



Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug policy

PO Box 7186, KALEEN ACT 2617

Email president@ffdlr.org.au

Email secretary@ffdlr.org.au

Web www.ffdlr.org.au

Twitter [@FFDLR](https://twitter.com/FFDLR)

21 January 2020

Prof Stephen King,
Commissioner,
Inquiry into Mental Health
Locked Bag 2, Collins St East
MELBOURNE Vic 8003, Australia

Dear Prof King,

Post draft submission on Mental Health

1. We take it from the reaction to our submission at the hearing you kindly gave us in Canberra on 25th November that the Commission does not consider that the review of drug policy falls within your remit. Even so, the nub of my halting presentation urged no more than what you simply and succinctly expressed in your draft report, namely that "for effective treatment there should be an alignment between mental health and alcohol and drug policies" (Draft report, vol. 1, p. 26). Indeed, on the basis of what you, the Commission, have so carefully assembled in your draft report, that conclusion is unavoidable.

2. We therefore propose that you reinforce your position with a specific recommendation to that effect in your final report and that the National Mental Health Commission specifically monitor the degree to which progress is being made in integrating mental health and alcohol and drug policies and programs as part of its routine monitoring of the Fifth National Mental Health and Suicide Prevention Plan:

In the light of the heavy burden on the mental health system of co-occurring substance dependency which is the expectation rather than the exception recognised by successive National Mental Health Plans and Drug Strategies, the government should examine how to better align and integrate mental health and alcohol and drug policies and programs.

This examination should draw upon available evidence about the successful integration of services to people's suffering from those co-occurring conditions and set out the elements of a national approach which will yield

measurable improvements for these individuals, families, the community and the economy.

That the National Mental Health Commission include monitoring the degree to which progress is being made in integrating mental health and alcohol and drug policies and programs in its monitoring of the Fifth National Mental Health and Suicide Prevention Plan.

3. As the rest of the letter summarises, it is only by the integration and alignment of mental health and alcohol and drug policies that the needs of people suffering from complex mental health conditions and stigma and alienation can be effectively addressed.

4. The Foundation for Alcohol Research and Education in its submission no. 269 has drawn your attention to the pertinent acknowledgement of the New Zealand Inquiry into mental health and addiction that addiction should be treated as a health rather than a criminal justice issue. According to that New Zealand government inquiry:

"The criminalisation of drug use has failed to reduce harm around the world. A shift towards treating personal drug use as a health and social issue is required to minimise the harms of drug use. Demand for addiction services is increasing and investment in more services is needed, from brief interventions in general practice and primary care settings to social and detox options and follow-up community-based services. Alcohol and other drug policy leadership and coordination also needs a clear home within government"¹

5. As we endeavoured to make clear in our submission and presentation, our interest focused particularly on the cohort of "consumers with the most complex mental health needs" (draft report vol. 1, p. 27) who in large measure suffer from a co-occurring substance issue. Indeed you acknowledge that: "The rate of substance use comorbidity among people who seek treatment is so high that it is considered 'the expectation, not the exception'" (vol. 1 p. 324).

6. At the core of your draft recommendations you have identified the need to assist "clinicians and other providers in the health system . . .to better deliver mental health services" (overview, p 25). You propose navigation platforms to facilitate entry of consumers to the mental health system via non-health pathways; care plans for those requiring intensive clinical treatment (p. 26) and care coordinators to oversee the implementation of care plans for the estimated 460,000 people with "the most complex mental health needs." (p. 27) - overwhelmingly those with co-occurring substance dependency and other mental health issues. To bring about these admirable changes you have recognised the need for "A health workforce that can

New Zealand, *He Ara Oranga – Report of the Government Inquiry into Mental Health and Addiction* (2018). Retrieved from <https://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf>, p. 14.

deliver the changes needed” (p. 27) by augmenting the knowledge and skills of GPs in mental health (p. 28) and, of course, by increasing the availability of mental health specialists (p. 29).

7. Essentially, these recommendations repeat a call for collaboration and capacity enhancement of services that are found in earlier national mental health plans. You are following their lead in looking to clinicians and other providers to resolve the current considerable problems and challenges of the mental health system – problems that are particularly burdened by people with complex needs.

8. Your draft report acknowledges this similarity of response:

“Nationally, substance use comorbidity has been a focus area for about 20 years. The National Comorbidity Project, launched in 2000, brought together the National Drug Strategic Framework and the Second National Mental Health Plan (DoH 2009b). This Project identified several areas for action, including greater collaboration between services and building the capacity for services to improve their response to comorbid mental health and substance use problems. This was followed by the National Comorbidity Initiative in 2003-04, which funded several research projects (Australian Government 2003, p. 175)” (Draft report, vol 1 p. 325).

9. Echoing the *Fourth National Mental Health Plan* at p.44, the current fifth National Mental Health and suicide prevention Plan of 2017 draws attention to the fact that:

‘The combination of substance misuse and mental illness makes diagnostic and treatment decision-making difficult and successful interventions are often dependent on concurrent responses to both disorders. It is therefore essential that the linkage and management of these comorbidities are considered in system and service planning. Implementation of the Fifth Plan will be progressed with reference to work committed to under the National Drug Strategy 2017-2026, which provides a framework to guide the work of governments, communities and service providers in minimising alcohol and other drug-related harms” (*The Fifth National Mental Health and Suicide Prevention Plan*, p. 8).

In its 2019 review of the Fifth Mental Health Plan, the National Mental Health Commission makes makes a similar point about the struggle of the existing mental health system to address the complexity of mental health needs and that progress requires “ . . . real commitment to integrate services and increase accessibility integration of services across government” (p. 8):

“ . . . The relationship between social determinants and mental health is dynamic and complex. As a result, the effects of social determinants on mental health and wellbeing should not, and cannot, be addressed by mental health interventions alone.” (p. 11).

10. Repeating in your draft a call for clinicians and other service providers to better coordinate their services is, thus, not innovative and unlikely to produce better, much less “the best possible mental health and wellbeing outcomes” sought by the Treasurer in his reference to you.

11. You correctly identify the need to reduce stigma (draft report vol. 1, p. 93) that the Submission of the Australian Drug Foundation points out is intimately associated with illicit drug dependence (a recognised mental health condition):

"The evident lack of treatment for people with substance use disorders is attributable partly to stigmatisation because drug dependency is regarded normatively as a consequence of “personal choice or moral failure” [27]. The World Health Organisation rates illegal drug dependence as the most stigmatised health condition and lists alcohol dependence as the fourth most stigmatised. Reducing the stigma around alcohol and other drug dependency is important if those in need are to gain help as early as possible." (submission 288).

12. We also applaud your recognition of the need to address a range of psychosocial factors if the burden of mental ill-health is to be reduced:

“the importance of non-health services and organisations in both preventing mental illness from developing and in facilitating a person’s recovery are magnified, with key roles evident for — and a need for coordination between — psychosocial supports, housing services, the justice system, workplaces and social security” (p. 2).

13. For all that, your draft recommendations do little more than repeat elements of existing mental health plans with the stress they place on destigmatisation of mental illness. The Fifth Plan regards “Reducing stigma and discrimination [as] critical to improving the wellbeing of people living with mental illness” (39) and places the reduction of stigmatisation and discrimination among the eight priority areas of the Fifth Plan (p. 15-16). Moreover, your draft report like these plans considers destigmatisation in the context of social inclusion:

Reducing stigma and discrimination is critical to . . .promoting better mental health within society. While there have been some improvements in knowledge about mental illness, there is still widespread misunderstanding, and people living with mental health illness still experience significant stigma. It will take a sustained and collective effort to dispel the myths associated with mental illness, change ingrained negative attitudes and behaviours and, ultimately, support social inclusion and recovery.(Fifth Plan p.39 and, similarly, 2009 – 2014 Plan p. 13)

14. Your draft also follows the fifth and the fourth plans in calling for an integrated approach to address psychosocial impediments to good mental health:

“An integrated, culturally competent and sustainable service system provides the right amount of tailored clinical and community supports, at the right time, for people with severe and complex mental illness” (Fifth Plan p.29).

In the words of the 2009 – 2014 Plan:

Recognition of the importance of social, cultural and economic factors to mental health and wellbeing means that both health and social issues should be included in the development of mental health policy and service development. The principle includes support to live and participate in the community, and

Effort to remove barriers which lead to social exclusion such as stigma, negative public attitudes and discrimination in health and community settings. The National Social Inclusion Principles should underpin reform in mental health. (p. 13)

15. Given your failure to identify any new credible strategy to reduce the very large burden of disease and personal suffering that flows from situations of comorbidity involving substance use, we are at loss to understand how you can realistically expect that the stepped care model that you favour will improve the situation. After all, you acknowledge that “Stepped care has been adopted nationally in Australia, and while its use is widely accepted, its implementation has proved challenging” (vol. 1, p.17). Why? Our submission and halting presentation offered an answer. The characterisation of this cohort as criminals creates and intensifies stigmatisation and alienation, colours the response of clinicians and other service providers, fractures family support, leads to the warehousing of people in prisons thereby intensifying their mental health problems and compounds their complex knot of social problems like homelessness, unemployment and poverty that are recognised risk factors for mental ill-health (and substance abuse).

16. Benefits from the elimination of the tensions created between the law’s characterisation of drug users as criminals and a caring and supportive therapeutic environment regarded as a *sine qua non* of good health care are obvious.

17. In our view it would be to kick the can down the road for the Productivity Commission to leave unaddressed the interaction between drug policy and the mental health system. Indeed, as I pointed out at the beginning of this letter, you have acknowledged that effective treatment requires “an alignment between mental health and alcohol and drug policies” (Draft report, vol. 1, p. 26). If you do not consider that your terms of reference authorise you to explore drug policy we urge you to at least point out in your conclusions the apparent potent interaction of drug policy and mental health. To reiterate, there is a need for a specific recommendation to address this:

In the light of the heavy burden on the mental health system of co-occurring substance dependency which is the expectation rather than the exception

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recognised by successive National mental health plans and drug strategies, the government should examine how to better align and integrate mental health and alcohol and drug policies and programs.

This examination should draw upon available evidence about the successful integration of services to people experiencing those co-occurring conditions and set out the elements of a national approach which will yield measurable improvements for these individuals, their families, the community and the economy.

That the National Mental Health Commission include monitoring the degree to which progress is being made in integrating mental health and alcohol and drug policies and programs in its monitoring of the Fifth National Mental Health and Suicide Prevention Plan.

Yours sincerely,

(Bill Bush)
President,
Families and Friends
for Drug Law Reform