Youth Substance Abuse Service

Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600

Dear Sir/Madam

Thank you for the opportunity to contribute to this Inquiry. The Youth Substance Abuse Service (YSAS) has a great interest in this issue, given that a number of clients of this service present with mental health as well as substance abuse issues.

While it is beyond the support and treatment focus of YSAS to comment in any depth on the more technical aspects surrounding the treatment of mental health issues, the attached submission outlines some issues of concern in relation to this matter.

The Youth Substance Abuse Service would welcome the opportunity to provide a more detailed submission to the Committee at a future date.

The contact person for this matter is Mr Rowan Fairbairn, ☎ 03 9415 8881.

Yours sincerely,

David Murray
Chief Executive Officer
Youth Substance Abuse Service

/ /

Head Office: Level 1, 131 Johnston Street (PO Box 2950) Fitzroy Victoria 3165
Telephone (03) 9415 8881 Fax (03) 9415 8882
www.ysas.org.au

Introduction

The Youth Substance Abuse Service (YSAS), which commenced operations in February 1998, is a statewide specialist drug treatment service providing a continuum of integrated services for young people between the ages of 12 – 21 who are experiencing significant problems with their alcohol and/or drug use.

YSAS provides a range of youth-specific outreach, treatment, withdrawal, rehabilitation and support programs in a number of locations in Melbourne and regional Victoria. These services currently include:

- youth drug and alcohol outreach
- youth home-based withdrawal
- youth community residential drug withdrawal
- youth residential rehabilitation
- day programs
- youth supported accommodation
- specialist local programs
- statewide telephone referral service
- education and training programs

The characteristics of the young people accessing YSAS services

The 'typical' young person accessing the services provided by YSAS has experienced multiple adverse events in his or her life, apart from and preceding those associated with their alcohol and/or drug use. The majority of these young people have experienced significant levels of trauma and abuse during their childhood and adolescence.

Young people accessing the services provided by YSAS therefore typically present with a multiplicity of mental health concerns such as self-harm, eating disorders, anxiety and depression. While the behaviours may vary from time to time, the cycles are similar – for example research and practice wisdom demonstrate that substance abuse, bulimia and self-harm show a tendency to occur in clearly patterned cycles of increasing tension, followed by bingeing/purging and then relief. In most cases, emotional regulation is reported to be the primary intent of such behaviours. In short, not only does the behaviour arise out of numerous factors and needs, requiring biological, psychological and sociological explanations, the lived manifestation of these deficits also appears multi-faceted (Bonomo, et al, 2004; Holgate & McDonald, 1999; Murray, 2002).

The experiences of YSAS clients in accessing the Mental Health System

Young people accessing YSAS repeatedly raise significant concerns about their mental health treatment experiences. In discussing their experiences of mental health service responses young people typically use powerful language citing terms such as 'abuse', 'trauma', 'neglect', or 'discrimination' to explain their experiences. This is particularly the case with experiences at Youth Inpatient Psychiatric Units. Negative experiences in such settings have included: concerns over a lack of staff contact or preparedness to engage with clients; a lack of time to discuss issues or develop trusting relationships; forgotten meals, medication and appointments; and the stigmatizing language and attitudes of mental health staff, including the perpetuation of power relationships associated with 'patient' / 'health worker' relationships (Bonomo, et al, 2004).

While young people generally consider mental health services capable and effective at providing mental health assessments, they state that staff lack important relationship development skills and this reduces engagement opportunities. Comments around perceived stigma, discrimination and poor communication and relationship development techniques are often highlighted by young people. It should be noted that previous negative mental health experiences may limit later capacity by young people to access, engage, and participate in treatment, and may exacerbate problems because they are not adequately dealt with as they arise (Bonomo, et al, 2004).

Those young people who were eligible for and had received ongoing support and treatment generally spoke favourably about these experiences. Outpatient treatments received by young people included assistance accessing pharmacotherapies, psycho-educational services, crisis support, and limited case management support. Young people were generally satisfied with many of these services (Bonomo, et al, 2004).

YSAS clients with previous experience of mental health services raised concerns around the structured and time limited nature of appointments, the limited availability of outreach services, and the poor referral and follow-up services received from mental health services. Young people persistently point out that mental health services were unavailable to assist with required complementary services such as accommodation, welfare support, and vocational, or other needs. By way of example, one young woman (18, years) noted that even when presenting as homeless

to her local CAMHS worker on the day and time of her appointment, she was unable to gain assistance for this very real need, and yet the mental health worker was disappointed when the young women then did not want to discuss her current mental health needs, preferring to continue her search for accommodation. This young woman also noted that required attendance at a counselling suite or clinically based environment "makes me nervous…[I]…always feel weird going to those places" (Bonomo, et al, 2004).

The young people state that mental health services are invariably accessed with the support of their AOD worker and that this facilitated integrated treatment planning where mental health services were secured. However, the young people also stated that mental health services were often unable to provide direct support to them. In this sense participants perceived case coordination and integration to be limited across the mental health and drug treatment service systems (Bonomo, et al, 2004).

However, it should be noted that the provision of secondary consultation services, clinical reviews and cross sector professional development opportunities (activities somewhat invisible to service users) have certainly facilitated improved capacity in Youth AOD staff, resulting in more seamless and integrated responses to identified needs

Where mental health and drug treatment services were working together with a young person, the client was generally happy with the level of communication and integration across the two systems (Bonomo, et al, 2004).

Bay way of comparison, the *Project i* research into homeless young people's health found that they experienced high rates of mental illness and self harm and were using alcohol and other drugs in a problematic manner. Many of the young people interviewed felt that while they needed assistance relating to depression and/or anxiety, only just over 50% actually sought help. Most who sought help were satisfied with the service they received. However, of concern is the high number of young people with clinical levels of depression, anxiety and psychosis who did not seek help because of level of stigma attached to such issues (Project i, 2002; Rossiter, et al, 2003).

Barriers to improved service responses

The dedicated provision of youth focused AOD services has contributed to improved engagement and increased frequency of drug treatment and associated complementary services (e.g. support and referral regarding legal, primary health, housing, vocational services, etc) to young drug users. It has also reduced young people's concerns about access to services and perceived stigma and discrimination in relation to their AOD health service provision (Pead, Virins, and Morton, 1998).

The past 10 years have seen an increasing interest in the prevalence of co-occurring mental health and substance use problems in young people. High rates of dual diagnosis (a simultaneous substance use and mental health condition) presentation in young people are increasingly well recognized. A number of studies report individual rates of comorbid substance use and mental health problems, ranging from 20% to 87% depending on the diagnostic measures used, psychiatric conditions tested, and service at which initial presentation occurs (Bonomo, et al, 2004; Gossop, et al., 1998; Holgate & McDonald, 1999; Kessler, 1995; Murray, 2002; RachBeisel, Scott, and Dixon, 1999; Room, 1998; Reiger, Farmer, Rea, et al., 1990; Ryglewicz and Pepper, 1996).

It has been suggested that with the comorbidity between adolescent substance use and mental health problems increasing, the identification of more effective treatment approaches for this group is now viewed as a priority given their high presentation rates in Australia (Bradley and Toohey, 1999).

There has been a considerable service development across both the alcohol and other drug (AOD) and mental health (MH) systems in Victoria, and improved coordination of treatment responses. This has occurred locally through initiatives such as newly developed youth dual diagnosis worker positions in Victoria, which have been useful in identifying gaps and deficiencies within and across the service systems, and in the embryonic development of effective and practical integrated service responses to young people experiencing comorbid conditions.

The development of dual-diagnosis positions in each metropolitan Department of Human Services (DHS) region, including the development of youth focused dual diagnosis positions, appears to have improved cross-sector knowledge around target populations, demand characteristics, service response capacities, and the understanding of comorbid substance use and mental health conditions.

Perhaps the greatest obstacle to comprehensive dual diagnosis treatments remains the philosophical differences apparent between the drug treatment and mental health service systems (Health Canada, 2002). Inconsistency of concepts, language, and approach remain an obstacle to engagement, retention, and compliance in dual treatments, (Ridgely, Goldman & Willenbring, 1990), and reduce capacity to effectively assess both problems (Bradley and Toohey, 1999).

A number of potential systemic barriers to more effective dual diagnosis treatment have also been suggested, including different funding sources, differing educational credentialing requirements, and a lack of cross sector training (; Hall, 1996; Ridgely, Goldman & Willenbring, 1990). Service providers (including YSAS staff and mental health service workers) and clients interviewed in a recent training and service development needs analysis identified similar barriers (Bonomo, et al, 2004).

The combination of more severe functioning problems, and inconsistency of service system responses may in part contribute to poorer treatment outcomes for this group (Bradley and Toohey, 1999). For example, the AOD frameworks highlighted within dual diagnosis models have historically been confrontational, disease based, 12-step approaches. It has been noted that such approaches often sit in direct contradiction to mental health frameworks that advocate pharmacological maintenance approaches to management of mental health issues. It is thought such differences are hard to integrate when moving between the two service systems, and can often lead to confusion over appropriate treatment approaches for clients. Such literature suggests we need to identify methods and means of supporting and treating this population that are more understandable and acceptable to those using these services.

These methods could include using the positively evaluated hanges that have occurred in recent AOD service approaches to addressing problematic substance use, such as the technique of Motivational Interviewing and the Stages of Change Model (Proschaska & Di Clemente, (1986), which provides a theoretical interpretation of the cyclical, repeated and ongoing attempts across a range of stages in managing and treating substance use issues (Bonomo, et al, 2004).

A range of attitudinal, educational, and resourcing barriers appear to mask clinician capacity to effectively engage with dually diagnosed clients, especially across the mental health service system (Todd, Sellman and Robertson, (2002)

Dual diagnosis capable clinicians, who can effectively assess, support, and treat both mental health and substance use needs have been highlighted as crucial to improving service user outcomes. Todd et al., (2002) note that deficient clinician skills may reduce treatment effectiveness to the dually diagnosed.

Different tools and systems across the sectors may contribute to reduced detection and treatment of co-occurring conditions, with some tools considered insensitive to identifying concurrent conditions (Carey and Correia, 1998; Kavangh, 2001).

Burdekin (1993) highlighted the re-occurring theme of increasing specialization and exclusivity of services, which in turn meant that primary care providers were providing the majority of care. Such specialization and exclusivity are highlighted as significant barriers to clients experiencing multiple needs simultaneously across distinct service systems.

Separate and distinct cultures associated with the different service systems (NSW Health, 2000); separate funding; different educational credentialing requirements (NSW Health, 2000; Ridgley, Goldman, & Willenbring, 1990) and a lack of cross sector training (Hall, 1996; NSW Health, 2000) compound access and treatment blockages and highlight the need for more integrated responses.

Such barriers mean that the dually diagnosed fail to receive, or receive lower quality and/or intensity of treatment than those with single disorder (Kavanagh, 2001); are excluded from programs (NSW Health, 2000); and often fail to receive important early intervention services which may reduce the morbidity and mortality of identified illnesses (Kosky, 1992).

Services require an ‘equity of access’ or ‘no wrong door’ policy such that irrespective of which organization or service system is initially engaged, the client will be directed to an appropriate service response. Kavanagh (2001) has also cautioned against developing further specialist services given the increasing recognition of comorbidity as an “expectation rather than an exception”.

The ideal would be for AOD services to provide integrated care for dual diagnosis clients in consultation with mental health services, rather than simply referring them to a mental health service (Bonomo, et al, 2004).

NSW Health (2002), Minkoff (1989), Sciacca and Thompson (1996), Primm (2000) and Ananth, et al (1989) suggest that routine, integrated screening and assessment measures are crucial in the provision of effective detection and treatment services for co-occurring conditions and should be a priority for the service systems. The missed detection of alternate disorders or conditions hampers effective provision of dual diagnosis services.

Recommendations

It is the recommendation of YSAS that the Senate Select Committee support:

1. Further prevalence research of comorbid mental health and substance abuse conditions amongst young people under 25 years of age who are not engaged in treatment.

2. Research assessing the potential of early intervention strategies in addressing combined mental health and substance use conditions, particularly amongst young people under 25 years of age.

3. The development of tools facilitating the identification, screening, assessment, case planning, treatment and evaluation of outcomes related to young people under 25 years of age presenting with comorbid conditions across all sectors of the service system, not just mental health services.

4. The development of Clinical Practice Guidelines to support and direct practice amongst young people under 25 years of age across all sectors of the service system in the following areas: integrating case planning and treatment; crisis mental health support and management; therapeutic and pharmacological treatment and management; mental health promotion; behaviour modelling and skills training; and client matching.

5. Provision of training and joint workforce development in relation the effective integration of case planning and treatment across service systems, including mental health, alcohol and other drug, homeless services, Correctional Services, and Juvenile Justice.

References:

Ananth, J., Vanderwater, S., Kamal, M., Brodsky, A., Gamal, R., & Miller, M. (1989). Missed diagnosis of substance abuse in psychiatric patients. *Hospital and Community Psychiatry*, 40, 297-299.

Bonomo, Y., Allen, N., Lubman, D., Cementon, E., and Rogers, N. (2004) Developing Integrated service Responses for Young People with Both Mental Health and Substance Use Problems – Report No 1 – Dual Diagnosis Training and Service Development Needs Analysis. Fitzroy: YSAS

Bradley, A., and Toohey, B. (1999). The Coffs Harbour Project: A Violence Prevention Program For Substance Misusing Mentally Ill.

Burdekin, B. (1993). Human Rights and Mental Illness. Report of the National Inquiry into Rights of People with Mental Illness: Human Rights and Equal Opportunity Commission.

Carey, K. B., and Correia, C. J. (1998). Severe mental illness and addictions: Assessment considerations. *Addictive Behaviours,* 23, 735-748

Drake, R., Bartels, S., and Teague, G., et al. (1993). Treatment of substance use in severely mentally ill patients. *Journal of Nervous and Mental Disease, 181*(10), 606-611.

Drake, R., Mercer-McFadden, C., and Muser, K., et al. (1998). A review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*(589-608).

Gossop, M., Stewart, M., Lehmann, P., Edwards, C., Wilson, A., & Segar, G. (1998). Substance use, health and social problems of service users at 54 drug treatment agencies. British Journal of Psychiatry, 173, 166-171.

Granholm, E., Anthenelli, R., Monterio, R., Sevcik, J., and Stoler, M. (2003). Brief Integrated Outpatient Dual Diagnosis Treatment Reduces Psychiatric Hospitalizations. *The American Journal of Addiction, 12*(4), 306-313.

Hall, W. (1996). What have population surveys revealed about substance use disorders and their co-morbidity with other mental disorders. Drug and Alcohol Review, 15, 157-170.

Hall, W., Lynskey, M., and Tesson, M. (2000). What is Comorbidity and Why does it Matter? : National Drug and Alcohol Research Centre.

Health-Canada. (2002). Best Practices: Concurrent Mental Health and Substance Use Disorders: Minister of Public Works and Government Services Canada, Cat. #H39-599/2001-2E.

Holgate, F. and McDonald, P. (1999) *100% Dependent* Fitzroy: YSAS

Kavanagh, D. (2001). "Treatment of Comorbidity". In Teeson, M., and Burns, L. (Eds.) *National Comorbidity Project.* National Drug Strategy and National Mental Health Strategy. Canberra: Commonwealth Department of Health and Aged Care, pp. 60-70

Kessler, R. (1995). The National Comorbidity Survey: Preliminary results and Future Directions. International Journal of Methods in Psychiatric Research, 5, 139-151.

Kosky, R. J. and. Hall., J. (1992). Mental Health: Is Early Intervention the Key? *The Medical Journal of Australia, 156* (February 3), 147-148.

Ley, J., L,, McLaren, S., and Siegfried, N. (2000). Psychosocial Treatment Programmes For People With Both Severe Mental Illness and Substance Misuse (A Systematic Review): Cochrane Collaboration.

Minkoff, K. (1989). An Integrated Treatment Model for Dual Diagnosis of Psychosis and Addiction. *Hospital and Community Psychiatry, 40*(10), 1031-1036.

Mueser, K. T., Drake, R. E., & Noordsy, D. L. (1998). Integrated mental health and substance abuse treatment for severe psychiatric disorders. *Journal of Practical Psychiatry and Behavioral Health, 8,*, 129-139.

Murray, D (2002) *100% Dependent Revisited* Fitzroy: YSAS

NAAH, (NSW. Association. For. Adolescent. Health). (2003). Caught in the Gap: Dual Diagnosis and Young People. A report on the issues.

NSW-Health. (2000). The Management of People with a Co-existing Mental Health and Substance Use Disorder (Discussion paper): NSW Health Department.

Pead, J., I. Virins and J. Morton (1999). *Evaluation of the Youth Alcohol and Drug Outreach Services.* Located at www.dhs.vic.gov.au/phd/0003145/0003145.pdf Accessed 18 December 2002

Primm, A. (2000). Assessment and Treatment of Patients with Co Occurring Psychiatric and Substance Abuse Disorders. http://www.dualdiagnosis.org/library/dual_network/primm_winter_00.html

Proschaska, J. & De Clemente, C. (1986). Toward a Comprehensive Model of Change. In P. Press (Ed.), *Treating Addictive Behaviors, Processes of Change.*

Project i (2002) W*orking with homeless young people* The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

RachBeisel, J., Scott, J., & Dixon, L. (1999). Co-occurring severe mental illness and substance use disorders: A review of recent research. *Psychiatric Services*, 50 (11), 1427-1434.

Reiger, D., Framer, M., Rea, D., et al. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Result from the epidemiologic catchment area study. *Journal of the American Medical Association*, 264, 2511-2518.

Ridgley, M.S., Goldman, H,H,, Willenbring, M. (1990). Barriers to the care of persons with dual diagnoses: organizational and financing issues. *Schizophrenia Bulletin, 16(1), 123-132.*

Room, R. (1998). The Co-occurrence of mental disorders and addictions: Evidence on epidemiology, utilization and treatment outcomes. (ARF Research Document Services). Toronto: Addiction Research Foundation.

Rossiter, B., Mallett, S., Myers, P. and Rosenthal, D. (2003) *Living well? Homeless young people in Melbourne.* The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

Ryglewicz, H., & Pepper, B. (1996). Live at Risk: Understanding and Treating Young People with Dual Disorders. New York: The Fress Press.

Sciacca, K., &, Thompson, M. (1996). Program Development and Integrated Treatment Across Systems for Dual Diagnosis: Mental Illness,

Drug Addiction And Alcoholism, MIDAA. *Journal of Mental Health Administration, 23*(3), 288-297.

Todd, F., Sellman, D., Robertson, P. (2002). Barriers to optimal care for patients with coexisting substance use and mental health disorders. *Australian and New Zealand Journal of Psychiatry, 36*(6), 792-799.