PENINGTON INSTITUTE

Productivity Commission – Inquiry into Mental Health

Response to Draft Report – Penington Institute

22 January 2020

About Penington Institute

Penington Institute advances health and community safety by connecting substance use research to practical action.

It's too easy to judge people who use drugs.

But, legal or illegal, the misuse of any psychoactive substance impacts us all.

At Penington Institute, we think it's far more productive to prevent and tackle drug use in a safe, effective and practical way.

Risky behaviours are part of being human.

Our focus is on making individuals and families safer and healthier, helping communities, frontline services and governments reduce harm, respect human rights and improve the rule of law.

Founded by needle exchange workers and people with lived experience of drug use in 1995 as a peak body, The Association of Needle Exchanges (ANEX) grew into Penington Institute, named in honour of Emeritus Professor David Penington AC, who led Australia's early and world-leading approach to HIV/AIDS.

Like Professor Penington, who remains our Patron to this day, we confront the most important issues and champion innovative evidence-based action to improve people's lives – no matter how challenging our perspective might appear.

A not-for-profit organisation, Penington Institute's research and analysis provides the evidence needed to help us all rethink drug use and create change for the better.

We focus on promoting effective strategies, frontline workforce education and public awareness activities. Our work has a positive impact on people, health and law enforcement systems, the economy and society.

An independent voice of reason on drug policy, we are a straight-talking ally for practical insights, information and evidence-based action for people in need.

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Introduction

Penington Institute welcomes the opportunity to respond to the Productivity Commission's Mental Health Draft Report.

Mental health is inextricably linked to broad social issues such as employment, economics, welfare, public health, education, housing and service availability. It is also closely tied to substance use; people with co-occurring substance use and mental health issues are among the most vulnerable people in Australia.

The Productivity Commission's Draft Report acknowledges that many people with mental illness will also experience a substance use disorder, as well as poor physical health.[1] It also notes the high prevalence of mental illness among people involved in the criminal justice system,[2] which, due to a response to illicit drugs in Australia that prioritises law enforcement, is also directly relevant to co-occurring substance use and mental health problems.

In this response to the Draft Report, Penington Institute focuses on the Productivity Commission's discussions of comorbidities (Chapter 9) and justice (Chapter 16).

Addressing the complexity of co-occurring mental illness and substance use

The Productivity Commission recognises that:[3]

> the presence of both mental and physical health conditions, sometimes including substance abuse, require[es] coordination between primary care and specialist mental healthcare and coordination with other clinical service providers (treating the physical illness).
>
> Improving outcomes for people with complex needs is about ensuring they have access to the services needed (both clinical and broader), when they are needed, with effective information flows and coordination between clinicians and other services.

Despite existing data on this co-occurrence of mental illness and substance use, there remains more to be done to understand its reciprocal causality and the common pathways that lead to different forms of co-occurrence. Penington Institute supports the Productivity Commission's suggestion that rates of use of licit and illicit drugs that contribute to mental illness in young people be used as an indicator to measure progress against the outcome of physical and mental health. In the absence of data on the different

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[1] Productivity Commission (2019). *Mental Health: Draft Report, Volume 1*. Canberra: Productivity Commission, Chapter 9.

[2] Productivity Commission (2019). *Mental Health: Draft Report, Volume 1*. Canberra: Productivity Commission, Chapter 16.

[3] Productivity Commission (2019). *Mental Health: Draft Report, Overview & Recommendations*. Canberra: Productivity Commission, p. 25.

pathways to co-occurring mental illness and substance use, our understanding of optimal interventions will necessarily be limited.

Nonetheless, the Productivity Commission suggests that addressing comorbidities among people with mental illness requires a range of measures, including:[4]

- addressing stigma and discrimination among healthcare providers that causes them to downplay the need to treat the physical ill-health and provide lower-quality treatments;
- addressing the difficulties people face in finding and accessing support, such as by assisting them to access services and by filling gaps in the availability of allied health services, such as dieticians and alcohol and other drug counsellors; and
- improving coordination and integration of mental and physical healthcare across all services, providers, professions and settings.

The Draft Report does not discuss the critical role that needle and syringe programs (NSPs) play in addressing the complexity of co-occurring mental illness and substance use. Penington Institute argues that NSPs should be included in the Productivity Commission's Final Report as they contribute significantly in this area by working to reduce stigma and discrimination, by supporting people to access services and by facilitating integration between the mental health and alcohol and other drug (AOD) service systems. Penington Institute itself is in a position to make valuable contributions to reducing stigma and discrimination.

Reducing stigma and discrimination

People involved with problematic drug use are among the most marginalised groups in the community, with levels of stigma particularly high among those who inject. Although there are no data available, it is likely that even greater stigma and discrimination are experienced by people who both use drugs and have a mental illness. The co-occurrence of the two circumstances presents particular challenges in terms of reducing stigma and discrimination.

Much work has been successfully undertaken to reduce the stigma associated with mental illness; very little, however, has attempted to reduce the stigma and widespread discrimination experienced by people who use drugs. This disjunction means that people who use drugs who also have a mental illness are not afforded the same level of protection against stigma as are others, which potentially acts as an obstacle to receiving appropriate treatment:[5]

> *The stigma often associated with substance use disorders—driven by perceptions that they are moral failings rather than chronic diseases—can exacerbate these treatment barriers. For example, negative attitudes among health care professionals toward people with OUD [opioid use disorder] can contribute to a reluctance to treat these*

[4] Productivity Commission (2019). *Mental Health: Draft Report, Volume 1*. Canberra: Productivity Commission, p. 323.

[5] Pew Charitable Trusts (2017). *The case for medication-assisted treatment*. Fact Sheet. Although the document focuses on opioid dependence, it is relevant to illicit drugs more broadly.

patients. "Stigma has created an added burden of shame that has made people with substance use disorders less likely to come forward and seek help."

Reducing stigma is important to encourage people into AOD treatment; stigmatising people who use drugs reduces the likelihood that those who need care will actually seek it. The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommends:[6]

> *Developing a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards meth/amphetamine use and dependence and enable affected individuals to seek treatment and help, is paramount to both minimising harm and reducing demand.*

Even in the health care sector, drug use is seen as a moral failure and personal choice, while mental illness is considered beyond a person's control. This 'moralisation' of drug use places the responsibility firmly on the individual for her or his life circumstances, rather than seeing substance use as a product of broader social forces, inequality and disadvantage.

The implications of this stigma can be profound. Anxiety about encountering stigma and discrimination can lead people to avoid seeking help from support services or to withdraw from treatment. Stigma can lead to health professionals refusing to offer services or responding to people who use drugs in a negative way. Indeed, survey data of NSP clients show that almost one-quarter (24%) have 'always' or 'often' experienced stigma or discrimination in relation to their injecting in the last 12 months, with a further 30% 'sometimes' experiencing stigma.[7]

There is significant inequity in the health system's response to people who use drugs,[8] based largely on the stigma associated with drug use.[9] For example, health professionals do not hesitate to treat chronic diabetes or heart disease, yet are reluctant to treat opioid dependence: despite evidence of its efficacy, medically-assisted treatment for opioid dependence is offered by less than 10% of general practitioners and 40% of pharmacies nationwide.[10]

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[6] Royal Australian and New Zealand College of Psychiatrists [NSW] (2019). *Improving the mental health of the community: Submission to the Special Commission of Inquiry into the drug 'ice'*. RANZCP, p. 10.

[7] Cama, E., Broady, T., Brener, L., Hopwood, M., de Wit, J. and Treloar, C. (2018). *Stigma Indicators Monitoring Project: Summary report*. Sydney: Centre for Social Research in Health, UNSW Sydney.

[8] For example, a New Zealand study identified service-related factors as key barriers to accessing MATOD, including staff having abstinence-oriented beliefs, poor staff/client relationships and negative staff attitudes. See further: Deering, D.E.A. et al. (2011). Consumer and treatment provider perspectives on reducing barriers to opioid substitution treatment and improving treatment attractiveness. *Addictive Behaviors*, 36(6): 636-642.

[9] Studies have shown that the stigma associated with substance use, and the stigmatisation involved in seeking help for substance use problems, contributes to low levels of help-seeking, such that people delay seeking help until their substance use problems start affecting multiple domains in their lives. When they do finally seek help, people often present with a variety of additional health and social issues, including unstable housing. See further: Lubman, D.I. et al. (2016). Characteristics of individuals presenting to treatment for primary alcohol problems versus other drug problems in the Australian patient pathways study. *BMC* Psychiatry, 16(1): 250.

[10] King, Ritter and Berends, 2011; cited in Kovitwanichkanont, T. and Day, C.A. (2018). Prescription opioid misuse and public health approach in Australia. *Substance Use and Misuse*, 53(2): 200-205.

Stigma may be a particular obstacle to accessing service in rural and regional areas, where inadequate training/knowledge, lack of access to addiction experts/services and the role of stigma in small communities all combine to exacerbate general barriers.[11]

The value of education in reducing stigma and discrimination

As a key strategy for reducing stigma and discrimination among people with co-occurring mental health and drug use issues, Penington Institute advocates public education around the nature, causes and consequences of drug use, as well as ways to support people who use drugs and their families. Through its own work, Penington Institute promotes public discussion and understanding to empower the community to rethink ways to tackle drug use, while also promoting hope and eliminating stigma.

A useful example is found in the organisation Release in the United Kingdom, which runs a campaign entitled 'Nice People Take Drugs' that aims to dislodge stereotypes about the kinds of people who use drugs.[12] Removing the 'us versus them' community perception of drug users has the potential to contribute significantly to reducing stigma and discrimination.

Results from the *National Drug Strategy Household Survey* identify an opportunity to undertake a similar campaign in Australia. Data show that the use of illegal drugs in Australia is not uncommon: one in eight people had used at least one illegal substance in the last year and one in 20 had misused a pharmaceutical drug. The use of any illicit drug is reported among people from all age groups; while illicit drug use decreased from 2001 to 2016 among people aged under 30,[13] it increased among people aged 40 to 49 and 50 to 59.[14]

Public education campaigns about the prevalence of drug use in the community across all 'types' of people (across age, socio-economic and other groups) can help remove the 'us versus them' delineation in the public mind and highlight that 'nice people' use drugs too. Public education around the links between drug use and mental health problems may also help to reduce stigma by tapping in to the tolerance and understanding that has been achieved around mental illness.

Education is an effective means of preventing and reducing drug harms including negative consequences for mental health, provided the education is evidence-based, non-judgmental and delivered through effective and accessible means. Education can be delivered in a variety of settings but should be tailored to the needs of specific audiences.

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[11] DeFlavio, J.R. et al. (2015). Analysis of barriers to adoption of buprenorphine maintenance therapy by family physicians. *Rural and Remote Health*, 15(1): 3019-3029.

[12] Release is the UK's centre of expertise on drugs and drugs laws. See: https://www.release.org.uk/nice-people-take-drugs

[13] Although the use of illicit drugs decreased among 20 to 29-year olds over this period, this cohort still has the highest prevalence of use: Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, p. 12.

[14] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, p. 13. As the survey is based on self-reports of drug use, and people may be reluctant to report using illicit drugs for a range of reasons, it is likely that the true prevalence of illicit drug use in the community is even higher than this survey shows.

Needle and syringe programs can be effective means of delivering education and informational resources to people who inject drugs and their families. However, due to a range of factors such as a lack of funding and untrained staff, the educational potential of NSPs is rarely realised.

A good practice example of a stigma reduction program

Penington Institute's work to build and share knowledge offers an example of the type of educational programming that assists in reducing stigma and discrimination.

In 2016, in response to the growing problem of crystal methamphetamine (ice) in Victoria, Penington Institute, with philanthropic funding support from the Lord Mayor's Charitable Foundation and the William Buckland Foundation, developed an educational online resource for young people at risk of ice use, their friends and their families – *Understand Ice*.[15] At the time there were no online resources for young people that provided calm, evidence-based, non-judgmental information.

Understand Ice provides accessible, straightforward information about ice and its effects on a person's health and life. The resource and the education program are evidence-based and non-judgemental. Evidence suggests that 'scare campaigns' tend to be ineffective and may (further) stigmatise people who use drugs.

The site's information is easy to understand and highlights practical actions that can be taken, including links to health services. It aims to help reduce the fear and anxiety for families and friends.

Penington Institute originally aimed to encourage 10,000 unique visitors to the *Understand Ice* resource during the whole project. As at 30 June 2018 (the end of the campaign) it had attracted more than 52,000 people (unique visitors) to the site, demonstrating the need for such a resource. In the wake of the success of this site, Penington Institute has since launched a similar website to provide information about treatment for opioid dependence and addiction.[16]

In addition to creating and disseminating information to the general public, Penington Institute also offers workforce development training to staff at NSPs and AOD services across a range of issues. Working with health professionals, law enforcement, frontline workers and managers, and other professional groups, Penington Institute provides resources and training to enhance the skills of workers who engage with people who use drugs. Training covers issues such as better understanding specific drugs (legal and illegal), changing drug trends, overdose prevention and response, and developing techniques on how to engage with challenging behaviours.

Such workforce development could also be targeted to those health-care providers who work in mental health, identifying the nature, causes and consequences of drug use as a way of improving understanding and dismantling the sort of stigma that causes them to downplay the need to treat the co-occurring issues faced by people with both mental illness and substance use problems. More broadly, training in communication and empathy would help to improve services for people with co-occurring mental health and drug use issues. Ultimately, treating clients more appropriately will help retain them in treatment and allow for better linkages with other services.

[15] See www.understandice.org.au.
[16] See https://lifesavers.global.

This sort of educational work is valuable to efforts to reduce stigma and discrimination and should inform the development of the Productivity Commission's final recommendations.

Supporting people to access services

NSP clients have significantly lower subjective wellbeing than is found in the broader community. Fischer et al. (2013) studied a sample of NSP clients in Brisbane and found that participants reported statistically significantly lower levels of quality of life than Australian sample norms in physical, psychological, social and environmental domains. Quality of life scores were lower even when compared with samples consisting of people with a range of serious and chronic illnesses, including heart disease, spinal cord injuries, chronic pain, neurological illness and stroke. Participants also reported significantly lower quality of life than prisoners.[17]

Studies of co-occurring mental health and drug use issues among NSP clients have shown similar overall results, with comorbidity found to be associated with greater risk of HIV and other blood-borne virus transmission and greater severity of problems in the medical and family/social domains.[18] A study of NSP clients in Melbourne found that 90% scored positive for one or more personality disorders: 13.6% had one personality disorder, 15.5% had two and almost two-thirds of participants (61.2%) had three or more. The prevalence of personality disorders among these NSP clients was nearly 14 times higher than the prevalence among the general Australian population (6.5%). Statistical analysis showed that there was a strong relationship between the number of personality disorders and the severity of substance abuse: people with more symptoms of personality disorders reported more severe substance use problems.

NSPs are a preventative and early intervention measure, located between supply reduction (such as policing) and demand reduction (such as abstinence campaigns). They offer a valuable opportunity to respond to people who both experience mental illness and inject drugs. In 2015-16 there were 3,509 NSPs in Australia: 102 primary, 786 secondary and 2,321 pharmacy-based NSPs. An estimated 755,000 occasions of service were provided at primary and secondary NSPs in 2015-16, with 49.4 million needs and syringes distributed. The NSP system is therefore a sizeable and much-used system.[19]

Properly resourced, NSPs can address the complex interactions between drug use, poor mental and physical health, socio-economic exclusion and crime. However, most NSP services are delivered not by health professionals, but by any available and willing staff member. Lack of adequate funding means that NSPs – especially the smaller secondary NSPs – may be unable to fulfil their potential for addressing complexity among people with co-occurring mental illness and substance use.

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[17] Fischer, J.A., Conrad, S., Clavarino, A.M., Kemp, R. and Najman, J.M. (2013). Quality of life of people who inject drugs: Characteristics and comparison with other population samples. *Quality of Life Research*, 22(8): 2113-2121.

[18] Disney, E., Kidorf, M., Kolodner, K., King, V., Peirce, J., Beilenson, P. and Brooner, R. K. (2006). Psychiatric comorbidity is associated with drug use and HIV risk in syringe exchange participants. *The Journal of Nervous and Mental Disease*, 194(8): 577-583.

[19] Iversen, J., Linsen, S., Kwon, J.A. and Maher, L. (2016). *Needle Syringe Program National Minimum Data Collection: National data report 2016*. Sydney: The Kirby Institute, University of NSW.

Often the only interface between people who inject drugs and healthcare services, NSPs are uniquely placed to address people's full range of needs by acting as a central hub and gateway for many clients to access a range of services and interventions. NSPs can assist clients by identifying intervention needs and appropriate services to match those needs, making referrals and offering follow-up support.

If people who inject drugs and who report poor mental and physical health have the most complex health and welfare needs, they also fall between traditional service boundaries,[20] often leaving NSP staff to attempt to achieve coordination and integration for their clients. With resistance among mental health workers to admit people with drug use issues, and reluctance among AOD services to admit people with mental health issues, properly addressing these complex needs is particularly challenging. NSPs provide a critical opportunity to help this cohort.

While they offer significant potential, NSPs (especially secondary NSPs) find themselves in a precarious position – typically located within other health care services, they are not necessarily sufficiently supported to deal properly with people who have both mental health and drug use issues. There remains more that NSPs could do, were they funded more fully. For example, research on 156 NSP outlets in Victoria found potential for better use of NSPs in providing harm reduction information and referrals to other services: while 83% provided clients with harm reduction information, three-quarters (78%) provided clients with information on other health and welfare issues and 60% provided referrals to health and welfare services. About one in five Victorian NSPs that participated in this research (22%) reported that they refer clients to mental health services and 17% made referrals to psychology services. These figures highlight that NSPs, while referring clients to mental health services, are not operating as effectively as they might – as they could, were they better funded.

Enhancing the ability of NSPs and their staff to identify mental health issues among their clients and strengthening referral pathways to clinical mental health services will allow better use of this point of contact. Improving the use of NSP providers will require government to ensure that sufficient funding is allocated to NSP programs so that they can fulfil their potential.

Improving coordination and integration

Many mental health services are not equipped to work with people who are still using drugs, requiring prospective patients to have completed drug detoxification prior to accessing the service, creating a significant barrier for those who are unable to cease their substance use. Similarly, some drug treatment and harm reduction services are ill-equipped to recognise and respond effectively to co-occurring mental health problems. For example, it is rare for needle and syringe programs in Australia to address mental health concerns proactively. This reflects the core aim of these services – preventing the transmission of blood borne viruses – but it represents a missed opportunity to take a more holistic approach to addressing an individual's broader health issues. This is particularly relevant given that more than 50% of

[20] Crofts, N., Reid, G. and Hocking, J. (2000). *Primary health care among the street drug-using community in Footscray: A needs analysis*. Melbourne: The Centre of Harm Reduction of the Macfarlane Burnet Centre for Medical Research.

NSP clients have been found to report at least one diagnosable psychological disorder or anti-social personality disorder.[21]

Ten years ago, the National Needle and Syringe Programs Strategic Framework 2010-2014 highlighted the need for better integration across a range of systems to ensure a more co-ordinated population health strategy to reduce injecting-related injury and disease, morbidity and mortality:[22]

> *NSP provision should be fully integrated into the practice of a range of disciplines including but not limited to: Mental Health (including homeless populations), Alcohol and Other Drug, Youth Work, Indigenous Health, Sexual Health and Pharmacy.*

Despite this Framework, NSPs are not working to their full potential. Lack of services within the community to which to refer clients, unwillingness of mental health clinicians to see people who use drugs, the stigma associated with the criminalisation of drug use – all these factors are hindering NSPs in their work.

Providing NSP outlets with an improved capacity to offer the level of care required – including developing partnerships and effective referral pathways with existing services across the AOD and mental health systems – is an obvious way to improve integration between the two.

Were additional funding provided, and gaps addressed, NSPs would be able to offer better access and more responsive services to a particularly vulnerable group, ensuring that:[23]

- NSPs have improved capacity to provide outreach and make contact with a range of other current users who are not utilising or accessing services – thereby improving population reach, coverage and penetration.
- NSPs have improved capacity for early identification and intervention to prevent the development of acute and chronic health problems – thereby alleviating pressures on other service systems, such as specialist drug treatment, hospitals and mental health treatment.
- There would be improved capacity for service integration and case management through the development of appropriate models and/or linkages and partnerships and referral pathways.
- There would be a skilled workforce that is able to deliver responsive and high-quality services.

People with co-occurring substance use and mental health problems 'fall through the cracks' – they cannot access the support they needed as AOD services lack the capacity to deal with the mental health issues, but clinical mental health services lack the capacity to deal with the AOD issues.

Integration between the AOD and mental health systems is not enough; both these systems need to be integrated with the family violence system. Family violence is widespread among men who access AOD

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[21] Kidorf, M., Disney, E. R., King, V. L., Neufeld, K., Beilenson, P. L. and Brooner, R. K. (2004). Prevalence of psychiatric and substance use disorders in opioid abusers in a community syringe exchange program. *Drug and Alcohol Dependence*, 74(2): 115-122.

[22] Victorian Department of Human Services (2010). *National Needle and Syringe Programs Strategic Framework 2010-2014*, Melbourne: DHS, p. 25.

[23] Ryan, J., Voon, D., Mackinlay, C. and Fletcher, K. (2008). *Integrating care: Victoria's Needle and Syringe Program*. Melbourne: Association for Prevention and Harm Reduction Programs Australia (Anex), pp. 122-123.

services, and family violence victimisation is commonly seen among women with substance use and mental health co-occurrence.

The prevalence of this triad – substance use, mental ill-health and family violence – means that an adequate response needs to address all three issues, with the three systems working collaboratively so that shared care approaches become the norm, regardless of the system by which a person enters support. It also requires that both the AOD and mental health workforce need to be skilled at identifying people involved with family violence (either as perpetrators or victim survivors).

Better integration between the various systems can be achieved using a range of strategies.

Workforce training

Workforce training is a key method for facilitating integration between the AOD and mental health systems. Clinical staff working in mental health may be unsure of their knowledge' of AOD issues, while those working in the AOD sector likewise may lack adequate understanding, experience and expertise in mental health issues. Staff should be trained specifically in dual diagnosis and its ramifications.

Spending one or two days at a workshop is insufficient to equip staff with the knowledge that they will need in practice. Instead, extended secondments would be a useful way to provide the exposure that can facilitate deeper understanding at the intersection of substance use and mental health.[24] Such exposure could also help reduce the judgment and fear that some clinicians experience around drug issues and would empower mental health staff and AOD staff to see that they work at the intersection of AOD and mental health every day.

Co-location of services

Embedding AOD services as a core part of the primary healthcare system would be an effective way to improve coordination and integration of mental health and substance use services. At its simplest, this could be achieved through co-location of services, such that referrals can be made to other professionals located on-site. For example, community health centres that employ both AOD workers and mental health counsellors offer a way to strengthen referral pathways.

A more intensive approach might involve mental health units – both inpatient and in the community – employing a full-time AOD worker and AOD services (including primary NSPs) employing a full-time mental health clinician. This would allow drug and mental health services to be provided at the same time, taking advantage of the opportunity while the person is amenable to service.

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[24] Some similar programs already exist. For example, the Victorian Dual Diagnosis Initiative has offered reciprocal rotations of 12 weeks' duration. Longer-term secondments, however, may prove more effective in facilitating integration between sectors.

Use of multi-disciplinary teams

The availability of multi-disciplinary teams allows a wrap-around model to be used for people experiencing both mental health and drug use issues. Rather than shuttling back and forth between professionals, a more holistic and team-based approach – where service providers from different streams meet for case management discussions about a client – means that a person's needs can be addressed as part of a total service package.

Addressing a range of social and health needs of those who are marginalised and vulnerable has been shown to be effective in addressing the underlying causes of drug use. Providing support and training in life skills and ongoing engagement at multiple levels, including psycho-education and health and wellness information to teach self-management skills, would have a significant impact on reducing harms associated with drugs for people who have co-occurring mental health problems. A multi-disciplinary, holistic approach would be particularly valuable for this cohort.

Obstacles to integration

There remain, however, several obstacles to the integration of the various systems. The requirement to cease drug use prior to entering mental health treatment is a key barrier to helping people with co-occurring problems, particularly in the absence of sufficient AOD services and difficulties in access for some groups, such as those in rural and regional areas. There are also unclear or inadequate referral pathways from NSPs to local service providers, which is linked to the availability of local services. Early intervention appears to be lacking as well: data from the Victorian Coroners Court show that, among the 416 overdose deaths where comorbidity was found, 32.5% of the deceased had a history of mental illness and drug dependence lasting more than ten years.[25] Each of these represents a significant barrier to proper system integration.

Integrated governance

While the case for improved system integration is clear, it is less clear how governance structures should account for integration. In particular, the question arises as to where in the departmental structure responsibility for drug and alcohol – and especially harm reduction – should be located. System-level integration has implications for higher-level integration – of governance structures, funding decisions and program design.

Penington Institute notes that the Productivity Commission is considering a 'Rebuild model', under which state-based 'Regional Commissioning Authorities' would pool funds and commission mental healthcare to create a seamless system with continuity of service and fill gaps in service provision, and possibly also hold funding for, and commission, alcohol and other drug services.

Penington Institute believes that the 'Rebuild model' is likely to offer greater opportunities for communities, including those in regional and rural Australia. A strength to the Rebuild model is that most

[25] Coroners Court of Victoria (2017). *Submission to the Victorian Parliamentary Inquiry into Drug Law Reform*.

relevant services are currently embedded in the health care system operated by State and Territory governments; building on this approach is likely to encourage stronger community input.

Regardless of the final model adopted, prevention, early intervention and a clear role for community input should be prioritised as primary goals for the chosen model.

The Draft Report notes that, despite various government initiatives and strategies and policy aimed at improving the response to co-occurring mental illness and substance use, past efforts have been constrained by wider systemic problems. Penington Institute supports the Productivity Commission's view that 'a wider reform agenda would maximize the potential to improve the lives of people living with mental ill-health and support their recovery' – that reform must take place at a system level to remove obstacles and enable seamless cross-sector service provision.[26] Reducing stigma and discrimination, supporting people to access services and facilitating integration between the mental health and AOD service systems are fundamental to this wider reform agenda.

People involved in the criminal justice system

Penington Institute acknowledges the extended discussion in the Draft Report of the interaction between the justice and mental health systems. At the same time, however, the Report does not acknowledge the role of criminalisation in creating this problematic interaction: that people with complex co-occurring issues may find themselves involved in the justice system only due to the criminalisation of substance use.

Vulnerability and disadvantage among prisoners

Research shows that a substantial proportion of people in prison have chronic mental health and substance abuse issues (especially among women) and have far higher rates of mental illness than the general population. The Victorian Ombudsman found that prisoners have 'dramatically higher rates of mental illness and acquired brain injury' than the general population: 40% of all Victorian prisoners have been identified as having a mental health condition (two to three times higher than in the general population), with prisoners being 10 to 15 times more likely to have a psychotic disorder.[27] But the justice system is ill-equipped to address the addiction and mental health disorder that led to the person being detained in prison in the first place.[28]

Female prisoners experience particularly poor mental health. Australian research with female prisoners found that 87% had been victims of sexual, physical or emotional abuse, with the majority being victims

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[26] Productivity Commission (2019). *Mental Health: Draft Report, Volume 1*. Canberra: Productivity Commission, p. 328.

[27] Glass, D. (2015). *Investigation into the rehabilitation and reintegration of prisoners in Victoria*. Melbourne: Victorian Ombudsman, p. 32.

[28] Royal Australian and New Zealand College of Psychiatrists [NSW] (2019). *Improving the mental health of the community: Submission to the Special Commission of Inquiry into the drug 'ice'*. RANZCP, p. 13.

of multiple forms of abuse. Abuse in childhood and adulthood were related to drug dependency and involvement in sex work, while mental health problems were related to drug dependency, violent offending and sex work. Almost two-thirds were regular users of illegal drugs, with high proportions of women attributing their offending to their illegal drug use.[29]

Female prisoners' vulnerability stems from their pathways to offending. Research on the unique offending pathways and needs among adult women have identified a range of issues where women's profiles are notably different from men's:[30]

- Trauma, victimisation and abuse: while research has shown that women under correctional supervision are more likely to have experienced physical and sexual abuse than male offenders or women in the general population, the link between abuse and offending remains unclear.
- Mental health: depression, anxiety and self-harm are more prevalent among female offenders, as are phobias and co-occurring diagnoses, including depression and substance abuse. The links between mental ill-health and offending are clear: stress, depression, fearfulness and suicidal thoughts/attempts are strong predictors of women's recidivism.
- Intimate relationships: women's identity, self-worth and sense of empowerment are defined by the quality of their relationships. High rates of abuse, trauma and neglect mean that female offenders are severely limited in their ability to recognise and achieve healthy relationships.
- Self-esteem: while low self-esteem is not a risk factor for men's recidivism, self-esteem for women is closely related to the notion of empowerment. Research has shown that belief that their lives are under their own control and power is critical to women's desistance from offending.
- Self-efficacy: while self-efficacy does not appear to predict recidivism in men, it has been suggested as important for women, although little is known about its impact.
- Parental stress: in the United States, more than two-thirds of women under correctional supervision have a child under the age of 18. When combined with economic marginalisation and substance abuse, feelings of stress and being overwhelmed by maternal demands may contribute to recidivism, with some studies detecting a relationship between parental stress and crime.

The period immediately following release from prison is particularly fraught, with recently released prisoners often experiencing precarious physical and mental health. Post-release support tends to be inadequate for the highly complex needs of people who have co-occurring drug use and mental illness, with service silos preventing optimal service provision. To illustrate, the Victorian Coroner found that 120 people died of a drug overdose following release from prison between 2000 and 2010, mostly due to heroin use.[31]

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[29] Johnson, H. (2004). *Drugs and crime: A study of incarcerated female offenders*. Canberra: Australian Institute of Criminology.

[30] Van Voorhis, P., Salisbury, E., Wright, E. and Bauman, A. (2008). *Achieving accurate pictures of risk and identifying gender responsive needs: Two new assessments for women offenders*. Washington DC: National Institute of Corrections, pp. 4-6. Research in Australia is consistent with the US findings; see, for example, Daley, K. (2014). *Dancing with death: Young people's pathways in and out of substance abuse*. PhD thesis, RMIT University; Johnson, H. (2004). *Drugs and crime: A study of incarcerated female offenders*, Research and Public Policy Series No. 63, Canberra: Australian Institute of Criminology; Shepherd, S.M., Luebbers, S. and Dolan, M. (2013). Identifying gender differences in an Australian youth offender population. *SAGE Open*, April-June 2013: 1–12.

[31] Coroners Court of Victoria (2013). *Overdose deaths of people recently released from prison and/or in the care of Corrections Victoria, 2000-2010*. Melbourne: Coroners Court, p. 5.

Forensic clients present multiple challenges. Many prisoners who are released are required to engage with mental health as part of their parole, but some mental healthcare providers will not see them until they have ceased taking drugs. There is often a lack of understanding that self-medication for underlying mental ill-health is widespread among released prisoners.

Given the vulnerability of prisoners, a stronger harm reduction approach is needed.

Harm reduction in prisons

Harm reduction in prisons should include the provision of condoms, opioid substitution therapy, naloxone and treatment for hepatitis C, as well as harm reduction education. While the provision of needle and syringe programs would add to the harm reduction toolkit for prisoners, no correctional centres in Australia currently provide sterile injecting equipment via a needle and syringe program. Research has shown that inmates report both a high level of understanding about the need for sterile injecting equipment and a high willingness to use sterile injecting equipment: more than 97% of prison inmates stated that they understood that using sterile equipment would protect against infections, and a similar proportion said that they would go out of their way to obtain sterile equipment when it was available in the community.[32]

The lack of NSPs in prison represents a significant gap in harm reduction strategies, as they have been shown to be both effective and safe within correctional environments.[33] It is also a missed opportunity to improve both health and mental health outcomes of this vulnerable cohort: people who use illicit drugs in custody may also experience mental health problems and may engage in risky injecting and sexual behaviours.

The case for controlled NSPs in Australian prisons has been previously argued by Penington Institute, based on the understanding that 'prisoner health is community health'.[34] While recognising the efforts that prison administrators have made in harm minimisation programs around supply and demand reduction, the report called for a more significant commitment to institutionalised prison management practices in the area of harm reduction and efforts to ensure that prisoners are entitled to health services comparable to those available to the general community. The Victorian Auditor-General's 2013 report on prevention and management of drug use in prisons noted that the case to introduce NSPs within Australian prisons is not condoning the use of illicit drugs within prison. Rather, the argument for prison-based NSPs is founded on the public health imperative that leads to the minimisation of harm when people continue to use drugs, whether inside prison or beyond.[35]

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[32] Justice Health and Forensic Mental Health Network (2015). *Network Patient Health Survey*. NSW Health.
[33] Kamarulzaman, A. et al. (2016). Prevention of transmission of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis in prisoners. *The Lancet*, 388(10049): 1115-1126; Lazarus, J. V. et al. (2018). Health outcomes for clients of needle and syringe programs in prisons. *Epidemiologic Reviews*, 40(1): 96-104; Stöver, H. and Hariga, F. (2016). Prison-based needle and syringe programmes (PNSP) – Still highly controversial after all these years. *Drugs: Education, Prevention and Policy*, 23(2): 103-112.
[34] Anex (2010). *With conviction: The case for controlled needle and syringe programs in Australian prisons*. Melbourne: Anex.
[35] Victorian Auditor-General (2013). *Prevention and management of drug use in prisons*. Melbourne: VAGO.

There is also proven value in supporting people as they transition from custody back into the community. The period immediately following release is known to be the most dangerous, with significantly elevated risk of death due to (accidental and intentional) overdose, violence and accidents. Interventions during the period immediately after release present valuable opportunities to reduce harms, including overdose.

Prison through-care programs begin in prison prior to release. They involve identifying people's needs for support and services after release and making linkages with community service providers while the person is still incarcerated. This approach ensures a level of continuity of care so that the person is not left unsupported.

Through-care offers tailored interventions that can improve someone's health, provide a range of social supports and ultimately reduce their risk of death. These include:

- pre-release education on overdose risks and prevention;
- initiation and continuation of medication-assisted treatment for opioid dependence; and
- improved referral to aftercare and community treatment services.

Part of through-care provision should be the ready availability of naloxone[36] as soon as people leave prison. While Australia offers naloxone access, its current arrangements for prescribing and dispensing naloxone are unduly complex and restrictive. Naloxone should be more easily available, at no cost, and with a greater diversity of products, including intranasal naloxone to facilitate wider use.

Penington Institute response to recommendations on justice

On the basis of the above, Penington Institute notes the Draft Report's recommendations with regard to the criminal justice system and offers the following responses:[37]

Recommendation summary	Penington Institute response
Draft recommendation 16.1 – Support for police: … Governments should implement initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations, ensuring that: • mental health professionals are embedded in police communication centres to provide real-time information on the individual to whom police are responding, to advise on responses and referral pathways, and to prioritise deployment of co-responder resources • police, mental health professionals and/or ambulance services are able to co-respond to mental health crisis situations if necessary • roles and responsibilities of all service providers are clearly defined	'Mental health crisis situations' should include situations involving people affected by drugs. In addition to embedding mental health professionals, AOD professionals could also be embedded alongside them to enable a more complete co-response in times of mental health crisis. Approaches should also be tailored to meet the needs of people who use drugs

[36] Naloxone is a medication that can temporarily reverse opioid overdose. It has no potential for abuse.
[37] These responses relate only to a selection of the recommendations from this chapter – those on which Penington Institute has current capacity.

• approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people.	
Draft recommendation 16.2 – Mental healthcare standards in correctional facilities: National mental health service standards should apply to mental healthcare service provision in correctional facilities to the same level as that upheld in the community.	To achieve this, a full range of AOD services, including NSPs, need to be available in prison. The implementation and maintenance of medication-assisted treatment for opioid dependence needs to happen in all correctional facilities.
Draft recommendation 16.3 – Mental healthcare in correctional facilities and on release: Mental health screening and assessment of individuals in correctional facilities should be undertaken to inform resourcing, care and planning for release. The mental health information obtained from the screening and assessment needs to be comprehensive enough to inform resourcing of mental health services in correctional facilities. Where appropriate, authorities should share this information with community-based mental health services to enable individuals with mental illness to receive continuity of care on release.	Full screening should include enhanced screening for co-occurring mental health and substance use issues, beyond the current assessment available in the LSI-R. Screening should be used to inform both within-prison and post-prison service provision and to allow genuine through-care to be implemented (including pre-release visits by community-based services staff).

Conclusion

Mental health cannot be addressed in isolation: it is bound up in other things, and often it is the most marginalised and vulnerable who suffer the most. Improving investment in services that cater to people who use drugs and that prioritise treating them with dignity and respect is crucial for improving the mental health outcomes for this vulnerable cohort, and the wider Australian community. This will have significant and ongoing benefits for Australia, including increased levels of economic participation and productivity.