



Submission to the Inquiry into the social and economic benefits of improving mental health

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

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About VAADA

VAADA is a non-government peak organisation representing publicly funded Victorian AOD services. VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug (AOD) use across the Victorian community. VAADA's purpose is to ensure that the issues for people experiencing harms associated with substance use and the organisations who support them are well represented in policy, program development and public discussion.

VAADA's membership comprises agencies working in the AOD field, as well as those individuals who are involved in, or have a specific interest in, prevention, treatment, rehabilitation or research that minimises the harms caused by AOD.

What does VAADA do?

As a peak organisation, VAADA's purpose is to ensure that the issues for people experiencing the harms associated with AOD use and the organisations that support them are well represented in policy and program development and public discussion.

VAADA seeks to achieve this through:

- Engaging in policy development;
- Advocating for systemic change;
- Representing issues our member's identify;
- Providing leadership on priority issues to pursue;
- Creating a space for collaboration within the AOD sector;
- Keeping our members and stakeholders informed about issues relevant to the sector; and
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drug services (and related services).

About AOD treatment

AOD treatment works and is cost effective

- AOD treatment provides a strong return on investment with evidence indicating that over a 12 month period, treatment provides a cost benefit ratio of \$8 saved for every \$1 spent (Coyne, White & Alvarez 2015);
- A large Australian treatment outcome study showed that individuals who accessed AOD treatment utilized less acute health services in the year after the treatment in comparison to the year leading up to the treatment:
 - Overall demand for acute services among those with AOD dependence issues decreased from 60 to 51 percent
 - ambulance attendances decreased from 35 to 29 percent; and
 - Hospital emergency admissions decrease from 53 to 44 percent (Manning et al, 2017)
 - AOD treatment reduces acute health service demand with a 16 percent reduction in research participants requiring ambulance, ED or hospital admissions in the year post treatment. Further, the authors assert that this is 'likely to reflect a substantial reduction in health care costs'.

- Evidence indicates that AOD residential rehabilitation is more cost effective than prisons, with the diversion of Aboriginal people to rehabilitation programs achieving a saving of \$111,458 per person with additional health related savings associated with lower mortality and better health outcomes valued at \$92,759 (ANCD 2012);
- AOD treatment reduces the average duration of heroin use from 20 to 11 years (NHS 2012)
- The Drug Court achieves a cost benefit ratio of 1:5.81 (VAADA 2013); a more recent review of the Victorian Drug Court (KPMG 2014) found that over two years it accrued \$1.2M in savings through reducing the prison population (these savings do not account for the range of other benefits including reduced recidivism and improved health and social circumstances)

Co-occurring AOD and mental health disorders is a very common phenomena and highly prevalent among many individuals in need of AOD treatment:

- *Approximately 35 percent of individuals experiencing AOD dependency also experience 'at least one 'affective or anxiety disorder, representing approximately 300,000 Australians' (Marel et al 2016, p 12); and*
- *62% of individuals using AOD daily experienced a mental disorder over the past 12 months (Marel et al 2016).*

It is evident that AOD treatment provides a return on investment and much of that return is achieved through the delivery of high quality support services to individuals experiencing co-occurring AOD and mental health issues.

VAADA welcomes the opportunity to contribute to this important inquiry and note that the Productivity Commission's inquiry into 'the Social and Economic Benefits of Improving Mental Health' is running parallel to the Victorian Royal Commission into Mental Health. Both activities are an opportunity to lay the foundations for significant social change to affect the lives of many vulnerable Australians who have experienced mental illness and accompanying morbidities for many years.

The systemic neglect of the many individuals experiencing mental illness and their families has contributed to a broad range of harms including recently year on year increases in suicide, the rapid growth in our prison system and a range of co-occurring harms including those associated with AOD dependence. We note that at a systems level, Victoria's mental health system has a per capita expenditure at 13 percent, and service access at 40 percent, below the national average (Mental Health Victoria 2018), leaving many Victorians struggling to get the help they need.

Current evolving endeavour such as the NDIS, which for many has been viewed as a landmark reform has at this stage not been strongly delivered for those experiencing mental illness. The episodic nature of mental illness creates challenges for some in accessing the NDIS, with reports noting that in Victoria, 135,000 people with severe mental health concerns will have to rely on 'non-NDIS mental health services' for support (Mental Health Victoria 2018).

We note with some concern that the Issues Paper prepared to inform this Inquiry situated AOD dependency as under consideration for being in scope. AOD issues are evident with approximately 50 percent of those who experience mental illness. Lubman et al (2017) note that those experiencing co-occurring mental health and AOD issues create more complexity in achieving positive treatment outcomes; such cohorts are more likely to consume more alcohol, more likely to relapse and require a more comprehensive treatment response. Essentially, if this review deems AOD out of scope than it is only examining the circumstances of half of the impacted population. Moreover, those experiencing co-occurring AOD and mental health issues

Recommendation 1: AOD should be in scope for this inquiry.

While we will not be responding to the specific questions contained within the paper, we will provide a response under a number of the themed headings.

Structural weaknesses in healthcare

The Issue Paper's two questions listed under this heading provide an opportunity to identify service gaps and limitations. We note those listed in the Issues Paper (page 12) as being enduring limitations in providing an optimal response to mental health issues. Inequity in access due to postcode, fragmentation, displaced resourcing, an absence of supported cross sector capacity building and coordination stymie the achievement of optimal outcomes. There is a need for supported cross sector coordination, the prioritization of local solutions and an emphasis on early intervention.

Recommendation 2: resource cross sector capacity building and coordination.

What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?

Within our capacity as peak body for the Victorian AOD sector our focus will be on the intersect between AOD and mental illness.

Within Victoria, the previous government undertook a recommissioning of both the community mental health and AOD systems. The new arrangements resulting from these reforms lead to the emergence of a number of new providers, new systems of service access and delivery and a new unit of funding for services. In the short term, the impact of this process was devastating for AOD service users, with a 20 percent attrition in service user access in the following 12 months. Many of those who could not access the sector would have experienced co-occurring AOD and mental health concerns. However, in the years following that reform, demand for AOD treatment increased as at risk populations became acclimatized to the new arrangements. With this in mind, any reform in either domain requires considerable depth in planning, sector consultation and participation and communication. Moreover, consumer involvement in all stages of any reform process is crucial.

Recommendation 3: ensure that any reforms are conducted with consideration to:

- **Ongoing and comprehensive participation from impacted sectors and service users**
- **clear channels of communication are established to provide up to date information to impacted workforces to minimize workforce churn**
- **realistic timelines for reform activity**
- **impact of reform process on service users, including access**

On broader reform, there is a need to support programs which function as early intervention. A greater emphasis on activity occurring within the school environment, with clear referral pathways, addressing stigma and involving the family if adverse circumstances are evident. Up to 75% of all mental health conditions occur prior to the age of 25 (Beyond Blue 2019) so a focus on early intervention among young people is vital. By way of example, the contribution of young people by

way of employment is limited in cases where mental health concerns are evident, and more so in cases where pre-existing vulnerabilities exist within the family structure (Carlisle et al 2019). In Victoria, a commitment to provide enhanced mental health support within each public school at a secondary level is a worthwhile initiative (Victorian Government 2018) but more is required to better respond to emerging issues.

Supporting young people as well as the broader family unit, especially in cases where vulnerability is evident, will engender a greater likelihood of future positive contributions and wellbeing.

Recommendation 4: greater support availed to young people within educational institutions

System reform needs to enable seamless cross sector engagement in cases where complexity and co-occurring conditions are evident; capacity for family engagement should also be supported. Opportunities to address frequently recurring harms emerging from regular emergency department attendances due to mental health or AOD issues should be prioritised. For instance, with AOD related frequent attendances, emergency departments should either host or have clear pathways to residential withdrawal facilities coupled with ongoing support with the capacity to step up back into the residential facility if there is a need.

Recommendation 5: further support to emergency departments to support frequently attending patients to engage in the required services to address the drivers of harm.

There is limited support from addiction medicine specialists (AMS) for people experiencing complex AOD issues in Victoria with only 30 AMS in the state and only one of those operating in a regional location; comparatively, NSW has over ten-fold the AMS in training as well as a number of funded positions (Statewide Pharmacotherapy Network 2017). There is a clear deficit of this service type in Victoria, many which support individuals with co-occurring AOD and mental health concerns. The roll out of Victoria's real time prescription monitoring system, *Safescript*, will create greater demand for AMS as those taking medications to address various forms of mental illness and anxiety are identified as at risk by the system. Currently, within one PHN, 4500 people have been identified by the system over the past six months (Victorian Government 2019); following this trend, it is likely that over 25,000 people will be identified by Safescript with many requiring various interventions. It is worth noting that currently the AOD sector caters to over 30,000 Victorians annually and there are approximately 15,000 people engaged in pharmacotherapy. If a significant portion of the indicated 25,000 are in need of an AOD treatment response or are required to engage the pharmacotherapy system, the system will be significantly overburdened. People waiting for treatment equate to people missing out on a necessary health intervention.

Recommendation 6: additional addiction medicine specialists AMS?

Recommendation 7: national recognition on the value of AOD services as a key support service to pharmaceutical related dependency presentations, particularly as various real time prescription monitoring systems emerge throughout the nation.

Health workforce and informal carers

This section reflects broadly on workforce issues including shortages, capabilities, different professions, churn and training. These issues are highly prevalent within the AOD sector, particularly in rural and regional areas of Victoria. Our survey of the sector in 2018 found that recruitment and retention were enduring issues for the sector, with the recent growth in the Victorian sector (additional rural and regional residential rehabilitation capacity among other areas of growth) creating greater demand for a highly skilled employees among a workforce that has experienced static growth. Recent reforms, including over the past decades, periods of uncertainty with regard to Commonwealth funded AOD programs has created anxiety within the AOD workforce, with many transitioning to seemingly more secure sectors. A growth in the community mental health sector would likely cause more highly skilled AOD workers to move to a more highly remunerated sector. While we support growth in the community mental health sector, endeavor must be employed to ensure that any attrition to the AOD sector is compensated through activity to build the workforce. An appropriate vehicle to safeguard the capability and durability of workforces is the development of a funded Industry Plan to build in and resource workforces, accounting for system change, demand for services and future expectations with regard to workforce composition and qualifications.

Supporting and maintain the workforce and building cross sector capability should be prioritised across the mental health and related service sectors.

Recommendation 8: significant investment in the mental health and related workforces:

- **develop a Sector Industry Plan**
- **prioritise cross sector capacity building**
- **introduce a loading for rural and regional areas to attract and retain workers**
- **ensuring that the impact of sector growth on the retention and stability of related workforces is accounted for**

Questions on Justice

The justice system acts as a holding facility for many vulnerable individuals experiencing serious mental health issues. The restrictive and punitive nature of the prison system outweighs any therapeutic benefit which is afforded through the therapeutic responses provided therein. One in two prisoners experience mental health issues which are often exacerbated by the oppressive nature of the prison system. With recidivism rates of over 50 percent in Victoria it is clear that attempts to find a circuit breaker on the churn of repeat offending remains elusive.

The growth of the prison industry has reached unsustainable heights with, in Victoria at least, each new term of government heralding a new prison or substantial expansion on existing facilities. Prisons represent a significant drain on resources with recent reporting noting that each prisoner costs the state over \$118,000 per annum (Hurley 2019). Prisons are unstable and unsafe environments, especially for vulnerable people experiencing mental health issues, with prisoner on prisoner assaults up 40 percent over the past five years. The prison population has quadrupled in the past 30 years, from just over 2000 in 1998 to 8205 in 2019 (Sentencing Advisory Council 2019; Preiss 2019). Regrettably, prisons are now a major employer with the necessary growth in correctional staff a clear sign of broader policy failure.

Maintaining the current trajectory (through retention of the current policy settings) will exacerbate the crisis. The current settings on recidivism alone will continue to drive up the prison population. The cost to the economy through reoffending, chronic prison based health issues (such as hepatitis C),

poorly supported mental health conditions and the highly unlikely prospect of employment due to the durability of a criminal record locks in recurrent expenditure in the billions with no positive return on investment.

Measures aligned with justice reinvestment, which champion an up lift in support services in high risk areas, the reduction in administrative offences and an emphasis on policies which address disadvantage should be prioritised. Ongoing support beyond the prison gate amounting to long term supported community integration covering a range of support services should also be funded.

Recommendation 9: Justice reinvestment should be underpinning Australian justice and welfare policy.

Reducing the prevalence and severity of mental health involves a broad based multisector approach which provides various supports throughout all life stages. The service responses must be coordinated, reflect evidence informed practice and be adequately resourced. Governments seeking to achieve savings in underspending on community services are forced to cover the avoidable excessive expenses relating to corrections and acute health issues.

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