WANADA mission statement

To improve the health and well being of Western Australians by strengthening and enhancing the work of organisations, individuals and the community to reduce AOD related harm.

WANADA key objectives

To promote co-ordinated prevention and treatment services that are effective in terms of cost and outcomes.

To develop and respond to policies regarding planning for effective service delivery, intersectoral co-operation, and most efficient use of resources and information.

To increase public awareness of AOD issues and provide information on the ways in which prevention and treatment services, and the community can work together to reduce the adverse effects of AOD use.

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Submission to :

Select Committee on Mental Health

Provision of Mental Health Services in Australia

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Provision of Mental Health Services in Australia

The Western Australian Network of Alcohol and other Drug Agencies (WANADA) represents over 90, primarily non-government, agencies working with persons with alcohol and other drug (AOD) problems. It is the experience of these agencies that in Western Australia the management of persons with co-occurring mental health and drug dependency disorders is grossly inadequate. WANADA therefore welcomes the opportunity to make a submission to the Inquiry on the provision of Mental Health Services in Australia, with WANADA's submission focused on Western Australian service provision.

The co-occurrence of drug dependence and mental health disorders is widespread and is associated with higher levels of hospitalisation, incarceration, suicide, homicide, housing instability and homelessness, unemployment and financial difficulties, and lower treatment compliance requiring more complex and more expensive care. Over the past decade the number of persons presenting to WANADA member agencies with both drug dependencies and co-occurring mental health conditions has substantially increased. This increase in the prevalence of co-occurring disorders has been well documented (e.g., see Tesson & Burns, 2001) and is also articulated in national initiatives both in Australia and overseas (eg, the creation of the Australian National Taskforce on 'Comorbidity' and the recent report on 'Comorbidity' by the UK Department of Health).

It is considered by WANADA that the existence of drug dependence, as outlined in DSM 4, is a mental health disorder and that all mental health services need to respond to the acute management of such disorders (e.g., detoxification and immediate post detoxification management). It is noted that the number of persons in Western Australia with drug dependency disorders has been estimated by Hall (2001) to exceed 100,000 and as such there are already access issues resulting from limited services.

WANADA is mindful that the separation of AOD services from mental health services is, for persons with co-occurring disorders, essentially an unhelpful practice that has not been associated with good outcomes. While treatment provision continues to focus on parallel and sequential care, any strategy to make the management of persons with AOD dependencies a core business for mental health services could greatly facilitate the integration of services and, importantly, the integration of care for clients.

Unfortunately, it is the experience of many members of WANADA that the degree of co-operation and assistance from the WA statutory mental health services has not kept pace with the changes in the clients presenting to local AOD agencies. Cooperation is currently

largely based around informal relationships between clinicians, which is not consistent with the priorities of the National Mental Health Plan 2003-2008 as to the development of partnerships in service reform, and quality and effectiveness of service delivery.

Despite initial joint sector collaboration at government senior management level, a shared understanding and ownership remains inadequate to achieve change in practice. The complexity of needs evident in people with co-occurring disorders requires this inter-sectoral approach, collectively providing medical, psycho-social, and welfare support. It is the experience of many WANADA members that the majority of referrals to mental health services are either not efficiently processed or are literally rejected. The AOD sector's perception is that the mental health services in WA are essentially acute psychiatric services, with the AOD sector responsible for the large and seemingly growing burden of clients with co-occurring AOD and high prevalence mental health disorders.

The delineation of the sectors is, however, not acknowledged and the limited resources in the WA AOD sector are extremely inadequate to meet demand. Staff working with people with such complex needs require ongoing training and support, and appropriate remuneration to recognise their skills and experience. While the majority of the AOD services in WA are offered through non-government not-for-profit organisations, services are cost efficient, however increasing wage disparity and disparity evident in work loads for government and non-government organisation staff would suggest funding of existing services is in urgent need for redress. To meet growing demands there is also a need for significant expansion of AOD service sector, workforce and staff development, and partnership support development with the mental health sector, including the development of the appreciation for the complementary roles of the two sectors.

A significant and effective, from the AOD sector's perspective, partnership and shared care building initiative was the Joint Services Development Unit (JSDU), which has recently seen changes following the recent state election. While it has previously provided significant support to the AOD sector, its new focus will be on supporting services for acute mental illness patients with co-occurring AOD problems. While this supports a recognised need, the changes made will see a gap in support for the AOD sector and disrupts the maintenance and sustainability of the support already offered.

It is recognised that funding received by mainstream mental health services only allows service provision of low prevalence disorders. While substance abuse is most commonly

associated with high prevalence anxiety and affective disorders, there is also a reported relationship between substance use problems and low prevalence disorders for people with co-occurring disorders, including anti-social behaviour (84%), bipolar (61%) and schizophrenia (47%) (Hillman et al, 2000). WANADA acknowledges that the majority of presentations at AOD services are in the domain of high prevalence disorders, there is a considerable gap between the provision of primary care and mental health to assist these clients, many of whom are accessing AOD services with situational crisis.

The formal estimate of persons with co-occurring disorders in Western Australia is 30,000 (Hall, 2001). The membership of WANADA considers that this figure, derived from the Australian National Mental Health Survey (Australian Bureau of Statistics, 1998) is essentially a low figure. It is noted that estimates for the prevalence of co-occurring disorders in AOD services is at least 50% (with many WANADA member agencies arguing that 100% of their clients present with co-occurring disorders). It has been estimated that the WA figure for co-occurring disorders could well be of the order of 50,000 (Saunders 2002). Whatever the 'true' figure it is clear from the magnitude of these estimates that there needs to be formal recognition that AOD services in Western Australia are currently managing a not inconsiderable proportion of persons with co-occurring mental health and drug dependency disorders.

The view of WANADA members is that the statutory Mental Health Services repeatedly leave the AOD sector to cope with complex cases that rightfully belong within the auspices of mental health. Indeed, there is a perception that the AOD agencies have been shouldered with an unacceptably high burden of care that is on occasions beyond the expertise and is significantly beyond the capacity of the AOD field to manage without additional assistance.

The importance of the National Mental Health Strategy is recognised by WANADA. Strengthening a commitment at all levels of government toward establishing effective linkages with other sectors in order to achieve collaborative planning in a way that builds capacity and takes into account local needs and circumstances is needed. Collaborative approaches need to be a two way, mutually beneficial process. Formal consultation and liaison networks between providers across sectors should be established to ensure continuity of care between services accessed. Development of and continuation of links with specialist and mainstream service providers is required to achieve an objective of the National Mental Health Plan 2003-2008 of a priority theme of increasing service responsiveness. Investment in workforce development to cross training mental health and

AOD professionals has been limited, with a commitment of interagency training with aims to foster closer working relationships between teams and between all agencies providing services to consumers with co-occurring issues urgently required.

It is the belief of the WANADA membership that a critical issue is the development of policy and procedures on the management of co-occurring disorders that may include a memorandum of understanding or protocols between the mental health and AOD sectors. Such policy and procedures could incorporate minimum standard requirements and possible performance indicators. Nonetheless, the members of WANADA believe that the lack of resources, to both the Mental Health and AOD service sectors, create significant barriers to even coming near meeting the needs of people with mental health, and specifically co-occurring, disorders.

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