there ever been a case of someone admitted to Graylands while experiencing meth psychosis, then released soon after as they cannot be detained under the Mental Health Act 2014?**
    - In certain circumstances, the *Mental Health Act 2014* (the Act) allows for a person to be detained and given treatment on an involuntary basis. An involuntary treatment order can only be made if all the criteria required in the Act are met. The decision to make (or not make) an involuntary treatment order is a clinical decision made by a psychiatrist.
    - This criteria includes: that the person has a mental illness that requires treatment; that there is significant risk to the person or another person; that the person is not well enough to make decisions about treatment; and that there is no less restrictive way of providing the person with treatment.
    - The Act states that a person has a mental illness if the person has a condition that is characterised by a disturbance of thought, mood, volition, perception, orientation or memory, and that significantly impairs (either temporarily or permanently), the person's judgement or behaviour.
    - The Act notes that a person does not have a mental illness merely because he or she uses alcohol or other drugs. However, the Act also notes that this does not prevent the serious or permanent physiological, biochemical or psychological effects of the use of alcohol or drugs from being regarded as an indication that a person has a mental illness. As noted above, this assessment is a clinical decision to be made by a psychiatrist in accordance with the provisions of the Act.
    - For specific information regarding individual cases and admissions to Graylands, data would need to be sought from the North Metropolitan Health Service. The MHC does not have access to this data.

9. **In those regions that do not currently have inpatient mental health services, are patients on involuntary treatment orders detained in general hospitals?**
    - The Act allows for persons, who are subject to involuntary treatment orders, to be detained at a general hospital.
    - Where this occurs, the Act requires that the treating psychiatrist at the general hospital is to report to the Chief Psychiatrist about various treatment matters, at the end of each 7-day period that the person is detained in the general hospital.
    - For specific information regarding patients on involuntary treatment orders detained in general hospitals, data would need to be sought from the Department of Health. The MHC does not have access to this data.

10. How much funding in the prevention space comes from the Commonwealth?

MHC only receives National Health Reform Agreement (NHRA) funding from the Commonwealth which is allocated to expenditure on Hospital Bed Based Services and Community Treatment. Therefore, the Commonwealth provides no funding to MHC for prevention services.