The Education and Health Standing Committee,
Western Australia Legislative Assembly.

Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia.

The Principle Research Officer,
Dr David Worth,

My name is Mark Porter and I am a psychologist employed since January 2006 as program manager of the South Metropolitan Area Health Service (SMAHS) Multisystemic Therapy (MST) Program. In this submission, I will focus on two areas relevant to your enquiry where I have professional experience.

1) The first is the high value of Therapeutic Communities as an AOD residential treatment option.
2) The other is the cost-effectiveness of expanding the Multisystemic Therapy (MST) Program.

1) Importance of Therapeutic Communities as a specialised treatment option in the AOD field:
Prior to my current appointment, I was the "Palmerston Farm" Program Manager from 1998 – 2005. The "Farm" is the residential treatment service of Palmerston Association Inc, one of this state's leading NGOs in the AOD treatment field. The "Farm" at that time was commonly regarded as the state's leading residential treatment service for adults with alcohol and other drug (AOD) problems. My recognised expertise in the AOD residential service field resulted in my selection on the Steering Committee of the Western Australian Alcohol and Other Drug Sector Quality Framework (2005). Under my direction and management became the first W. A. AOD residential treatment service (1999) to respond to the increasing problem of mental health problem comorbidity by working closely with the Kwinana & Rockingham Mental Health services and regularly accept medicated comorbid clients. Prior to the Farm accepting clients prescribed psychiatric medications for a range of diagnosed serious mental health problems, all W.A. residential AOD treatment services typically denied entry to these persons. I recognised that the W.A.-wide policy of denying entry to residential services of persons prescribed medications for mental health problems, meant they were having to abruptly cease their use of prescribed medications to qualify for entry. Consequently most of these persons were withdrawing from illicit and prescribed medications at service entry, and most quickly left the service and relapsed.

From 1998 - 2004 the Farm almost doubled its client capacity (10 to 19 beds) with minimal increase in counselling staff (3.5 to 4.5 counsellors), began accepting clients on medications for mental illnesses, and responded to the sudden change from opiates to amphetamines as clients' primary drug of abuse. The increased demands on the service at this time prompted a major change to the program structure resulting in the program changing to a "Therapeutic Community" (TC) model of operation. The Farm was the first residential AOD treatment service in Western Australia to introduce a typical TC structure that places less emphasis on counselling, and more on increasing client responsibility and education. To better meet client needs with serious mental illness in conjunction to substance abuse problems, it was critical to attract and retain counselling staff with appropriate professional qualifications. The Farm introduced a unique workplace agreement in 1999 that offered flexible hours of work enabling me to attract several experienced clinical psychologists as "senior clinicians" over the following years.

After these changes were introduced the Farm programs "Average length of client stay" increased from 40 days to 100 days on a consistent basis (2003 -2005) whilst operating at near maximal capacity. Average client length of stay in AOD residential treatment is internationally regarded the most reliable predictor of long term AOD treatment success. These treatment outcomes were remarkable given the Farm almost doubled client capacity whilst almost halving clinical : client staff ratio, and was servicing a younger, amphetamine-abusing population, with increasingly prevalent mental health problems. In summary, I believe the AOD Therapeutic Community residential program structure is very important for improved treatment and cost-effectiveness of AOD residential services and enables a safe reduction in the staff : client ratio without sacrificing treatment standards. However I strongly believe it should be mandatory to have at least one clinical psychologist (not necessarily full-time) on the clinical staff of all residential services. This senior clinical position helps maintain professional communication between the AOD treatment service provider and the local mental health services. This position is required for supervision of less qualified staff, the maintenance of evidence-based treatment standards, and maintaining ethical and professional standards of clinicians working with a vulnerable population.

2) Multisystemic Therapy (MST) as substance abuse prevention and early–intervention service:

This MST Program was the recipient of the 2008 Mental Health Good Outcomes Award (Mark Rooney Award, Improvements to Child & Adolescent Mental Health), and 2008 Healthy Communities Award. MST is also a finalist for this year's Premier's Award and the National Mental Health Services Award. The program is a home and community-based specialist child and adolescent mental health program targeting 10 - 16 year olds with severe conduct disorders (disruptive behaviour disorders). The Program has an impressive international evidence base, and is listed in several recognised practice guidelines as the best intervention for older child and adolescent conduct disorders (e.g. The Werry Centre, 2007).

The importance of targeting child and adolescent conduct disorders in an attempt to reduce substance use and abuse is realised when it is understood that conduct disorder reliably predicts substance abuse. The Supplemental issue of the respected journal "Drug and Alcohol Dependence" 88S (2007), was specifically devoted to an analysis of the issue of psychiatric comorbidity and the prediction from psychiatric comorbidity to drug use and abuse. The supplement's leading editorial (P. S97-S99) states:

"First, the link between conduct disorder and drug use and abuse is confirmed in great detail. Evidence is presented cross-sectionally (Roberts) and prospectively (Cohen, Costello, Gibbons, Fergusson, Pardini, Wittchen), for conduct disorders as a strong predictor of the use and abuse of tobacco (Fergusson), alcohol (Costello, Fergusson, Pardini), cannabis (Cohen, Ferguson, Wittchen), and other illicit drugs (Fergusson) across the age range from age 7 to adulthood. The wealth of prospective data presented here does away with any concerns about order effects: Conduct Problems precede drug use and abuse". This editorial notes that pre-school interventions may be most suited for the prevention of conduct disorder (and therefore prevention of substance use and abuse), but also notes the strongest association with conduct disorder and substance abuse occurs between ages of 13 – 16 years.

The Health Department's MST program is targeting children from 10 to 16 years who have been referred from a wide range of Government services including various Child and Adolescent Mental Health Services (CAMHS), the Department of Child Protection, Department of Education and Training, Department of Corrective Services, and various NGO's. Surprisingly, although Next Step Youth was an original partner of the service we have not received referrals from Next Step or any NGO involved in the western Australian AOD treatment field in the last 4 years. We are at a loss to explain this lack of service utilisation given research connection between conduct disorder & substance abuse.

Part of the reluctance of AOD treatment service providers to utilise the Program may be because MST uses the parents as the primary agent of change, rather than the reliance on professional counselling. The MST intervention is intensive with multiple visits weekly to the families home and clinicians being available to support families on a 24/7 basis. The intervention only lasts 4 to 6 months and is specifically designed to empower parents to appropriately manage the behaviour of their children. Most commonly, following the intervention there is a significant improvement in both the young person's internalising and externalising behaviours as measured by a very reliable measure of child behaviour (CBCL). The longitudinal research being conducted on MST by the Department of Health has shown that in the majority of these cases, the gains made during the intervention are maintained. Families involved in the program include a significant proportion of aboriginal families and success has been reliably achieved with these families also, including the cessation of solvent sniffing.

In summary, the Multisystemic Therapy Program should be considered as an existing and useful early intervention treatment for young persons with conduct disorders who are at high risk of developing substance use and abuse behaviours. If there is sufficient interest, I can speak to a detailed PowerPoint presentation better describing the MST Program and our research showing treatment effectiveness. Unfortunately various ethical approval constraints prohibit making this research publicly available.

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