CHIEF PSYCHIATRIST
of Western Australia

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Committee Clark
Select Committee into Alternate Approaches to
Reducing Illicit Drug Use and its Effects on the Community
Legislative Council Committee Office
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Via Email to ridu@parliament.wa.gov.au

Dear Ms Sharpe

RE: SUBMISSION – INQUIRY INTO ALTERNATE APPROACHES TO REDUCING ILLICIT DRUG USE AND ITS EFFECTS ON THE COMMUNITY

Thank you for the opportunity to comment.

Please find enclosed submission for your consideration.

Yours sincerely

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30 November 2018

Enclosure: Submission

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Submission to the Select Committee into Alternative Approaches to Reducing Illicit Drug Use and its Effects on the Community

The Office of the Chief Psychiatrist welcomes the opportunity to contribute to the Select Committee's inquiry into *Alternative Approaches to Reducing Illicit Drug Use and its Effects on the Community*.

The Chief Psychiatrist has responsibility under the Mental Health Act, 2014 for overseeing the treatment and care provided to all voluntary and involuntary patients by a mental health service, including patients required under the Criminal Law (Mentally Impaired Accused) Act 1996 to be detained in an authorised hospital. Given my role, I would particularly like to focus on one of the biggest challenges facing mental health services, the treatment and care of people with comorbid severe mental illness (including schizophrenia and related disorders, bipolar disorder and major depression) and substance use disorder.

As Chief Psychiatrist, I have a position that individuals with comorbid mental health and drug problems require access to appropriate health services irrespective of whether they are in the general community or within a corrective services facility.

The size of the problem

The best source of data in Australia on the use of illicit drugs amongst people with a severe mental illness is *People Living with Psychotic Illness 2010*, known as the SHIP Study (Morgan et al., 2011). This study found that the proportion of people with severe mental illness with a lifetime history of cannabis or other illicit drug abuse or dependence was very high at 63% of males and 42% of females. By comparison, amongst the general population, the rates were 12% and 6% respectively. One of the most disturbing findings was the very large increase in the rates of illicit drug use amongst males (77%) and females (137%) compared to those found in the 1997-98 survey of people with psychosis.

Cannabis was found to be the most commonly used illicit drug, with one third of participants having used it in the previous year and two thirds over their lifetime (see table below; SHIP Study). Almost 60% of people using cannabis in the past year were using it at least once a week, with nearly 40% using it daily.

	Proportion (%)	
	Past year	Lifetime
Cannabis	32.8	66.4
Amphetamines	12.5	40.1
Tranquillisers	4.1	11.9
Ecstasy	4.0	23.1
Heroin	3.7	15.7
Hallucinogens	2.7	25.4
Cocaine	2.0	13.3
Solvents/inhalants	0.4	10.3

The impact on service users

People with psychosis and coexisting substance misuse have significantly poorer outcomes including poor engagement with treatment programmes, poor medication adherence, increased likelihood of relapse, increased use of inpatient services, increased homelessness, poor physical health and social outcomes, increased risk of self-harm/suicide, increased risk of violence and increased contact with the criminal justice system (Blanchard et al., 2000; WHO, 2009; Lai and Sitharthan, 2012). Just over 60% of participants in the SHIP study reported having social/legal problems over their lifetime as a result of illicit drug use (Moore et al., 2012). Because the onset of psychosis at a younger age is also an indicator of poor prognosis, people with a combination of younger age of onset and coexisting substance misuse may have a particularly poor prognosis.

When compared to the non-Aboriginal population, Aboriginal men are over 4 times and Aboriginal women over 3 times more likely to be hospitalised for mental disorders attributable to psychoactive substance misuse (Wilkes et al., 2010).

Service response

Despite over a decade of research and policies calling for integrated comorbidity treatment and care, the results have been disappointing. The attempt at better integration of mental health and alcohol and other drug (AOD) services in WA through the Mental Health Commission has not resulted in the delivery of integrated services for people with comorbidity at the clinical level. This problem is not unique to WA, with the vast majority of mental health and AOD services across Australia typically operating in silos, being separately staffed, located and funded, and offering care according to their respective service models and practices.

Service users are frequently refused entry by mental health or AOD services and advised to seek treatment with the other service, without adequate recognition of the mutual influence that each condition has in maintaining or exacerbating the other.

This failure to better integrate care for this group of service users has had a profound effect on individuals and their families. The question is why has this problem been so difficult to resolve?

Essentially, mental health and AOD services are embedded in their own 'cultures' with different philosophies and training that shape their respective treatment approaches. In sharp contrast to the AOD services which have traditionally relied on client motivation and commitment for treatment, underpinned by a harm minimisation philosophy, mental health services have responded to the challenge of engaging people with serious mental illness and substance use disorder with an assertive community outreach approach. The evidence suggests that what is required is an integrated approach in the provision of comorbidity care to these high risk clients. Lack of adequate training and professional development and support for mental health and AOD clinicians, combined with their ambiguity about their role in providing comorbidity care, often results in clients falling through the gaps.

Proposed future directions

1). Redefinition as a health and social issue

The decriminalisation of the possession of small quantities of any illicit drug for personal use would reduce the harms caused to individuals with severe mental illness by involvement in the criminal justice system. Evidence from the SHIP study showing a substantial increase between 1997-98 and 2010 in the use of illicit drugs by people with severe mental illness highlights the limited effectiveness of the current approach to reducing the demand and supply of illicit drugs in this group. The Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists, in a joint policy position statement (2002), took the position that *"... Governments must re-define illicit drugs primarily as a health and social issue, with funding for health and social interventions increased to the same level as law enforcement".*

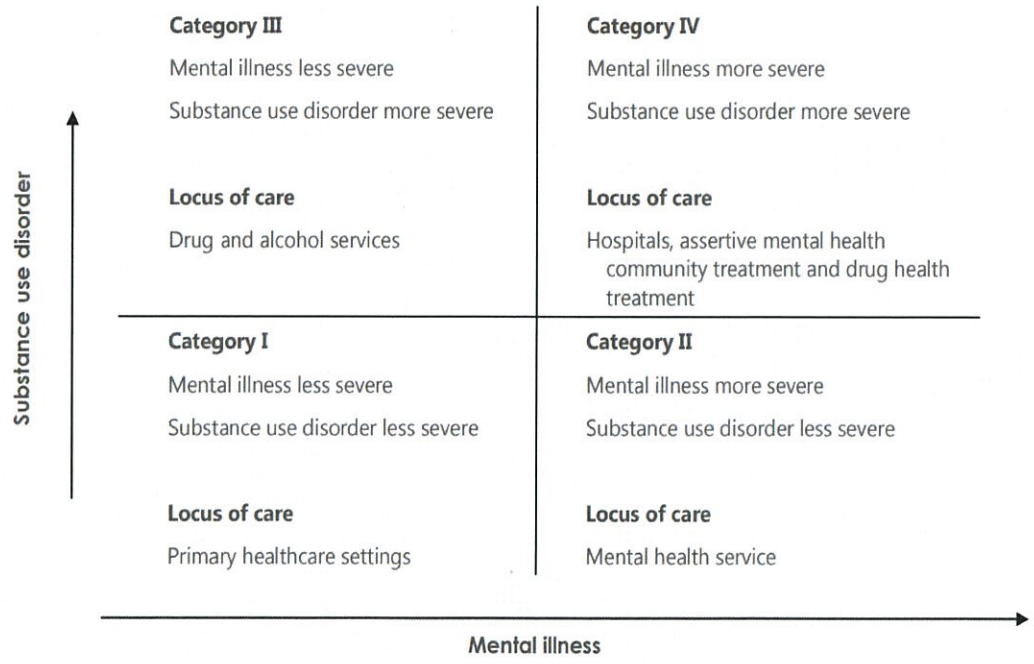
Western Australia has significantly lower numbers of forensic mental health beds comparative to other jurisdictions. The recent report by the Western Australian Office of the Inspector of Custodial Services, *Prisoner Access to Secure Mental Health Treatment,* published on 27 November 2018, identified that 30% of prisoners referred under the Mental Health Act 2014 do not have their referral formed enacted, and 61% of all Mental Health Act 2014 referral forms in prison are never enacted. This is a major current restriction on the access to care for those individuals in prison with severe mental illness- including the significant subsection who have comorbid mental health and drug issues.

WA has recently increased resources for both drug-related corrective service facilities and Emergency Department services in WA Health.

2). Comorbidity treatment

The overall consensus of research evidence is that psychiatric or addiction focused treatments on their own are not sufficient to manage comorbid mental health and substance use problems. The Australian National Mental Health Commission (2013) highlighted the importance of integrating care for this population. Coordination of care between mental health and DOA has proved universally difficult to achieve in practice, leading the US Substance Abuse and Mental Health Services Administration (2005) to provide guidance on the roles and responsibilities of the respective parties in the provision of treatment of substance misuse. The resulting 'Level of Care Quadrants' provides a useful framework for determining the primary locus of care in a matrix, based upon the severity of the substance use disorder and of the mental illness.

Level of Care Quadrants*



Effective Models of Care for Comorbid Mental Illness and Illicit Substance Use, New South Wales Ministry of Health, 2015

Adopting this approach, the NHS has determined that the primary responsibility for the provision of comprehensive care for people with serious mental illness and substance use should rest with mental health services. The rationale for this is that mental health services are better placed to offer assertive community outreach, crisis management and long-term care. This is particularly so for people who are difficult to

engage in treatment in which continuity of care is important for the development of trust. It is expected that AOD services will provide support, when necessary, for mental health services.

Going forward, should there be a decriminalisation of certain currently illicit drugs, consideration will need to be given to the impost this may have on the health and mental health resourcing required to manage the individuals with mental health/drug comorbidity.

3). Training and professional development

In order for clinicians in mental health services to take on this role, there will need to be investment in building capability. The Centre for Clinical and Academic Workforce Innovation in the UK (2006) proposed a capability framework with three levels of competence:

- ***Core***: for workers who come into contact with this user group (Category I workers such as ED staff, police and community support workers);
- ***Generalist***: for workers who work with people with comorbidity regularly (Category II workers such as mental health professionals including psychiatrists, nurses and psychologists);
- ***Specialist***: for comorbidity specialists (Category IV workers such as staff working in intensive community outreach teams).

4). Resourcing integrated comorbidity services

Assertive community treatment teams are not available in all mental health services in WA and, where they are available are generally not well resourced. Nor are there are adequate intensive inpatient and community-based rehabilitation services for people with more severe comorbidity and challenging behaviours. These gaps in service all too often lead to these individuals ending up in the justice system.

5). Housing

People with severe comorbidity, particularly when accompanied by challenging behaviour, and those who have been through the justice system, have very significant problems in being accepted by housing providers/or maintaining their accommodation and often end up homeless. This exacerbates the challenge of providing appropriate treatment and care. There are a number of promising housing models, such as Housing First, providing a growing body of evidence demonstrating that they improve residential stability for people with comorbidity.

Appearance before the Committee

I would value the opportunity to appear before the Committee to further elaborate on the issues raised in my submission and to answer any questions.

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