EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 8 JUNE 2010

SESSION THREE

Members

Dr J.M. Woollard (Chairman)
Mr P. Abetz (Deputy Chairman)
Ms L.L. Baker
Mr P.B. Watson
Mr I.C. Blayney

Hearing commenced at 11.40 am

GUARD, MR NEIL STUART
Acting Commissioner, Mental Health Commission,
examined:

JAMES, MR DAVID WYNNE
Manager, Mental Health Commission,
examined:

The CHAIRMAN: Good morning. On behalf of the Education and Health Standing Committee, I would like to thank you both for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference. At this stage I would like to introduce myself, Janet Woollard, and Mr Peter Abetz, Mr Ian Blayney and Mr Peter Watson. On my right is our principal research officer, Dr David Worth, and we also have Caroline and Liam from Hansard.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure of the Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee, and did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: Would you now please state your full name and the capacity in which you appear before the committee?

Mr N. Guard: My name is Neil Stuart Guard, and I appear as the Acting Commissioner of the Mental Health Commission.

Mr D.W. James: My name is Wynne James and I am the manager of the strategy, policy and planning directorate of the Mental Health Commission.

The CHAIRMAN: Thank you very much. We will not get caught out again! We might ask you if you would like to make your presentation now, and then we will go around the table and ask you some questions.

Mr N. Guard: That is absolutely fine. Thank you very much for the invitation and the opportunity to meet with the standing committee today. We understand from the letter that we received on 19 May and my subsequent conversation with Dr Worth that the main evidence the committee seeks from us relates to term of reference 2 about the broader social cost to Western Australia of the consumption of alcohol and the associated drinking culture. In particular, I understand that the committee is looking to us for information in relation to the mental health associations of alcohol and drug use. That is primarily how we have focused today, although some of the information that we have built into the presentation also relates to associations with illicit drug use. That is not the primary focus, but we will present some of that information as well. My understanding is that we have about an hour in total, so we thought we would pull together some brief slides and information. It might be best for the committee to interrupt as we go along, if that is how the committee would prefer to do it, and ask questions and probe as we go, if that is fine.

The CHAIRMAN: Thank you.

Mr N. Guard: Firstly, some alcohol-related statistics. Alcohol misuse in Western Australia, and in Australia generally, presents some very serious and substantial issues. In Australia, it is second only to tobacco as the leading preventable cause of death and hospitalisation, and that comes from the Ministerial Council on Drug Strategy's "National Drug Strategy: Australia's Integrated Framework 2004–09". It is conservatively estimated that alcohol costs the Australian community some $15.3 billion a year when factors such as crime, violence, treatment costs, loss of productivity and premature death are taken into account; that is from research conducted by Collins and Lapsey in 2008. The cost of third parties might not have been well accounted, suggesting that that figure may well be an underestimate rather than an overestimate.

It is also estimated that 61% of alcohol consumed in Australia —

The CHAIRMAN: Could I just ask: the Collins and Lapsey research was Australia-wide; has any research been done within Western Australia to look at the cost to the community?

Mr N. Guard: That study, as the Chair rightly says, was an Australian study. The Drug and Alcohol Office is trying to do some work in this particular area specific to Western Australia. I am not sure whether that has been presented or finalised as yet, but it is actually trying to do that at a Western Australian level, so that we end up with the Western Australian story. That is my understanding.

It is estimated that 61% of alcohol consumed in Australia is above the recommended alcohol guidelines. This is for short-term and long-term harm. That statistic comes from the Ministerial Council on Drug Strategy's "National Drug Strategy: Australia's Integrated Framework 2004–09". More specifically, in 2008 Heale et al estimated that 51% of alcohol consumed is drunk at levels that pose a risk of short-term harm. That is where that particular statistic comes from. Regular drinking above recommended health limits presents significant impacts for the Australian health system. In 2006 in Western Australia, total alcohol-related hospitalisation costs, other than emergency room presentations, were estimated at more than $33 million. In 2005–06, the cost of alcohol-related emergency department attendances for injury and assault was estimated at $7.15 million, which excluded road trauma and law enforcement costs. In addition, in 2006 the cost of conditions such as alcohol intoxication and withdrawal in all metropolitan emergency departments was more than $1.15 million. There are some significant costs associated with the impact of alcohol on the health system of Western Australia.

ABS data from 2005 estimated that one in eight adults—approximately two million people—drink at risky or high-risk levels. It is estimated in research conducted by Dr Tanya Chikritzhs in 2007 that more than 3,000 Australians die each year as a result of harmful drinking.

The CHAIRMAN: That one in eight in 2005 would have been based on the previous guidelines, so that would probably be much higher, given the current guidelines.

[11.50 am]

Mr N. Guard: Which actually set the limits. It could well do.

In summary, the long-term harmful use of alcohol is associated with a variety of adverse health effects and is a major risk factor for conditions such as stroke, depression, liver disease, cardiovascular disease, pancreatitis, diabetes, some types of cancer and mental illness. That is the perspective of the data that we have here today.

Looking specifically at mental illness and substance use, the data specific to Western Australia is actually fairly scarce, largely because the data on clients with mental health and AOD problems accessing Western Australian services is not reliably collected. We need to properly work on that area. However, studies frequently indicate high rates of substance use by people being treated for mental illness, such that many now argue that dual diagnosis, which is some of the terminology that is now used, should be seen as the expectation rather than the exception. I will pass across to Wynne to talk about these in a moment. For example, a 2007 population health study in Victoria suggested that at least half of all Australians with a mental health disorder also have an alcohol or other drug issue. A 2005 Australian study by Burns, Teesson and O'Neill, which is titled "The impact of comorbid anxiety and depression on alcohol treatment outcomes" found that 69% of people in outpatient treatment for alcohol problems had at least one co-occurring depressive or anxiety disorder. The most common was depression, followed by generalised anxiety disorder and social phobia. The 2008 National Drug Strategy Household Survey first results reported that in 2007 around 15.3% of Australians aged 18 and over who were at high risk of alcohol-related harm in the short term also experienced high or very high levels of psychological distress. The Australian Bureau of Statistics' "National Survey of Mental Health and Wellbeing: Summary of Results, 2007" reported that 21.4% of those diagnosed with a mental disorder in the past 12 months consumed alcohol every day. There are some close linkages based on that data. Those that I just quoted are consistent with many of the landmark studies, such as those of Regier et al, which is shown on the slide. I will pass across to Wynne who has pulled together the next sequence of slides.

The CHAIRMAN: I think it is said that one in five people will at some stage in their life develop a mental illness. Do you know how much alcohol was drunk in the community 10 years ago—was it one in five or one in 10? Has there been an increase in the consumption of alcohol with a subsequent increase in the number of people who develop a mental illness? Do you have that data on that or are you able to get that data for us?

Mr N. Guard: The stat generally quoted is that one in five will experience some type of mental health disorder in a year and it is something like —

The CHAIRMAN: Within a year? I thought it was within their lifetime?

Mr N. Guard: It is one in five within a year.

The CHAIRMAN: Oh my goodness!

Mr N. Guard: One in five will, within a year, have experienced a mental illness of some type in the past 12 months and it is something like 46% in a life time. It is more significant when we talk about lifetime stats. I am not aware of any data that looks at alcohol consumption levels and mental illness prevalence 10 years ago. We can look to see whether we can find any data.

The CHAIRMAN: We are looking at which way the correlation works.

Mr D.W. James: We will delve into that!

The CHAIRMAN: Will you try to provide that information by way of supplementary information?

Mr N. Guard: So that we are clear about what you are after, you are looking at alcohol trends over a period of years and mental illness and mental health trends and whether there is a link between the two.

The CHAIRMAN: Yes.

Mr D.W. James: You are probably wondering why I have included a nearly 20-year-old study. This study is called the "Epidemiological Catchment Area Study" and it was conducted in America. It looked at about 20 000 consumers of mental health services who met criteria stringent enough to be categorised as people having mental disorders. It was a landmark study, because for the first time the extent of substance use amongst this population was identified. There has been a lot of research done on comorbidity or dual diagnosis, terms that are used interchangeably. What we have understood from this is that people with a mental illness were using substances at very high levels, much higher than we previously thought. The implications—I will talk more about those —are quite serious. It was a landmark study and studies that have been replicated within other industrial nations and within nations Australia, while statistics are slightly different here and there, it is all a ballpark figure. Everybody is reporting the same sort of things. If a person has a serious mental illness, he or she is more likely to have a substance-use disorder and vice versa.

When we look at alcohol use and we start to narrow things down, people with a severe mental illness—when I talk about severe mental illness, I mean low prevalence disorders, such as schizophrenia and bipolar disorder, which affect a low prevalence in the community, say between one and three per cent. When you look at their use of substances it is quite remarkable. About 40% of those with a severe mental illness will experience an alcohol-use disorder at some time during their life and something like 12% within any 12 months. When you look at people who present to services not with a primary mental illness, but with substance-use disorder as their primary issue, they also have high rates of both low prevalence disorders and high prevalence disorders, such as anxiety, depression and antisocial personality disorder, with women being more prone to high prevalence disorders.

The CHAIRMAN: Was that looked at in age groups? Is there more of an effect in those relationships —

Mr D.W. James: There is a breakdown in terms of age. I do not have that data with me, but I could provide it.

The CHAIRMAN: That would be interesting to see whether there is a relationship, particularly in the younger drinker.

Mr D.W. James: The next slide refers to an interesting study done at Fremantle where consumers of mental health services, both inpatient and community services, were asked about their use of substances in the month leading up to their contact with the service. It is a self-report; it was not supported by any biochemical or urinalysis. Again, we start to see the flavour of the extent of substance use amongst consumers of mental health services. I think the more astonishing statistic is that about 47% are using more than one substance within the month leading up to their contact with mental health services. This is WA, this is Fremantle—this is real life people using our mental health services. It probably would have been higher if we had asked for a urine analysis to be undertaken.

The CHAIRMAN: That could be alcohol and cannabis or alcohol and cocaine?

Mr N. Guard: Yes. We are not aware of that having been done since 1999.

Mr D.W. James: We are not aware of any Western Australian-based data to the extent of this data.

What are the effects of alcohol use on mental health? The impact will depend on the type and severity of alcohol use and of the mental illness. Somebody with an anxiety disorder who is drinking slightly above the recommended level will have a different treatment path than, say, somebody with schizophrenia who is clearly alcohol dependent. What we do understand is that the risks for comorbidity and suicide are almost six times greater. If a person has a concurrent mental health problem and a substance-use disorder, he or she is six times more likely to commit suicide or

attempt suicide than those who do not. We also know that with treatments they attend more often and they stay longer. Their treatment is more costly and they use up the limited available resources.

The CHAIRMAN: Neil, in your new role as the Mental Health Commissioner, what relationship do you have with the hospital sector, both tertiary and secondary?

Mr N. Guard: We purchase specialised mental health services from the public health sector. We are not a provider of services; we are a purchaser of services. The commission's roles are the policy planning and purchasing in particular, not the providing part. That has been removed from the department and we purchase those services from the public health system, the private provider system, the community system and the non-government organisation system. We are not a provider of those services

The CHAIRMAN: Are you able to put in any provisos within contracts.

Mr N. Guard: Yes.

The CHAIRMAN: Now might be an appropriate time given that we are talking about the increased risk of suicide to mention the committee's report that was presented to Parliament last month. It referred to the guidelines that should be followed if someone has attempted suicide. A person who has attempted suicide should be contacted within six day of leaving hospital. That is not being done in Western Australia. In terms of your relationships and contracts, are you able to ensure that we meet those national standards?

Mr N. Guard: We will certainly be looking at contracts, including a range of clauses around discharge planning and expectations, including follow-up contact. We have the ability to spell out expectations as far as policy and practice is concerned and build those things into contractual agreements. As part of the service monitoring, we can try to monitor the extent to which that is being achieved.

[12 noon]

In fact I think the discharge follow-up is also one of our own performance indicators, so it is there as part of the performance indicators for the commission.

The CHAIRMAN: So how will we as a committee be able to check on what has happened over the next few months? It is just that we would like to know that that was followed-up on. We will get a report, obviously, from the minister but that may not have been sufficient time for you to have set something in process. When do you see being able to set something like that in process?

Mr N. Guard: We will be starting to put in place service level agreements, memoranda of understanding and contracts almost immediately. Now that the mental health budget has been extracted from the bigger Department of Health budget, we will be purchasing services back from the department and also from non-government organisations and community providers. So, the template for that and the clauses that we build in that will progressively develop over time, but this can be one of those that I can advise you on as to whether we have made progress in building something along this line into those service agreements.

The CHAIRMAN: Thank you. If we could have that by way of supplementary information, we would very much appreciate that.

Mr N. Guard: That is good.

Mr D.W. James: The effects are not positive effects; they are generally negative effects. There are poorer treatment outcomes with that, such as a worse illness course, a patient being more difficult to manage within inpatient community settings and being at a higher risk of incarceration and all these things.

When we discussed the presentation today, Neil and I pulled data from our mental health information system which looks at service utilisation within our public mental health settings. We

asked the data set to tell us how many people were admitted to our inpatient services with either a primary or a secondary diagnosis of an alcohol disorder. When people are admitted to our mental health settings, everybody is obviously given a diagnosis and we are able then to categorise people according to those diagnoses and count them. There was quite interesting data within the year 2008–09; two% across the public mental health bed stock were admitted with a primary reason of alcohol and 14% with a secondary diagnosis. When we look at Graylands data—we look at Graylands because it provides a statewide function and sometimes a different set of results than just our broader area-based services—we are getting the same in a much significantly higher level of secondary reasons, and that could be related to people coming in from country, clearly, without having these issues addressed first and then being addressed within Graylands. So three% are actually admitted with a primary diagnosis of alcohol being the main driver that they end up in public mental health services. Nearly one in five also has it as a secondary issue too. Again, this really supports the sorts of rates and levels that we are seeing within our psychiatric populations, but that is not reflective in our community settings. That probably is to do with our broader range of services out there. The reason that people require inpatient services is probably related to situational crises, or a combination of the two causes such significant safety issues for people that their illnesses becomes unmanageable and they require inpatient status to help stabilise matters for them.

When you look at illicit substances as being the main reason for admission, this increases the primary reason for admission to four% and the secondary reason to 18 per cent. It is higher again when you look at Graylands. Again, I think that is a reflection probably of the availability of resources across the WA country health regions where there is not the availability of inpatient beds to help stabilise people—perhaps secondary to a drug-induced psychosis—so they end up becoming brought in by the Royal Flying Doctor Service and treated at Graylands. These sorts of statistics really support the landmark studies that were done and reflect a significant burden being placed on mental health services.

The CHAIRMAN: In relation to those people who are now coming into Graylands and are being transported by the Royal Flying Doctor Service, would you be able to provide us with the data for the last, say, two financial years in terms of the number of people who have come initially, I guess, to be admitted to Graylands or to one of the other mental health hospitals, who in fact were diverted to maybe Royal Perth or Charles because of asphyxia? I believe in the Kimberley there is now a protocol for dealing with these patients. As a committee we are in fact going up to the Kimberley in two months. I do not know with your breakdown later today whether you actually have the data that breaks down mental health problems by the metropolitan area and the regional areas, but I am told that there is a very high incidence in the Kimberley and whilst there are going to be four acute mental health beds at Broome District Hospital, I do not think they are necessarily going to be able to deal with them. I think there will be a need for many patients to be coming down and so I am interested in —

Mr N. Guard: Can I just check whether you want the numbers that are being flown down largely from country areas generally or just from the Kimberley?

The CHAIRMAN: I am particularly interested in those from the Kimberley, because I am wondering whether the —

Mr P.B. WATSON: What about the number down south?

The CHAIRMAN: I am sorry, do you think there is a problem down south too, then?

Mr P.B. WATSON: Yes.

Mr N. Guard: So the Royal Flying Doctor Service into Perth.

The CHAIRMAN: Into Perth, because we need to see how many mental health beds there are in those regional areas because it is a great cost bringing someone down.

Mr N. Guard: Yes.

The CHAIRMAN: So maybe with those transfers, the cost. If we could have how many patients and the cost to the government of those transfers, because it may be that it is far more cost effective for us to recommend to the government that rather than it being four beds in Broome—I am not sure how many beds there are down at the Albany hospital for mental health, but it may be four or six beds. I know we were shown the unit when we went down there but I cannot remember how many beds there were going to be in that new unit. It might be worth us considering making a recommendation to increase the number of regional mental health beds, rather than having to fly those patients into Perth.

Mr N. Guard: So, just to make sure I am clear, the Royal Flying Doctor Service data for the past two financial years that have been flown from country areas —

The CHAIRMAN: Yes, from regional areas.

Mr N. Guard: From north and south regional areas into Perth for their mental health treatment.

The CHAIRMAN: Yes.

Mr P.B. WATSON: I think down south it may not be Albany because Bunbury probably has figures, and they drive the patients up.

Mr I.C. BLAYNEY: They have also got a reasonable number of beds at Bunbury.

Mr N. Guard: Yes.

The CHAIRMAN: They may have the beds but they do not have the psychiatrists down there, so they get transferred up here because there are not psychiatrists. Maybe we should look at transfers both through the Royal Flying Doctor Service and via St John's, because I know that a large number come up from Bunbury because they need 24-hour care and there are not the psychiatrists down there on call for the 24 hours, and I believe that is why they then come up from some of those other regional areas.

Mr I.C. BLAYNEY: For that information to be useful to us, though, because we are looking at the drug and alcohol issues, we would really need to know whether they are drug and alcohol-related ones; otherwise it is not really related to our inquiry. I am not sure whether it is possible to break that down.

The CHAIRMAN: Yes. I thought that was —

Mr D.W. James: With a primary or secondary diagnosis?

The CHAIRMAN: Yes.

Mr I.C. BLAYNEY: It may be difficult to match that; I do not know.

Mr N. Guard: We will see what we can find.

Mr D.W. James: Clearly, we felt we needed to say something—I say "clearly"—about the dreadful implications of alcohol misuse amongst Indigenous people. Suicide and mental health clearly are closely related. The statistics here are quite significant that of all the alcohol-attributed deaths amongst the Indigenous people, 40% are even counted through suicide or liver cirrhosis. Looking at people dying in their mid-30s is just significant, just so significant.

We will talk a little bit later about some of the planned initiatives that we do have in train with the commission regarding Indigenous people and mental health, so we will come to that, but we just felt that we needed to put something —

Mr N. Guard: A snapshot of the current data here around alcohol and Indigenous people, not specifically mental health. Clearly this is a significant issue from the point of view of your own inquiry.

[12.10 pm]

The CHAIRMAN: That was from the person from AOD—I cannot think of her name—so that was WA data, was it not?

Mr N. Guard: That is Tanya.

The CHAIRMAN: Tanya, yes.

Mr D.W. James: While we have been talking about the burden of substance misuse on mental health services, it is also important to understand the burden of mental illness on substance misuse services as we deal with a cohort of people who have mental health and substance use problems. Substance misuse services are also managing a cohort of people who present with substance use but when you look more closely have a lot of other mental health problems—again, significant levels. As Neil said earlier, you really are talking about this is the expectation rather than the exception; the majority of people attending substance misuse services will at some time during their life have experience of a mental health problem.

Mr P. ABETZ: With that dual-diagnosis or co-morbidity thing, what comes first, the chicken or the egg? Has any research been done on actually sussing that out?

Mr D.W. James: I am just talking through the association and that is literally that. Why do we see such high levels of co-morbidity within our mental health and drug services? The debate is still on. When you talk about certain mental illnesses like, say, Korsakoff's or Wernicke's encephalopathy where somebody has been drinking to the extent that they have caused themselves serious neurological damage, there is clearly a cause and effect. The debate really sort of rages around drugs like cannabis causing schizophrenia and there are two parties that are in disagreement. The data is quite interesting. Clearly, there are some people who are predisposed to some serious mental illnesses for whom taking psychoactive substances like cannabis just seems to inflame the situation. We know that cannabis use has increased significantly over the past 20 years and the strength of cannabis has also increased significantly in the past 20 years—sometimes eight to tenfold in terms of the amount of THC, which is the psychoactive component. What we have not seen, which is an interesting fact, is a rise in the baseline levels of illnesses like schizophrenia, so if that argument was true you would also expect to see a significant increase in the prevalence of schizophrenia and we just do not see that at the moment. What we do see are most people who are vulnerable to perhaps developing schizophrenia in the longer term. If they start to use psychoactive substances, that can certainly bring on the illness. But the debate rages around this; there are clearly two camps. What we could think about are shared risk factors. If we know that issues like domestic violence, child abuse—understanding that some of the social determinants of substance misuse also have an effect on mental health.

There is also the debate about whether we see higher rates of substance misuse because people with serious mental illness are actually trying to self-medicate themselves. We know people with schizophrenia suffer a complex called negative symptoms where they become socially withdrawn, their interactions become less and there is general poverty in terms of their ability to interact socially. If they take certain substances that perhaps improve that, you could sort of understand then maybe. Again, it is a debate; the evidence to underpin that is not forthcoming. The evidence does suggest that people with severe mental illness use substances for the same reason that the general population use substances—that is, because their friends do it, because it is done in a social setting, because they want to help mediate a difficult day, they have had a long day—they are the same sorts of reasons. We have done some work looking at the motivations for substance use amongst this population and the overriding findings are that they use substances for the same reason that everybody else uses substances, not because they want to manage hallucinations or paranoia.

Another argument put forward is that mental illness predisposes to the positive reinforcing effects of substances. Again, if you are suffering with some of the negative effects of serious mental illness and you are able to sort of overcome them with certain substances, then you could argue that that is one of the main reasons. Clearly, some people who have certain mental illnesses use substances that

seem to aggravate the chemical underpinning to that mental illness. I am thinking about schizophrenia and dopamine and we know that drugs like LSD and methamphetamine can aggravate those same mechanisms, so then again you could suggest that there is a relationship between the two.

Social vulnerability: people with serious mental illness and severe substance misuse often go on a sort of downward trajectory in terms of their social situation. They often find themselves in housing where the availability of substance use is greater than perhaps the rest of us find ourselves in, so they have access to greater amounts of psychoactive substances. The other reason, which I have also just touched upon, is that they often use because of the same reasons that the general public report. So I cannot give you a definitive answer; it is a complex mix of factors, some perhaps are more reflective of certain disorders than others.

What I am trying to say is that this is a complex group of people as well. We talk about dual-diagnosis and co-morbidity. They really are umbrella terms and they hide a significant amount of differences within groups and that really hinders us in understanding the best sorts of treatments that we should be putting in place for certain disorders. People with schizophrenia who have a serious alcohol disorder require much different treatment interventions than somebody with a mild anxiety problem who is using two joints of cannabis a week. Unfortunately, terms like co-morbidity and dual-diagnosis do nothing to help us in terms of understanding the complexity of it. But when you look at the data, you tend to see four groups of people. There are people with addictions who then experience some form of psychiatric problems. There are people with serious mental illness who also use substances, and there is an interrelation. There are also groups of people who just have both disorders appear at the same time. There are some people who have just experienced a substance use disorder and then later in their life they have experienced a serious mental illness. Again, they are all labelled together. So that is a picture really about the data and what we understand so far. I will hand you back to Neil now. Neil will talk about what is best and what works.

The CHAIRMAN: If in society we lowered the consumption of alcohol—it seems over the past decade to have been increasing—or the amount of illicit drug use in the community, would we therefore see a decrease in mental illness?

Mr D.W. James: The question is: an increasing amount of substance use and alcohol use in society —

The CHAIRMAN: If alcohol and drugs, particularly alcohol, which the police are telling us is 90% of their problems—everyone who is coming in is saying alcohol then the illicit drugs. If we could lower the amount of alcohol that was being drunk, would we see then a fall in the number of people developing or being treated for mental illnesses?

Mr P. ABETZ: Neil might be without a job!

The CHAIRMAN: That is all right; I think he would be happy with that!

Mr N. Guard: I would be happy.

Mr D.W. James: Certainly, amongst people with some of the high-prevalence disorders like anxiety or mild depression there is clearly a link with excess alcohol use and people developing or experiencing anxiety problems and some forms of depression.

The CHAIRMAN: So if we could shift that normal curve over a bit and cut back —

Mr N. Guard: You would expect that that would be the direction it would go. If you take the slide from earlier on, the Spencer 1999 study and the admissions to Graylands with the primary reason for admission being alcohol use or the secondary reason being alcohol, and similarly with the illicit drug use, you would expect that if you were able to reduce the consumption of alcohol in the community, you would start to reduce some of those numbers too.

Mr P. ABETZ: It would be an interesting one to observe. If I remember correctly, the number of young people smoking cannabis has actually percentage-wise dropped off somewhat, so that would be an interesting one to watch in terms of the development there.

Mr N. Guard: And that has been the trend over the past three national drug strategy household survey periods and also the ASSAD data is saying the same thing; cannabis use has dropped, particularly over the past three periods.

Mr P. ABETZ: I wonder whether it is actually part of the anti-smoking thing; has that helped to contribute to that as well.

Mr N. Guard: I would certainly back the argument that that has been a significant contributing factor—the disassociation now with smoking or the dislike of smoking or the changed attitudes towards smoking—you would expect that to be a by-product.

However, in the next two to three slides I just want to talk a little about what we know about the management or the evidence of what works, or works better, in terms of effective treatment and management for the population of people with mental health and alcohol and other drug issues. I think it is probably fair to say at present there is no known gold standard for this particular population, that is as even as recent as the Cochrane reviews in 2009.

[12.20 pm]

They are following all the things I am about to talk about; some of the better practice principles that are based on the evidence that should inform our thinking about what we need to do. The reality, just to open this up, is that the treatment that will work best for a particular situation will depend on the individual and the level of dependency, the goal of the treatment and cognitive ability, amongst other things. There is no one-size-fits-all approach to this. Firstly, we know that the most effective outcomes are generally achieved when the treatment seeks to address both disorders concurrently; in other words, integrated treatment rather than prioritising one treatment—for example, the mental health issue at the expense of the other. As a principle, that seems to work best. Secondly, we know that better outcomes are generally achieved when the treatment seeks to enhance the motivation; for example, with a simplified form of motivational interviewing that thoroughly explores and addresses factors such as the reasons for use, the relationship between use and the mental health problems and the concerns of use. We also know that it is really important to try to influence and change the environment from which the person came—the family situation, housing, education and availability of social supports—because it will clearly be very difficult to sustain any improvement and the motivation to keep that improvement and that reform if the person's lifestyle is unlikely to improve after, for example, ceasing high-risk alcohol and other drug use. Those are some overarching principles.

I turn to the second set of principles about what works. The first of those is setting small, realisable, achievable goals. That is probably the same in other walks of life, too, but steps that can actually be achieved and which therefore encourage further steps to be achieved as well. Structured problem solving and a skills enhancement approach is equally important with this particular population group. The final one is managing risk. This population is at high risk of a range of other health issues—for example, contracting blood-borne viruses, poor nutrition, accidents and assaults. It is important with this particular population to do what we can to recognise them in the first place and put in place strategies to help manage those particular risks. The other terminology is reducing harms associated with these.

Finally, as I mentioned before, there is no one-size-fits-all solution or treatment. The inventions that do work are those that generally reflect the patient's readiness to change; they seek to increase their awareness of the impact of each of the problems and address those. The next one is around family, carer and other important—friends, colleagues and others—people in a person's life wherever possible and there is a clear association where you can do that while achieving better outcomes for

the individual, and recognising that withdrawal management may assist in the long term to engage the person and continue that engagement in care. Also, to include as part of that overall package of support the provision of information, structured problem solving, motivational interviewing to maintain the motivation to change and reform, and the brief behavioural or cognitive approaches that are equally important. Those three are some of the principles based on evidence around Australia and other countries of the types of things that work best for this particular population if you can package them together.

Mr P.B. WATSON: Alcoholics and gamblers have the 10 Steps programs and they go to meetings to get support. Is there anything available in mental health or are there any thoughts of doing that in mental health?

Mr P. ABETZ: There is Narcotics Anonymous. It is exactly like AA.

Mr P.B. WATSON: I am talking mental health.

Mr D.W. James: Often 12 Step programs work well for people with these problems as well because it is a very black and white approach: you are either on the wagon or off the wagon. I think sometimes people with quite serious mental illness quite like that black and white approach. One of the biggest studies into treatment effectiveness found in something called Project Match that whether you use CBT solution focus therapy, motivational interviewing or 12 Steps, what was really important was the way the service interacts with the client, the relationship that they form. When they compared treatment across the three different modalities what really stood out was when the incumbent rated their relationship with the therapist as good, their outcomes were better. As Neil stated earlier, there is no gold standard; they are all as good as each other but what really is important is how well the service is provided.

Mr P.B. WATSON: We have a thing called Fellowship House in Albany for schizophrenic people. It is a place where they can meet and there is help for them. It is not pushed on them but it is there. It is a tremendous service. Are there any others like that throughout the state?

Mr N. Guard: There is an example of GROW Western Australia, based on Canning Highway, which engages with a number of people, including people who seek support not necessarily for themselves but family and other people who have experienced mental illness. They get together as a general support group. That is a very successful organisation. It has grown significantly over the past few years. It has branches in other parts of the state as well. That is a good example. There are other examples like that here in Western Australia and other jurisdictions.

The CHAIRMAN: We have heard from both the Department of Health and non-government organisations that a service is not available after hours. I would like to know how you are planning addressing the after-hours problem, not just in the metropolitan area but in regional areas. Also, Neil, I come back to what you said before about the funding. Because of this link between mental illness and alcohol, will the funding arrangements that you are looking at also look at care of patients who have alcohol problems?

Mr N. Guard: I will come to that in a second. I have a couple of slides about the stuff that we have already been doing over several years and what we are intending to do moving forwards. It might cover some of the points that you raised. Your point about after-hours is probably true. One of the roles of the commission is to do what we can to expand community-based services. We need services in place in the community when people need them and where they need them. It will take a little while to achieve that and it will require some reform of what we already have. We are also trying to access additional funds and new moneys to be able to expand that raft of services. I agree that it is not just the mental health area; it is also in the alcohol and other drug area that a number of those services are not available into the evening when people do come seeking them. Again, it is another one of those issues on the agenda for the commission to look at what we can do to literally meet that agenda of support available when people need it and where they need it, and that is in the

community. It is a genuine issue and we need to look at what more we can do in that area because it is not there to the extent that it is needed at the moment.

The CHAIRMAN: You might move on to your other slide.

Mr N. Guard: I move on to the last few things. In the context of those last three slides, we tried to present some of the things that we know work best based on the evidence. The current service delivery or the way it is done in practice presents a number of challenges. The reality is that mental health services and alcohol and other drug services have developed over a significant period of time, generally with different historical and philosophical origins. There are separate structures, albeit those structures are now working a lot better together than they were and that has been a real focus for both mental health services and alcohol and drug services in the past five years or so. Even if you looked at some of the non-government organisations funded by the alcohol and drug sector and those funded by the mental health sector, there is not a lot of overlap between those organisations. We need to build the capacity of both sets to deal with the population of co-occurring, substance use and mental health problems. Generally, they would provide parallel or sequential treatment rather than integrated treatment; in other words, either two streams of treatment going on at one time or one after the other rather than trying to deal with the person's issues holistically. Generally, mental health services receive mental health training and other drug services receive alcohol and other drug training, so it is separate. A lot of work has gone on in that particular area, again over the past two to three years and is now going on, for example, with the DAO training calendar, which has a semester dedicated to co-occurring mental health and alcohol and drug use issues. Generally, the skills in the alcohol and drug area—I use the word "generally" because you cannot say this across the board—would not necessarily be as good when dealing with people with mental health issues and vice versa. I think it is realistic to say that based on that philosophical origin, there are some entrenched values out there and there is still some opposition to doing things differently. I think we have overcome a lot of that based on the work that has happened over the past two or three years to the extent that there is now a much more vocal commitment to doing better for this group of people with co-occurring mental health and substance use issues.

[12.30 pm]

Just very briefly, to talk about some of the things over the past four to five years, I said significant effort has been applied to building more effective linkages between the mental health and alcohol and drug services in Western Australia. Some of the most significant of those are listed on this slide. One of the most significant there is the state strategic dual diagnosis planning group, which was an initiative sponsored by both the mental health division and the Drug and Alcohol Office and which brought together many of the significant key stakeholders from across the two sectors to basically advance a more integrated agenda. Some significant achievements there include the establishment of memoranda of understanding between local drug and alcohol services and mental health services across the state, so they are largely, if not now entirely, in place between local mental health and drug and alcohol services. Joint workforce development planning is significantly supported by the workforce development and resources of the Drug and Alcohol Office in trying to make that happen. Also, there are things like piloting and evaluating joint assessment tools. I think it would be fair to say that now within specialist drug and alcohol services, for example, the comprehensive assessment of people with an alcohol problem now routinely occurs. It would include an assessment of associated problems—for example, general and mental health—as part of their upfront assessment of how they go about doing this, and other social, legal and family issues.

The one underneath is outreach workers from the Western Australian Substance Users Association will provide counselling services for inpatients at Graylands Hospital who have co-occurring drug and alcohol problems. The third one on the list there is the commonwealth government funded improved services initiative, which provided funding of about $6 million two and a bit years ago to 11 consortia of drug and alcohol treatment services in Western Australia to build those linkages

between drug and alcohol and mental health services, so a lot of work has gone on through the funding provided to those consortia. Unfortunately, that funding I think runs out at the end of this year, so we need to think about continuing the work those consortia are doing. The Headspace project, which is funded by the Australian government under the promoting better youth mental health initiative, also focuses on early identification and intervention for young people at risk of or experiencing co-occurring drug and alcohol and mental health issues. Obviously, the establishment of a shared ministerial portfolio for mental health and the Drug and Alcohol Office is a deliberate attempt to try to get both streams there to work very closely together and is building on the work that the state strategic dual diagnosis planning group has been doing over the past few years. So a lot of focus has happened in this particular area and has made some good progress over the past four to five years.

That effort is continuing. The state strategic dual diagnosis planning group is now being replaced by the Western Australian collaboration on substance use and mental health. The membership of that collaboration now includes the Mental Health Commission, the Drug and Alcohol Office, divisions of general practice, the commonwealth government Department of Health and Ageing, the WA network of alcohol and drug agencies, the WA Association for Mental Health and the Office of Aboriginal Health—so some of the key players are around the table, trying to drive continuing reform in this particular area. Four priority areas that that group is now working on are joint workforce development, or workforce development across both alcohol and drug and mental health, and increasingly across GP divisions and others to whom people with mental health and alcohol and other drug issues would probably present upfront. The development of integrated care pathways is trying to look more closely at this issue from the point of view of the person who has presented, wherever they present, and trying to move away from the default position being around, "Well, once we get to this stage, we will hand you across to the other service to actually take it on", by really focusing on this from the point of the individual and seeing whether we can use that as a means to redesign the system of how we work together. That is that one.

Prevention and health promotion is so there is more focus in this particular area about how we best work collectively to prevent both alcohol and other drug and mental health issues. Another smaller group as part of that is around trying to effectively work together between alcohol and other drug and mental health services to maximise the opportunity for accessing funding when it becomes available—so positioning and identifying those potential funding sources and working in partnership to access that and maximise the return for Western Australia.

The CHAIRMAN: Why are prisoners not included in that group, when 80% of prisoners have a mental illness?

Mr N. Guard: They will be.

The CHAIRMAN: They are going to be included?

Mr N. Guard: They are. This particular structure was driven out of a joint mental health and alcohol and drugs sector planning session back in July last year. That did include people from outside. What we decided to do and what we are trying to do here is to start small and make sure it is working within those services that immediately within the health system work together to do that. The reference group for this, which will meet once a year, will include groups like Corrective Services, Child Protection and others with whom we need to engage. The intention is that down the track we will then engage those members as far as this collaboration is concerned, once we have got evidence of how we are making things work.

The CHAIRMAN: Because of the serious mental health problems in prisons, how long do you think before —

Mr N. Guard: Six months.

The CHAIRMAN: We may not have finished our report by then.

Mr N. Guard: We will tell you how we are doing.

The CHAIRMAN: We may well be contacting you to find out what has happened in that area.

Mr N. Guard: That is good.

I think the thrust of the last two slides was to try to get it across that this is an issue and we are trying to drive progress in there. A lot of the lead has been taken by the Drug and Alcohol Office and the mental health area now is very much engaging in this particular agenda because there is a recognition that we can do better for this particular group. These are some of the streams within it. Those streams have been equally recognised through the consultations that have progressed about developing the mental health strategic plan for the next 10 or so years. Some of the early initiatives that are focused within that plan were around developing the integrated care pathway to address the complex needs of people with both substance use and mental health problems, looking at innovative funding models to ensure a coordinated approach between mental health and drug and alcohol services, and that will obviously include planning for those, and increasing the capacity as a workforce to provide more effective treatment to people with both substance use and mental health issues. Key areas are focused so that that plan will continue into the future.

The last two on this slide are two obviously associated issues now being driven by the Mental Health Commission, the first one being the WA suicide prevention strategy, where over the next two to three years we are looking at a significant engagement of communities, particularly some of those early communities being high-risk communities, whether that be of a geographical nature or whether it be other communities; for example, people leaving mental health systems who are probably at high risk of considering and committing suicide. So that can be around a different group of people, or geographical or otherwise. That strategy has obviously committed $13 million over the next three years to really try to progress this particular agenda. A lot of that is around community engagement and development of community action plans. Your earlier comment, for example, around people leaving the hospital system —

The CHAIRMAN: And the telephone call, yes.

Mr N. Guard: — might be well be one of those where you say, "If there is risk in that population group, we could potentially define it to the ministerial council and potentially define a community around that."

The CHAIRMAN: I hope also that the ministerial council will look at it. This is something that we did as independent members rather than members of this committee. Peter and I went along to Sir Charles Gairdner with Eric Dillon and met with Dr David Mountain. From those meetings it was made very clear that whilst Next Step play a very valuable role in treating the clients that they treat, there is a big gap in the system for the numbers of people presenting to emergency departments with alcohol-related problems, because whilst it is called Next Step, it is really a treatment program for people who have been identified and who are going in for a three-day program, but the gap at the moment is the person who goes into accident and emergency because of an overdose of alcohol and then may be kept in accident and emergency for two or three days. Next Step with their 13 beds cannot take them because they have got people booked. Particularly in our tertiary hospitals, it is very expensive, and we certainly believe that money could be much better used having a program within the community, so that they can be discharged from the hospital to another facility, maybe next to a hospital, where they are given that counselling and the treatment services that they need. I hope with your new funding arrangements, there is a gap there and you will be looking at that gap.

Mr N. Guard: It is sometimes referred to as step down, step up—the subacute-care part—so it means that you are not in the hospital system but it helps you transition back out into the community, as well as other community-based supports.

[12.40 pm] 12:39:17 PM

The CHAIRMAN: We will be watching that line as well.

Mr N. Guard: Do that.

The CHAIRMAN: When is the new mental health strategy likely to be released? Will it be released this year?

Mr N. Guard: I hope it will be released this year. We have one further round of consultation on the documents that have been produced up until now, and the plan is that that will happen over a three-month period while there is a final rewrite of documents that will be able to be presented. That is the current plan. The last point in the presentation was the Closing the Gap initiative. We talked a little about the issues associated with the Indigenous population. We have been given $22.47 million to develop a state specialist Aboriginal mental health service. That will be rolled out over the next two to three years in the metropolitan area and in regional Western Australia. We are working currently to design how that flow might work and what the model of care for that will be, but that is specifically targeting specialised support for the Aboriginal population and will include the ability to support co-occurring mental health and alcohol and drug issues.

The CHAIRMAN: Because of the time, I am going to ask members if they have any urgent questions. Because there are several questions we wanted to ask now but have not been able to, we will put some questions on notice. Do members have any burning questions?

Mr P. ABETZ: I have just a quick question about the mental health commission. Will it have responsibility for the Drug and Alcohol Office or will that be totally separate?

Mr N. Guard: No, that is totally separate. The mental health commission will work very closely with the Drug and Alcohol Office, like we are doing now, particularly for this group of people requiring treatment for co-occurring issues. There is a dedicated focus of the two streams, but there is an opportunity for both to work very closely together, particularly around this population.

The CHAIRMAN: There are several more questions that we have not asked here. Could we put those questions to you in writing?

Mr N. Guard: Absolutely.

The CHAIRMAN: I want members to have a break before we start our afternoon session.

Mr N. Guard: I apologise if we ran on a little longer.

The CHAIRMAN: No, you did not. We were running late. It is our fault for running late. I apologise. Thank you for your evidence before the committee today. I have some further questions for you, but do you want to sum up?

Mr N. Guard: I hope that what we have presented today was useful for the committee in terms of trying to understand.

The CHAIRMAN: Could we have a copy of your presentation?

Mr N. Guard: Absolutely; we are doing that. We are happy to provide any follow-up information that we can and to provide any further assistance to the committee.

The CHAIRMAN: Thank you for your evidence before the committee today. The transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days of the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections, in the sense that your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you both very much.

Hearing concluded at 12.42 pm