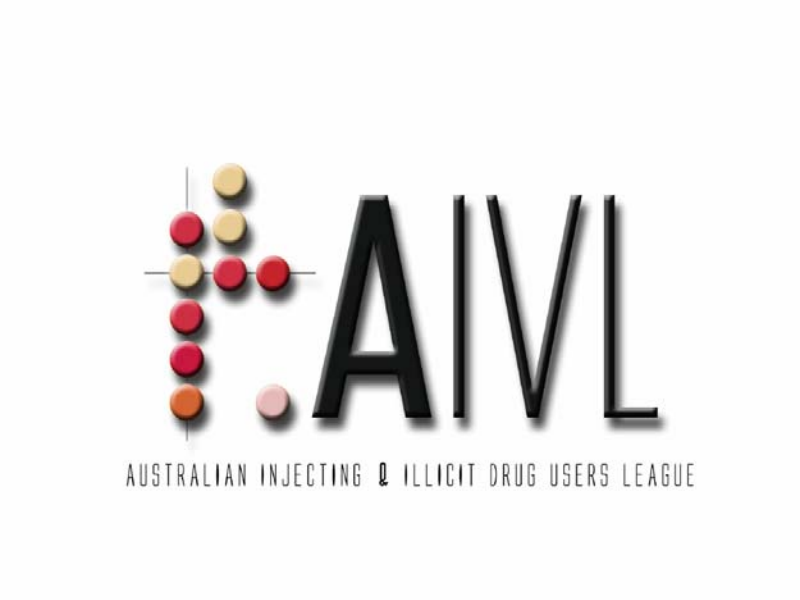

Submission to the Senate Select Committee on Mental Health

May 2005

Introduction

The Australian Injecting & Illicit Drug Users League (AIVL) is the peak national peer based organisation for the state and territory drug user organisations and represents people who use illicit drugs on issues of national significance.

AIVL remains concerned about the issues that people living with comorbidity experience. For many, living with comorbidity actually means being pushed from one service provider to another, not being understood, self medicating and experiencing a poorer quality of life. Comorbidity continues to be exacerbated by the at times additional complexities that some people experience such as homelessness, poverty, poor physical health, living with blood borne viruses such as Hepatitis C and HIV. In addition issues such as marginalisation and discrimination ensure that those living with comorbidity are less likely to be sufficiently empowered and able to access appropriate services.

For the purpose of this submission, AIVL will focus on the following term of reference:

> f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

Comorbidity is a hot topic within Australia there is a great deal of discussion, documentation, research and pontificating on this subject however this is having little baring on the lives of people living with comorbidity.

People with comorbidity experience:

- Inability to access services
- Having services withdrawn from them
- Experiencing lesser rights and standards of care
- Lower quality of life
- Being incarcerated
- Living within a continual cycle of being pushed from one service to another
- Remaining at risk of physical health issues such as blood borne virus transmission
- Isolation from families and friends
- Misdiagnosis

The experiences of people living with comorbidity are exacerbated due to:

- Drug treatment and harm reduction services being insufficiently able to manage people with comorbidity

- General Practitioners lacking sufficient experience in managing complex need
- Mental health services not being skilled in drug and alcohol problems
- Generic services not being trained in comorbidity
- There is a resistance to and therefore lack of partnership working between MHS, AODS and other services that work with this client group.

Other issues

- The complexity of drug trends and drug using patterns impact on people living with comorbidity. An example of this is the increase in the use of methamphetamine. This is great concern among MHS and AODS due to an increase in prevalence of people presenting at services experiencing drug induced psychosis. AODS workers report that they are insufficiently skilled and unable to manage people who present at their services. Equally, MHS are limited in the way that they provided services and care. At times the only support available when managing people with psychosis is from the police. This is of course inappropriate and can exacerbate the situation.
- AIVL is aware that in parts of the country, MHS services refuse to send out crisis teams when a person has used illicit drugs. Often responses from crisis teams can be that the person should be in AODS services or that they have got borderline/antisocial personalities. Accessing crisis response teams can be difficult and at times impossible for people who use illicit drugs.
- Current responses to comorbidity are unsurprisingly highly entrenched within medical models. At their peril MHS and AODS are not incorporating harm reduction within their responses. Too often demands of abstinence are made upon people who are living with comorbidity and this can result in people falling through the net – unable to meet treatment demands. Services for people with comorbidity need to be more pragmatic and accept that drug use is established and that harm reduction strategies must be used alongside more traditional forms of treatment.
- The issue of self mediation can be ignored by treatment and service providers. Many people self mediate by using illicit drugs to manage the symptoms of their mental health problems. Anecdotal evidence suggests the effects of heroin and cannabis are 'helpful' in peoples attempts to focus away from the distress and pain of hearing voices (auditory hallucinations), and the effects of cocaine and amphetamine in counteracting the extreme sedation and lethargy induced by anti psychotic medications, and negative symptoms (Phillips, P & Labrow, J. 1998). In addition, Dixon et al (1990), in one of the few studies which have examined this area suggest from a study undertaken with eighty three psychotic inpatients in a New York teaching hospital, that although drug use may exacerbate psychotic symptoms, it may also lead to symptom

reduction in some groups of people with schizophrenic illness[1]. The management of comorbidity needs to be holistic in approach and recognise the complexities that people with comorbidity present. Traditional models of mental health treatment where one prescription fits all needs to be broadened when working with such complex need.

- Social issues also impact on people who are living with comorbidity. Homelessness, poor nutrition and physical health issues all compound on a persons life.
- Other health issues that people who inject drugs live with for example hepatitis C can also exacerbate comorbidity issues. The diagnosis of having hepatitis C can in itself lead to people experiencing feelings such as grief, fear and guilt. If left these may develop into more demanding mental health states such as anxiety and depression. Many people living with hepatitis C receive little treatment and support. Comorbidity places another challenge for the individual to manage. Services working with people living with hepatitis C need to be skilled in managing comorbidity issues from testing and diagnosis, symptom management through to treatment.
- Drug interactions between the illicit drugs a person may take and those prescribed to treat a person's mental health problem also need to be more greatly considered when working with people that are living with comorbidity. Poor drug interactions can lead to people not adhering with treatment regimes. This compounds the stereotype of people with comorbidity being "difficult and unable to engage in treatment".
- AIVL has also received reports from our member organisations and individuals regarding the over prescribing of antidepressants to people who are receiving drug treatment. We are aware of people receiving antidepressants with their daily dose of methadone and having no knowledge of why they are being prescribed medication for depression.
- It is possible for people to become dependent on the medication that is being prescribed to them for their mental health problem. This can make treatment complex and unsatisfactory. It is not uncommon for people who are receiving long term treatment from specialised mental health teams to then be referred on to AODS should they discover that a person is not taking their medication as prescribed and has become dependent upon it. Rarely are shared care agreements established and people can be left feeling further isolated, confused and abandoned.
- Indigenous people face further challenges. It is common for a person's cultural beliefs and values to be misdiagnosed as mental health issues. In addition as one person quoted to AIVL, "They are attending services that are already not able to deal with their complex health issues and many of the Indigenous specific services are not dealing effectively with drug or

[1] Dixon, L., Haas, G., Weiden, P., et al (1990) Acute effects of drug abuse on schizophrenic patients: clinical observations and patients' self reports. Schizophrenia Bulletin. 16, 69 – 79

mental health issues so it leaves them pretty much out in the cold (and homeless)".

- People from culturally and linguistically diverse backgrounds can also find comorbidity issues more difficult to manage due to language barriers and a misunderstanding of their cultural values and beliefs. Culturally specific treatment options need to be developed and implemented.
- A significant number of people incarcerated within Australia's prisons are people who have committed drug related crime. We know that incarceration itself can result in people experiencing mental health problems and diagnosis and on going treatment can be hard for a prisoner to access. Prisoners that are initiated and continue to use illicit drugs while in prison are not likely to disclose such behaviour for fear of repercussions. This ensures that people in prison with comorbidity will have poorer treatment outcomes. It is vital that MHS and AODS in prisons are able to work in partnership in a productive and confidential way to ensure that prisoners are able to get appropriate treatment.
- Often, families are left to manage and cope with a family member who is experiencing a mental health problem. There is a need to provide support services that include education and counselling to families. Such services should be provided by MHS and AODS.
- More information needs to be made available on the nexus between drug use and mental health.

Recommendations

- Appropriate models of shared care need to be carefully developed.
- Harm reduction strategies need to be seen as a valuable component of treatment for people living with comorbidity.
- Prisons need to develop assessment and referral models for when people leave prison and return to the community.
- Diversion to ethical and appropriate treatment programs as an alternative to custody need to be considered for people living with comorbidity.
- A workforce development program needs to be implemented for both the AODS, MHS and other related services to enable services to better provide for people living with comorbidity.
- People living with comorbidity need to be empowered to retain a stronger advocacy role within the various sectors.
- The role of peer education and support needs to be expanded.
- National initiatives such as the National Comorbidity Taskforce which has been disbanded need to be reinstated with appropriate funding.

Conclusion

AIVL would like to thank the Senate Select Committee on Mental Health for the opportunity to participate within its processes. AIVL would also welcome the opportunity to discuss our issues further within a public hearing.