Directions Health Services submission to the ACT Government's Budget Consultation 2018-19

Integrated Mental Health and Alcohol and Other Drug Treatment Services

Identified Service Gap and Proposed Response

Directions Health Services has identified a service gap in the support of people who are struggling with co-occurring mental health and substance use issues.

It has been noted that, where co-occurring substance use and mental health issues are present, it is often "difficult to differentiate psychopathological symptoms, which represent an independent (primary) mental disorder, from symptoms of acute or chronic substance intoxication or withdrawal."[1] The distinct, reflexive relationship between substance use and mental health was articulated in a 2014 study by Vella *et al*, where participants noted that change in one domain resulted in causal symptomology in the other. There are increased risks of chronicity and criminality for people with coexisting substance use and mental disorders and poor prognoses for both disorders[2] if treatment does not address both issues concurrently. Both conditions may serve to maintain or exacerbate the other.[3]

It is to this distinct relationship of mutual influence that this submission speaks. Directions Health Services proposes the need for an innovative, integrated and multi-disciplinary service model, incorporating AOD, mental health and primary care specialists. This model should be underpinned by a recovery-oriented, stepped care approach that supports responsive, holistic and appropriate service provision, customised to individual client need.

Context

The comorbidity of mental health and substance use has been well recognised and documented[4], with 63% of Australians who have issues with alcohol and other drugs (AOD) also experiencing a mental health disorder[5]. This compares to approximately 20% of the general population. Significantly, however, the rate of comorbidity is even higher within the cohort of people seeking treatment from AOD support programs, with up to 75% of AOD

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[1] Torrens, Mestre-Pinto & Domingo-Salvany (2015) *Comorbidity of substance use and mental disorders in Europe 2015:17,* European Monitoring Centre for Drugs and Drug Addiction

[2] Ibid (2015:20)

[3] Marel C, Mills KL, Kingston R, Gournay K, Deady M, KayLambkin F, Baker A, Teesson M (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* (2nd edition). Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales.

[4] NSW Ministry of Health (2015); Marel C, Mills KL, *et al* (2016); Torrens, Mestre-Pinto & Domingo-Salvany (2015)

[5] ABS 2007, cited Vella V E *et al Comorbidity in detoxification: symptom interaction and treatment intentions, Journal of Substance Abuse Treatment* (2014)

program participants experiencing lifetime mental health disorders[6]. A significant deficit in life expectancy has also been noted for people with co-occurring mental health and substance use issues, with an estimated reduction in life expectancy of up 30 years suggested[7]. This deficit is frequently attributable to lack of health care; untreated, serious chronic illnesses; and late diagnosis of potentially terminal illnesses.

People with co-occurring substance use and mental health concerns struggle with multiple and compounded issues[8]. This often has profound and debilitating impacts. These may include any or all of the following, which not only significantly affect the individual, but also resonate through family and community, and generate significant economic costs to society[9]:

- homelessness
- poverty
- inconsistent and often incomplete education
- poor labour force participation
- poor physical health
- criminal behaviour
- increased risky behaviours
- a high level of other co-occurring conditions
- stigma and discrimination
- family breakdown
- social isolation

Treatment of co-occurring mental health and substance use issues presents as one of the critical challenges facing the Australian health system[10]. Although best practice evidence identifies an integrated treatment approach as ideal for optimal client outcomes, single disorder treatment models remain the dominant approach[11]. Services are often provided either sequentially, based on identification of the primary issue, or in parallel, with separate, specialist service providers.

Despite recognition that the siloed structure of the health system and the differing treatment approaches of mental health and AOD services pose considerable access barriers to those experiencing co-occurring substance use and mental health, the system remains fragmented and difficult for clients to navigate. This inevitably leads to poor outcomes for people with coexisting disorders and their families, and all too frequently preventable, early death through poor health, suicide or misadventure.

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6 Centre for Substance Use Treatment (2007)

7 Lawrence, Holman & Jablensky (2001), *Duty to care: Physical illness in people with mental illness*, cited O'Halloran P (2014)

8 Bower Place – Ibid

9 Torrens, Mestre-Pinto & Domingo-Salvany (2015) European Monitoring Centre for Drugs and Drug Addiction, *Comorbidity of substance use and mental disorders in Europe p13*

10 NSW Ministry of Health (2015)

11 Ibid

Outcomes and Benefits

In line with recommendations from Marel et al[12], the aim of such an integrated program is to improve clients' health and quality of life across all life domains - including health, social welfare and housing, relationships, employment, criminal justice, and of course, AOD and mental health. This would be best achieved through a co-ordinated and multi-disciplinary approach, supported by intensive case management. The aim would be to also build the participant's capacity, over time, to advocate for themselves, enabling them to increase their personal agency and improve their access to mainstream services.

This submission posits that the combination of intensive mental health and AOD support, in addition to primary health care, will scaffold service participants across all domains of significant vulnerability. This will enable more holistic engagement, with service participants able to access supportive from health practitioners who are familiar with the implications of, and best practice response to, coexisting mental health and substance use.

The objective, then, is to ensure that the ACT's most vulnerable sub-populations - those experiencing coexisitng AOD and mental health issues - are able to access appropriate services and are supported to:

(a) minimise the harm resulting from their substance use, and
(b) positively manage their mental health.

Directions anticipates that participants will:

- have the information that they need to make informed decisions
- be better equipped to manage their needs
- be connected to services
- reduce the harms associated with their substance use
- be better able to manage their comorbid mental health & AOD issues
- experience improved mental health
- experience improved physical health
- experience improved life outcomes and quality of life

It is to these challenges that Directions Health Services speaks with this proposal, recognising that the ACT has long been recognised as an adaptable jurisdiction, with an emphasis on maximising best practice opportunities13. Such practices also offer the potential for significant, long term, social cost benefits to the ACT community, as well as to the public health and welfare systems.

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[12] Marel C, Mills KL, Kingston R, Gournay K, Deady M, KayLambkin F, Baker A, Teesson M (2016). ibid

[13] Hughes & Ritter 2008, cited Hughes, Shanahan et al 2013 *2013 Evaluation of the Australian Capital Territory Drug Diversion Programs p78*

The estimated cost of such a program in the ACT, with a team of primary health care, allied health, specialist mental health and AOD clinicians (approximately 8.5 FTE) working intensively with the identified cohort, would be in the vicinity of $1.1 million per annum.

Contact Details:

Bronwyn Hendry
Chief Executive Officer
Directions Health Services

Bronwyn.Hendry@directionshealth.com
02 6132 4800 or 0417 827 776

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Pre –Charge AOD Diversion Program for low level, non-violent offenders

Identified Service Gap and Proposed Response

Directions Health Services has identified a service gap in the diversion system for non-violent offenders whose alcohol and/or drug use has contributed to the commission of low-level offences that would result in criminal charges, fines and/or imprisonment.

Such diversion, prior to engagement in the judicial system, but premised on offender acknowledgement of responsibility, would enable more effective management of the substance dependency and other critical life circumstances for these offenders. This approach has proved very cost effective in reducing criminal recidivism; improving health, wellbeing and life outcomes for participants; significantly reducing economic cost of the judicial process and incarceration; and reducing the cost of participants' future reliance on welfare and service supports across multiple life domains.

This option would provide an opportunity for earlier intervention in a person's offending, before the offences become more serious, as well as respond to people with long standing dependency who are consistently charged with possession of a small amount of illicit substances for personal use and other low level offences. The people this service would target are not eligible for the Drug and Alcohol Court as their offences are not sufficiently serious to warrant that level of intervention and resource.

Context

The ACT Criminal Justice Statistical Profile as at September 2016 indicates that, of all charges (63,282) laid in the ACT in the 5 year period to September 2016, **alcohol was involved in 15,090** (almost **24%**). Alcohol has also been a factor in the apprehension of 12,053 people during the 5 year period, with young men in the 18 -21 year and 25 – 29 year age groups particularly prevalent (14.6% and 14.3% respectively). Significantly, this data also indicates that the 18 – 21 year age group is significantly over-represented in charges laid from apprehensions for Illicit Drug Offences (23%), Unlawful Entry with Intent (22.7%), Theft and Related Offences (19.6%) and Public Order Offences (20.7%) across the 5 year period. The 25-29 year age group similarly registers significantly across these offence areas. This data has informed Directions Health Services proposal.

Directions Health Services understand that the ACT Justice suite already includes a number of diversionary programs for people with alcohol and other drug issues.

Police Drug Diversion Programs:

- Simple Cannabis Offence Notice Scheme (SCON) - police notice and financial penalty for low level possession or cultivation of cannabis
- Police Early Intervention and Diversion (PED) - police referral to assessment and education / treatment for low level possession of cannabis, other illicit drugs or illicit possession of a licit drug (excluding alcohol)

- Early Intervention Pilot Program (EIPP) – police referral for education and support for young people (under 18 years) found intoxicated, consuming or in possession of alcohol

Court Drug Diversion Programs:

- Court Alcohol and Drug Assessment Scheme (CADAS) – pre-sentencing and sentencing assessment / treatment option to engage offenders in AOD assessment and treatment
- Youth Drug and Alcohol Court (YDAC) – pre-sentencing program for the Children's Court to address the AOD-specific needs of children and young people facing incarceration

None of these diversion programs, however, enable pre-charge diversion of chronic, low level, non-violent offenders whose alcohol and/or illicit drug use has informed or been a factor in their offending behaviour. This is an opportunity that is currently being missed and by using the model highlighted within this proposal, substantial benefits can be realised.

Whilst Directions Health Services acknowledges that the existing CADAS program can potentially reach some of the identified participant cohort, the numbers are limited, with only 32% of potential diversion candidates across drug, theft/burglary, unlawful entry and public order offences afforded the opportunity to undertake a diversionary program. Further, the protracted judicial and administrative pathway to CADAS services presents a barrier to engagement of chronic low level offenders who have severe dependence and have difficulty complying with a structured model.

The PED program recorded an average 99.6% uptake and treatment completion by recommended clients from 2007 – 2011. Post program recidivism was monitored for PED program participants, with 12.3% detected for a drug offence within two years of program diversion and 37% detected for any other offence during the two year post program period. No data on CADAS post program drug use or offending was available for outcome analysis[1]. It is unfortunate that the PED program is currently only available for low level possession offences, as Directions Health Services believes that, for low level offenders whose alcohol or drug dependency is implicit in their offences, diversion away from the judicial system has the potential to significantly reduce recividism.

ACT Drug and Alcohol Court

Directions Health Services welcomes the ACT Government commitment to establishing a Drug and Alcohol Court (DAC), and associated support programs, with this noted as one of the 2016/17 Judicial Priorities. We support the eligibility criteria for the DAC, which is targeting people who commit more serious offences. Directions is encouraged by the ACT Government's continued progression of a comprehensive therapeutic jurisprudence framework, which acknowledges the integral relationship between substance dependency and criminal undertaking, and the multiple comorbidities and other domains of disadvantage (such as mental health, homelessness, unemployment) that are important factors in offending behaviour.

However, Directions Health Services believes that significant benefit can also be delivered to the ACT community through offering an additional, low cost AOD diversionary program for lower level offenders. It is proposed that people with a substance dependence who are engaged in chronic low level offending are diverted by Police to drug and alcohol intensive case management services prior to charges being laid, thereby preventing progression through the criminal justice system for relatively

[1] Hughes, Shanahan et al (2013) *Evaluation of the Australian Capital Territory Drug Diversion Programs*

minor charges. Directions has participated in the consultations and will continue to contribute to the development of the DAC as opportunities arise.

Intensive Case Management Model

This model is designed to meet the needs of people with severe dependence who commit relatively minor offenses that relate to their inability to earn an income, manage their finances and meet their daily living needs. Directions Health Services strongly advocates for consideration of a program offering for these offenders which has been demonstrated to achieve good outcomes for this cohort, including to:

- reduce recidivism,
- improve individual participant outcomes relating to safety, stability and self-sustainability (ie. housing, employment, health & wellbeing),
- reduce the harm resulting from substance dependency,
- reduce public costs associated with judicial administration, prosecution and/or incarceration as well as costs associated with other health and community services

Drawing from the LEAD (Law Enforcement Assisted Diversion) program operating in the United States, Directions Health Services notes that very positive outcomes have been recorded across each of these domains through the provision of wrap around service support to substance dependent offenders. The LEAD program recorded significant reductions in criminal recidivism for program participants, with a 58% reduced likelihood of arrest subsequent to engagement in the program. Intensive case management is particularly noted as an essential element of programs that achieve substantial reductions in recidivism.[2]

The provision of flexible case management, underpinned by a harm reduction philosophy and respect for the participant's stage of change, coupled with brokerage support where needed, is lauded as the success component of the program, leading to improvements in psychosocial, housing and quality of life outcomes. Employing a trauma informed, harm minimisation approach which informs individualised, collaborative case management towards client driven goals, the LEAD program 'promotes self-efficacy and motivation to change'. The effectiveness of this approach with cohorts struggling with substance dependency, homelessness and/or mental health issues has been espoused through a number of studies[3]. By engaging and retaining participants, the LEAD program is facilitating improved whole of life outcomes for participants and proving itself to be a productive judicial alternative.

A n important difference in the model compared to other diversion programs is that, whilst the offender is encouraged and supported to reduce or stop their use of substances, it is not an eligibility requirement for participation in the program. The case management model enables participants to address the areas of concern that are a priority for them across multiple life domains, for example, homelessness. This approach facilitates development of trust and provides a platform for the case manager to work with them to address their substance use.

[2] Warner T, Kramer J (2009) 36:89-109; Braga A et al (2009) 46(4):411-436; Loveland & Boyle (2007) 51(2): 130-150

[3] Cited Collins S, Lonczak H & Clifasefi S (2015) *Lead Program Evaluation: Criminal Justice and Legal System Utilisation and Associated Costs* (footnotes 15, 20. 2, 26)

Outcomes and Benefits

The University of NSW highlighted that DAC's are resource intensive and have the potential to waste resources if not appropriately targeted[4]. This LEAD program proposed for the ACT has been shown to reduce the financial burden experienced by the justice system.

Quantifying the local context, in the three years between 2014 and 2016, the average number of detainees in ACT correctional facilities at any given time for low level, non-violent offences were as follows:

Offence	2016	2015	2014
Illicit Drugs Offences	8	8	5
Theft (Other – not motor vehicle)	8	10	8
Unlawful Entry	24	16	17
Other Offences Against Good Order	2	4	2
Total	42	38	32

It should be noted that this does not represent the total number of people across a given year, rather it is indicative of the number of bed days taken up in our correctional facilities by people in these circumstances. For example, 42 people at any one time is the equivalent of 15,330 days in a correctional facility, with all the direct and indirect financial and social cost that this incurs for individuals and their families.

It is likely that a minimum of 80%[5] of the 42 low level offenders incarcerated in 2016 at any one time were substance dependent - that is 32 people at any one time in 2016. Applying the average daily operating cost of $296.04[6] to maintain incarcerated offenders equates to more than $3.5 million, invested purely in incarcerating these offenders, without addressing the impetus for their offending. Significant cost savings could potentially be achieved in the management of this offender cohort, were a LEAD type program available to offer an intensive case management alternative to incarceration.

McCollister, French & Fang cogently note, in their estimation of the cost of crime to society[7], that **'even modest reductions in criminal activity can generate economic benefits that significantly outweigh the cost of treatment'**.

Other noteworthy benefits the LEAD program has recorded include improvement in health and wellbeing outcomes for participants, improved employment prospects 18 months after commencing

[4] Hughes, C., Shanahan, M., Sotade, O. & Ritter, A. (2017). Towards a new ACT Drug and Alcohol Court: A program and systems perspective. *Drug Policy Modelling Program, NDARC, UNSW Sydney*.

[5] Stoove & Kirwan noted that 79% of inmates at the Alexander Maconachie Centre reported that their offence was committed whilst under the influence of alcohol, drugs or a combination of both

[6] Report on Government Services 2016 - Justice Vol C

[7] McCollister K, French M & Fang H (2010) *The Cost of Crime to Society: New Crime Specific Estimates for Policy and Program Evaluation* in *Drug Alcohol Depend* 2010 Apr 1: 108 (1-2) 98-109

with the program; and likelihood of obtaining permanent housing during this time. Each of these factors also translate into significant public welfare cost savings.

As mentioned earlier, the population who tend to commit the offences in question are young people, therefore the LEAD program may also offer currency for early career offenders escalating to chronic offending. Given that illicit drug use continues to be most highly subscribed to by these same age cohorts,[8] the lifetime value of early drug diversion for these low level offenders cannot be underestimated.

The challenges, as noted in the *2013 Evaluation of the Australian Capital Territory Drug Diversion Programs*[9], are:

- for the system to recognise the beneficial role that drug diversion plays for young offenders, in particular;
- to enhance support for, and subscription to, drug diversion programs from all stakeholders along the judicial continuum;
- to ensure that clear program objectives, eligibility and protocols exist to guide stakeholders and to ensure that allocated resources are channelled efficiently;
- to create a synergistic suite of drug diversion programs in the ACT

It is to these challenges that Directions Health Services speaks with this proposal, recognising that the ACT has long been recognised as an adaptable jurisdiction, with an emphasis on maximising best practice opportunities. [10] By engaging multiple opportunities for diversion, at differing entry points along the judicial continuum, targeting different cohorts of offenders and levels of offence, the ACT justice system would be exercising best practice protocols around not only diversion practices, but also around systemic accessibility and equity. Such practices also offer the potential for significant, long term, social cost benefits to the ACT community, as well as to the public health and welfare systems.

The estimated cost of a trial LEAD program in the ACT, with three full-time case managers working intensively with the specified offender cohort, would be in the vicinity of $500, 000 per annum. The cost benefit to the ACT community in the long term, over and above the direct cost saving to the judicial system, could be significant.

Contact Details:

Bronwyn Hendry

Chief Executive Officer

Directions Health Services

Bronwyn.Hendry@directionshealth.com

[8] National Drug Strategy Household Survey 2016

[9] Hughes, Shanahan et al 2013 *Evaluation of the Australian Capital Territory Drug Diversion Programs*

[10] Hughes & Ritter 2008, cited Hughes, Shanahan et al 2013 *2013 Evaluation of the Australian Capital Territory Drug Diversion Programs p78*

0417 827 776