ADF | Alcohol and Drug Foundation

PREVENTING HARM IN AUSTRALIA
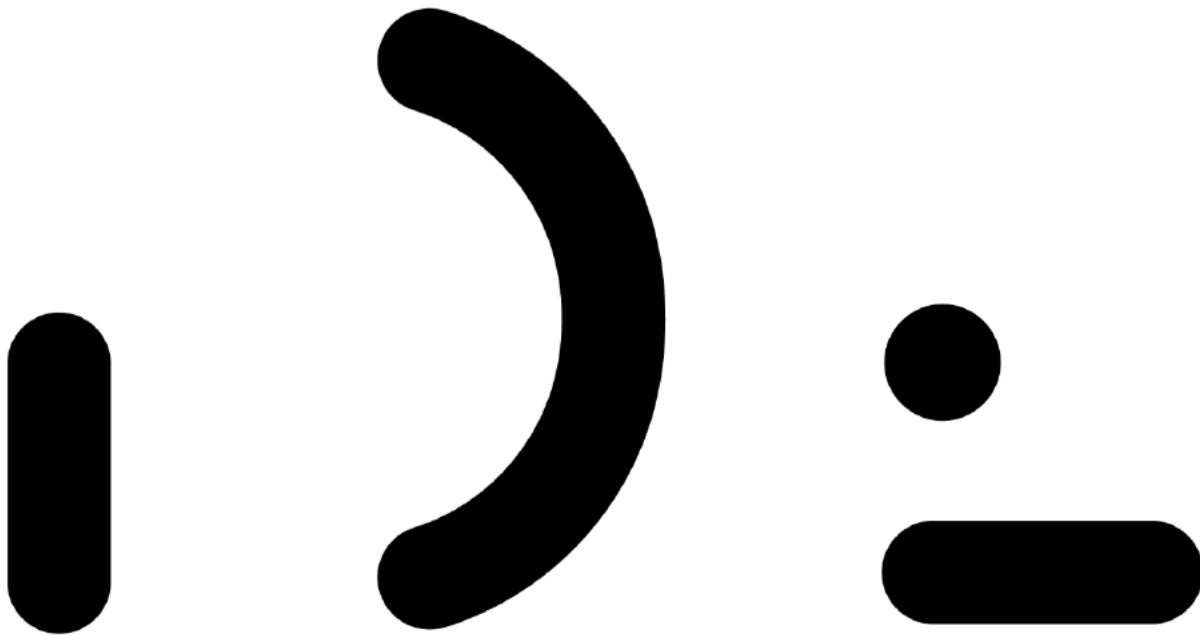
Royal Commission into Victoria's Mental Health System

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1 Contents

Response to Royal Commission into Victoria's Mental Health System

2   Introduction - Alcohol and Drug Foundation

The Alcohol and Drug Foundation (ADF) welcomes the opportunity to contribute to the Royal Commission into Victoria's Mental Health system and would be pleased to provide further advice should the Royal Commission consider that useful.

Founded in Melbourne in 1959, the ADF has contributed 60 years of continuous service to communities across Australia. The ADF works in partnerships with communities to reduce the burden of disease caused by alcohol and other drug problems. We also provide information on alcohol and other drugs that reach all corners of Australia through our website, SMS and telephone services. Our focus is on prevention and early intervention and our strategies include community action, health promotion, education, information, policy, advocacy, and research.

The ADF has a significant role in reducing alcohol and other drug related harm in Victoria. This role includes leading the Good Sports program which currently assists 2850 Victorian sporting clubs to control the use of alcohol, to develop and implement policies regarding illegal drugs, to promote healthy eating and mental health. The ADF also coordinates the Local Drug Action Team program (LDATs) that enable communities to develop evidence-informed social change projects to prevent and reduce alcohol and other drug problems and harms. LDATs typically include combinations of non-government organisations, community groups, local government, police, sporting clubs and health services. At present 58 LDATs are operating in Victoria.

3   Summary of Recommendations

Recommendation 1: That the Royal Commission identify the important role of alcohol and other drugs in the development and exacerbation of mental health disorders.

Recommendation 2: That the Royal Commission report on the reciprocal nature of alcohol and other drug and mental health conditions and note that without appropriate treatment for co-occurring problems, the individual is less likely to make a full recovery from either condition.

Recommendation 3: That the Royal Commission recommend the Victorian government develop and implement strategies to assist health care professionals to combat stigma for people with alcohol and drug and mental health conditions.

Recommendation 4: That the Royal Commission recommend the integration of care for people with co-occurring mental health and alcohol and other drug problems, to ensure they receive the most effective care for a full recovery from both conditions.

Recommendation 5: That the Royal Commission recommend that all mental health services and alcohol and other drug services are required to ensure their staff have the capability to identify and assess all patients and clients for mental health and alcohol and drug problems.

Recommendation 6: That the Royal Commission recommend the routine screening of all clients for co-occurring mental health and alcohol and other drug conditions should be adopted by general practitioners and mental health and alcohol and other drug services.

Recommendation 7: That the Royal Commission recommend higher levels of funding of research into the etiology and treatment of co-occurring alcohol and other drug problems and mental health conditions.

Recommendation 8: That the Royal Commission recognise the importance of reducing early alcohol and other drug use by young people to lower the incidence of alcohol and other drug problems and adverse mental health states among young people.

Recommendation 9: That the Royal Commission recommend the Victorian Government ensure Aboriginal and Torres Strait Islander people and communities have access to extensive prevention and treatment for alcohol and other drug and mental health disorders.

Recommendation 10: That the Royal Commission recommend the Victorian Government ensure alcohol and other drug and mental health programs for Aboriginal and Torres Strait Islander populations are developed and delivered with the support and participation of Aboriginal and Torres Strait Islander people.

Recommendation 11: That the Royal Commission recognise the factors unique to the experience of LGBTI people that increase vulnerability to alcohol and other drug use, harms and dependency, including the prevalence of mental health disorders.

Recommendation 12: That the Royal Commission recommend that LGBTI people have access to tailored primary prevention and treatment for substance use and mental health conditions that are designed and implemented in consultation with LGBTI people.

Recommendation 13: That the Royal Commission recommend that preservice and inservice training is required to assist primary health care staff to communicate effectively with LGBTI populations on matters related to alcohol and other drug and mental health problems.

Recommendation 14: That the Royal Commission recommend that further research into alcohol and other drug use in LGBTI populations is required to inform effective prevention, treatment and harm reduction.

Recommendation 15: That the Royal Commission recommend the Department of Education invest in the training of teachers for the delivery of effective drug education and ensure that all schools are resourced to provide pastoral care services that will assist all students to complete secondary schooling.

Recommendation 16: That the Royal Commission note the success of the Icelandic Planet Youth model of community-based alcohol and drug prevention and its relevance for the promotion of mental health.

Recommendation 17: That the Royal Commission recognise the valuable role played by well governed community sports clubs in reducing alcohol and other drug problems and in promoting mental health across Victoria.

Recommendation 18: That the Royal Commission recommend that the Victorian government support current evidence-informed, community-based prevention programs in Victoria that are addressing relevant risk and protective factors to reduce the prevalence of alcohol and other drug and mental health problems.

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4   Royal Commission Terms of Reference

1. How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.

2. How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages.

3. How to best support the needs of family members and carers of people living with mental illness.

4. How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health.

5. How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.

5   The burden of disease attributable to substance disorders and mental illness

Mental health and substance use disorders significantly affect the people of Victoria and the state's system of healthcare. Nearly half of the population aged 16-85 years (45 per cent) will experience a mental health condition during their lifetime and 20 per cent will do so in a twelve-month period. [1] In its latest analysis of the burden of disease in Australia, the Australian Institute of Health and Welfare found the combination of 'mental health' and 'substance abuse' was the third most important disease group and responsible for 12 per cent of the total burden of disease in 2015 [2]. In addition, mental health and substance use disorders were the second largest cause of disability (non-fatal disease burden) and responsible for 22 per cent of the disability burden. [1] Tellingly, the AIHW classified substance use disorders as a major form of mental illness alongside anxiety and mood disorders, principally depression. [2]

Alcohol and illicit drug use in Australia were jointly responsible for 4.5 per cent of all deaths (6,660 deaths) in 2015 and 6.7 per cent of the total burden of all disease and injuries (9.1 per cent for males and 3.8 per cent for females). [1] Similarly, for young people, mental health and substance use disorders and injuries were the largest contributors to the burden of disease [2]. This is consistent with the World Health Organization's Global Burden of Disease study which reported the biggest contributors to the burden of disease in young people aged 10–24 years are mental health disorders and substance use disorders, which represented 19 per cent of disability adjusted life years [3].

6   Reciprocity of drug use and mental health conditions

The relationship between problematic drug use and mental health conditions is reciprocal [4]. The consumption of one or more psychoactive drugs, either episodically or over an extended period, can generate and/or exacerbate a mental health disorder (e.g. anxiety, depression, psychosis) and people with a mental disorder can turn to drug use as a coping strategy in response to the symptoms of their underlying mental condition [4]. In each case the result can be a co-occurring drug problem and mental health condition which creates a worse impairment and worse prospects for recovery than people with either condition alone [5]. People with those dual problems face higher rates of relapse and subsequent hospital visits, incarceration, unemployment, and family difficulties [6]. Additionally, stigma is attached to both conditions and is responsible for further marginalisation of individuals as they can be inhibited from seeking treatment for substance use problems and mental health conditions alike.

Common factors which may precipitate problematic drug use and mental health problems include genetic factors, personality, biology, and social and environmental characteristics [5].

Co-occurrence of mental health disorders in people who are substance dependent is an enduring concern. Epidemiological studies have indicated that at least 55 per cent of people with a substance disorder have a co-occurring mental health disorder and 60 per cent of people with a mental health disorder have a co-occurring substance dependency [7]. For some conditions, including alcohol dependence and depression, the co-morbidity of mental health and drug disorders is bi-directional: alcohol dependence can arise from self-medication for depression while depression can be an outcome of alcohol dependence [8]. Co-occurrence of mental health and drug problems creates more substantial problems [7]. People with conjoint substance use disorders and severe mental health conditions such as schizophrenia, bipolar affective disorder and antisocial personality disorder are less likely to be have their substance use issues successfully treated; they are more likely to be arrested and incarcerated and to spend more time imprisoned, than those with a substance use problem alone [7].

An Australian study of 10,000 people reported a higher prevalence of mental health conditions among people who were current and past users of cannabis compared to people those who had not used cannabis; the risk diminished after cannabis use ceased, for 'past users' had a lower prevalence of mental illness than 'current users' [9]. This study estimated that 2.4 per cent of males who use cannabis weekly or more often will experience severe mental health problems compared with 1.5 per cent of males who use monthly, 1.4 per cent of males who are past users and 0.9 per cent of males who have never used cannabis. For females the overall result was similar, but the impact was felt not at weekly use but for a few times over several months, consistent with the higher rate of mental ill-health in females [9].

6.1 PROBLEMATIC DRUG USE AND PERSONALITY DISORDERS

A personality disorder is an enduring pattern of inner experience and behaviour that is inflexible and leads to clinically significant impairment or distress in social, occupational or other significant domains of life [10]. Personality disorders are common among people engaged in problematic drug use: up to 50 per cent of drug clients meet the criteria for at least one personality disorder, at a rate equivalent to the psychiatric population and four times that of the general population [10]. Anti-social and border line personality disorders are the most common types found among clients of drug treatment services. Investigation of the source of comorbidity between people who share a personality disorder and drug dependence suggest the personality disorder is primary and predisposes the individual to problematic use of drugs. Effective treatment of these co-morbidities must address both conditions and is typically a slow and complicated process. [10]

6.2 THE IMPACT OF ALCOHOL AND DRUG USE ON ANXIETY

Anxiety and anxiety disorders (including panic attacks, social phobias and post-traumatic stress disorder) manifest in symptoms including agitation, increased heart rate and respiration, increased blood pressure, nausea, excessive sweating. Treatment of these conditions often includes the prescription of central nervous system (CNS) depressants such as barbiturates, benzodiazepines and opioids to reduce tension. As alcohol is a CND depressant, people with anxiety often 'self-medicate' with alcohol, or other CNS depressants, and can develop a dependency on that substance [11].

Drug dependency occurs due to repeated use of a psychoactive substance such that the individual feels compelled to consume the substance and has trouble in ceasing or modifying their consumption [12]. Typically, the person who is drug dependent will experience tolerance to the drug and a withdrawal syndrome when use of the substance is interrupted or ceased [12].

Co-occurring anxiety and problematic alcohol use are relatively common in the population and is responsible for a large proportion of illness [11]. An Australian National Survey of Mental Health and Wellbeing found 16 per cent of people with an anxiety disorder also had an alcohol disorder; of the people with an alcohol disorder, 20 per cent also met the criteria for a panic disorder, 13 per cent for agoraphobia, 17 per cent for social phobia, 15 per cent for obsessive compulsive disorder, 24 per cent for post-traumatic stress disorder and 17 per cent for general anxiety disorder [11].

Co-occurring alcohol and anxiety problems are reinforcing as alcohol can induce anxiety as well as reduce it, and symptoms associated with withdrawal from alcohol mimic the symptoms of anxiety. Similarly, anxiety symptoms mimic the state of withdrawal from alcohol and other drugs.

The nexus between anxiety and drug use is accentuated by the effects of other psychoactive substances, such as benzodiazepines, cannabis, cocaine, amphetamines and opioids which also mimic some symptoms of anxiety which can confuse a person into thinking they are suffering the effects of anxiety, which can stimulate further drug use to ameliorate or control those symptoms [11].

A person with the co-occurring conditions of an anxiety disorder and an alcohol or other drug dependency can be locked in a 'catch-22' like state where a resolution seems impossible: consequently the treatment of both disorders is required or the one condition will undermine attempts to treat the second condition [11]. This underlines the need for treatment for both conditions to be integrated rather than taking place in 'silos' independent of each other.

6.3   THE IMPACT OF ALCOHOL AND DRUG USE ON PSYCHOSIS

Many psychoactive licit and illicit drugs taken by large numbers of Australians are implicated in the development and exacerbation of psychotic episodes and longer-term experience of psychosis. The drugs include alcohol, cannabis, meth/amphetamine, cocaine, psychedelic drugs and the class of illicit drugs known as 'new psychoactive substances'. While 4-7 per cent of the general population is estimated at having a current or lifetime (non-alcohol) drug use disorder, estimates of drug disorders among people with a lifetime diagnosis of schizophrenia run between 15-28 per cent [13]. A study of nearly 800 people aged 15-30 years admitted to the Early Psychosis Prevention and Intervention Centre in Melbourne, 74 per cent had a lifetime substance use disorder and 66 per cent had a current substance use disorder. Cannabis was the main drug reported by that cohort and polydrug use was common [13].

An association between psychotic illnesses, such as schizophrenia, is established and it is accepted that cannabis is a causal factor that can precipitate the onset of schizophrenia [14]. Degenhardt and Hall report meta-analyses of prospective population studies find, after accounting for confounders, that regular cannabis use doubles the risk of psychotic outcomes and that schizophrenia appears 2.7 years earlier among cannabis users who develop the disorder [15].

Cohort studies and studies of general populations have found those who had used cannabis had between two and three times the incidence of psychotic symptoms in the follow up period [14]. Most people who use cannabis do not develop psychosis but, for a minority, the use of cannabis appears to be the 'tripping point' or 'cumulative causal factor', alongside genetic and environmental causes, which led to schizophrenia [14]. A longitudinal study in Dunedin, New Zealand found intensive cannabis users who possessed a common variation in the COMT gene were five times more likely to develop a psychosis than intensive cannabis users who lacked that gene variation [13]. This finding might explain why the more prevalent use of cannabis in recent decades has not been accompanied by a corresponding rise in schizophrenia [9].

Mental health problems associated with use of meth/amphetamine include psychosis as well as anxiety, panic attacks, paranoia, mood swings, hallucinations, and suicidal thoughts [16]. Many of these effects occur during meth/amphetamine intoxication and occasional users are at high risk of harm. Some of those effects can resolve after use ceases; however, adverse mental states may last for weeks or months [17]. The prevalence of psychotic symptoms among methamphetamine users was reported in one study as 11-12 times that seen among the general Australian population [18]. Within the past year 23 per cent of users had experienced clinically significant psychotic symptoms of suspiciousness, hallucinations or delusions, and people who were dependent on methamphetamine were three times more likely than their non-dependent peers to have experienced psychotic symptoms [18]. In 2010 one fifth (20.8 per cent) of recent methamphetamine users reported high or very high levels of psychological distress, and one quarter (25.6 per cent) reported being diagnosed or treated for a mental illness within the previous 12 months [19].

6.4 THE IMPACT OF ALCOHOL AND OTHER DRUG USE ON DEPRESSION AND SUICIDE

Suicide has been described as the hidden issue of drug use and the dimension of the problems is such that one-third of those who enter drug treatment will have attempted suicide over their lifetime and one in ten will have done so within the previous twelve months [20]. Different rates of suicide apply for people who are dependent on different drugs, but they are always at rates far higher than the general population: dependency on benzodiazepines multiplies the risk of suicide 45 times; for opioid dependence 14 times; for alcohol six times and for cannabis dependence four times [20]. The vulnerability to suicide of people who use drugs excessively is amplified because factors that predict a higher risk of suicide independently predict a higher risk of drug dependence: these include psycho-pathology; personality disorder; family dysfunction; social isolation [20] [8].

Longitudinal studies have generated strong evidence to indicate alcohol is a causal factor in depressive disorders [15] [8]. A recent primary care international study across 14 countries found that excessive consumption of alcohol is associated with an elevated risk of a new depressive episode [21]. The World Health Organization Global Status Report 2018 states alcohol intoxication can intensify suicidal ideation and that the risk of a suicide attempt rises seven-fold after drinking and 37-fold after heavy drinking [22]. An 'alcohol use disorder' doubles the risk of depression, suicidal ideation, suicidal attempts and completed suicides [22].

Recommendation 1: That the Royal Commission identify the important role of alcohol and other drugs in the development and exacerbation of mental health disorders.

Recommendation 2: That the Royal Commission report on the reciprocal nature of alcohol and other drug and mental health conditions and note that without appropriate treatment for co-occurring problems, the individual is less likely to make a full recovery from either condition.

7 Treatment of alcohol and drug and mental health problems

According to Australia's National Drug Strategy (p27): "Given the strong relationship between mental health and alcohol, tobacco and other drugs, it is imperative to improve the collaboration and coordination between services to ensure that the most appropriate treatment and supports is being made available to the individual." [23].

A recent WHO Mental Health Survey reported substance related problems are responsible for 11 per cent of the global burden of disease and, within a twelve-month period, an estimated ten per cent of people with a substance use disorder in high income countries similar to Australia receive treatment [24].

The evident lack of treatment for people with substance use disorders is attributable partly to stigmatisation because drug dependency is regarded normatively as due to "personal choice or moral failure" [25]. The World Health Organization rates illegal drug dependence as the most stigmatised health condition and lists alcohol dependence as the fourth most stigmatised [26]. Reducing the stigma around alcohol and other drug dependency is important if those in need are to gain help as early as possible. Medical professionals who provide mental health and alcohol and other drug services have an important role in changing public discourse so that drug dependency is viewed as a health issue and not a moral failure.

People with a co-occurring problem have worse impairment, a more trying course of illness and are more difficult to treat than people with a singular problem [8]. Co-morbid patients and clients usually have their health problems dealt with singly which often results in one condition going untreated which places their recovery from the treated condition in jeopardy. When one co-occurring condition is unrecognized, the misdiagnosis will confuse and frustrate the clinician and patient alike. For example, the treatment of psychosis is often overlooked because the onset of psychosis and the onset of drug use typically occurs during adolescence and early adulthood [13]. Conversely, the psychomimetic qualities of many drugs can result in a person being wrongly diagnosed for a drug-induced psychosis when they present for the first time [13]. Misdiagnosis delays proper treatment with adverse consequences for the eventual outcome [13].

Contemporaneous treatment of anxiety and substance use problems is difficult, and some experts advise it may be efficacious to treat the substance problems first, as anxiety symptoms often cease or reduce markedly when problematic drug use is discontinued [27]. However, this presents a challenge for clinical staff as some patients in psychiatric services prefer their anxiety and depression is treated without addressing their substance use [27]. Mattock and O'Brien, who advocate for psychiatric staff and drug services staff to exchange knowledge and skills, point out that motivational counselling techniques employed by drug clinicians to persuade clients of the value of addressing problematic drug use could be usefully adopted by psychiatric services [11].

Staff involved in treating drug dependency need to include treatment of psychiatric disorders for co-morbid clients and psychiatric staff similarly require the capacity to introduce substance treatments into mental health service programs [27]. Treatment of people with co-occurring problems will require the training of general practitioners and staff in alcohol and other drug services and in mental health services. Mattock and O'Brien emphasise that clinical tools for screening, assessing and responding to presentations for mental health issues and alcohol and drug problems are already available [11]. Proudfoot and Treason suggest standardised and manualised treatment packages for the range of co-occurring drug and mental health conditions in primary care and specialised service settings would expedite those developments [27]. Nevertheless, as little research has been conducted into treating co-morbid conditions there is a dearth of evidence about effective treatment interventions [27].

To enable the development of tested models of treatment for co-occurring conditions, treatment programs need to be defined rigorously and implemented faithfully to allow for robust evaluations. This will help future treatment of co-morbidities to proceed with confidence [27]. The most effective and cost-effective approach may be to improve the understanding and skills of staff in drug treatment and mental health services so that they can address both adverse health conditions.

Recommendation 3: That the Royal Commission recommend the Victorian government develop and implement strategies to assist health care professionals to combat stigma for people with alcohol and drug and mental health conditions.

Recommendation 4: That the Royal Commission recommend the integration of care for people with co-occurring mental health and alcohol and other drug problems, to ensure they receive the most effective care for a full recovery from both conditions.

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Recommendation 7: That the Royal Commission recommend higher levels of funding of research into the etiology and treatment of co-occurring alcohol and other drug problems and mental health conditions.

8   Vulnerable Populations

Alcohol and other drug and mental health problems are not distributed equally throughout the population. Many people are vulnerable due to genetic, environmental, social or biological factors over which they have little control: they may experience a severe difficulty or trauma in their life or face chronic personal, social, or economic problems. According to Alexander, addiction to a substance is a way of coping with 'psychosocial dislocation', which occurs when people live without a clear role or purpose in a stable, established community. Psychosocial dislocation is a common experience of persons who are subjected to dispossession, stigma, unemployment, physical or emotional abuse, neglect or mental illness. [28]. While people who grow up or who are exposed to difficult circumstances are not fated to use substances or develop a dependency, the most vulnerable include:

- People who are emotionally distressed, disengaged and disconnected from society through lack of employment or mental health problems.
- People who grow up with or live with drug use within their family or peer settings.
- Young people who are disengaged from the school system – children with learning difficulties, or from dysfunctional families.

Primary prevention can moderate drug and mental health problems by strengthening individuals' resilience, fostering healthy connections between people, and building cohesive communities which offer support to troubled people. By strengthening our communities, we reduce the prevalence of personal and social problems, including those related to drug use and mental ill-health, and the various associated costs.

8.1   YOUNG PEOPLE

Early use of psychoactive drugs produces a heavier history of substance use and problems and increasing risks of early drug dependence and self-harm [8]. Heavy episodic drinking by adolescents has been shown to increase the risk of suicide after controlling for depressive symptoms and the risk of self-harm is elevated using any drug [29]. In addition to anxiety and suicide, heavy drinking during adolescence is associated with other psychiatric co-morbidities including bipolar disorder, conduct disorder, and attention deficit hyperactivity disorder [30]. An example of the early impact of drug use is found in an Australian study of the relationship of cannabis use to mental health in adolescents: daily use of cannabis by females resulted in a five-fold increase in depression and anxiety after controlling for effects of other substances; weekly use of cannabis in females predicted a subsequent two-fold increase in depression and anxiety in early adulthood, after controlling for baseline mental health status and other confounders. Notably, symptoms of depression and anxiety in adolescence did not significantly predict cannabis use [31].

A high proportion of young people in Victoria engage in problematic substance use. One quarter of the cohort aged 16 years (25 per cent) and one third of the cohort aged 17 years (37 per cent) drink alcohol

during the year. Two-thirds (67 per cent) of young Victorians aged 12-24 report drinking at levels that put them at risk of harm from a single drinking occasion [32] [33] and 15 per cent of Victorians aged 18–24 do so on a weekly basis. The most common illicit drug consumed by secondary school students is cannabis: up to 44 per cent of students aged 17 years have used cannabis and smaller proportions have used inhalants (18 per cent), ecstasy (6 per cent) and hallucinogens (4 per cent) while up to 2 per cent have tried amphetamines, cocaine or opiates. [34]

Mental health problems typically surface during adolescence and they often overlap with substance problems. One in four young people aged between 12-25 years have a mental health disorder and the Department of Human Services reports a quarter of young people aged 16-25 years who are clients of mental health services have a co-occurring drug or alcohol problem. [35] The need to prevent drug and mental health problems and to intervene early for those affected is underlined by the youthful suicide rate: intentional self-harm is the leading cause of death among young people aged 15-24 years old. [35]

Recommendation 8: That the Royal Commission recognise the importance of reducing early alcohol and other drug use by young people to lower the incidence of alcohol and other drug problems and adverse mental health states among young people.

8.2   ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The state of health and wellbeing of Aboriginal and Torres Strait Islander people in Victoria cannot be divorced from history. Following dispossession of their lands and the consequent loss of cultures, traditional roles, communities and family and kinship relationships, many Aboriginal and Torres Strait Islander people have used alcohol and other substances to assuage their trauma and loss of identity. This process is also evident among the colonised aboriginal peoples in North America, South America and New Zealand. [28]

Although abstinence from alcohol is higher among Aboriginal and Torres Strait people than non-Aboriginal and Torres Strait Islander people, rates of harmful drinking are also higher in those populations. [36] Excessive consumption of alcohol is directly and indirectly responsible for high rates of mortality and morbidity via injury, motor vehicle accidents, street violence, domestic violence, homicide, suicide and it is a major contributor to family breakdown [37]. Over half of Aboriginal and Torres Strait Islanders in Victoria (58 per cent) drink risky amounts of alcohol [38] and they are four times more likely than non-Aboriginal and Torres Strait Islanders to be hospitalised for alcohol related problems [37]. Other drug use is also high among Aboriginal and Torres Strait Islanders as 27 per cent used an illicit drug in the last 12 months which was 1.8 times higher than for non-Aboriginal people (15.3 per cent). [32]

Similarly, mental health problems and suicide contribute to the disparity in life expectancy between Aboriginal and non-Aboriginal people: they represent 10 per cent and 4 per cent of the health gap respectively. [39] Aboriginal and Torres Strait Islander people are 5.2 times more likely to intentionally harm themselves and youth suicide, anxiety and depression are disproportionately higher than in the general population. [39]

Injury, mental disorders and cancer are chief contributors to the burden of disease among Aboriginal and Torres Strait Islander peoples and excessive acute or chronic alcohol use is implicated in each one of those conditions. [40] The impact of alcohol on the Aboriginal and Torres Strait Islander populations is indicated by the relative alcohol-related mortality rate: between 2013-2017 it was five times the rate as among the non-Aboriginal and Torres Strait Islander population [41]. During 2011–2015, 40 per cent of male suicides and 30 per cent of female suicides among Aboriginal and Torres Strait Islander people were attributable to the consumption of alcohol. [42] Pearson argues the high rate of alcohol (and other drug) dependence is the most pressing issue facing Aboriginal communities because it steals agency and stands in the way of Aboriginal progress [43].

Aboriginal and Torres Strait Islander people need access to culturally appropriate interventions which enable individuals, families and communities to address harmful alcohol use. Further, it is important that Aboriginal and Torres Strait Islander people can take control of their own needs. Aboriginal and Torres Strait Islander organisations and communities have unique knowledge and expertise to contribute to holistic and culturally appropriate AOD services [44]. As Aboriginal and Torres Strait Islander communities are diverse generic solutions that do not account for that diversity will often be ineffectual; whereas Aboriginal and Torres Strait Islander community ownership supports place-based solutions, locally designed initiatives have a greater likelihood of success. [45]

Alcohol and drug prevention and treatment interventions that are effective in non-Aboriginal and Torres Strait Islander populations may not be culturally appropriate for Aboriginal and Torres Strait Islander people. Adapting strategies to the cultural needs of Aboriginal and Torres Strait Islander people is important given differences of worldview, literacy and language [46]. An approach known as Motivational Care Planning has been found effective in addressing alcohol use, mental health and comorbidity In the Northern Territory. Motivational Care Planning was developed with Aboriginal Mental Health Workers in three separate communities and utilises an approach, tools and metaphors that resonate with Aboriginal and Torres Strait Islander people. [46] However, it may not suit Aboriginal Torres Strait Islander communities in other locations.

The health of Aboriginal and Torres Strait Islanders and reductions in problematic use of alcohol and other substances is unlikely to improve until the lives of Aboriginal and Torres Strait Islander people are founded more securely. This includes access to safe housing, education and training, and ongoing employment. [47]. It will also be important that policies, programs and measures to improve the health and wellbeing of Aboriginal and Torres Strait Islander people rest as much responsibility as is possible in Aboriginal and Torres Strait Islander peoples and their appropriate organisations.

Recommendation 9: That the Royal Commission recommend the Victorian Government ensure Aboriginal and Torres Strait Islander people and communities have access to extensive prevention and treatment for alcohol and other drug and mental health disorders.

Recommendation 10: That the Royal Commission recommend the Victorian Government ensure alcohol and other drug and mental health programs for Aboriginal and Torres Strait Islander populations are developed and delivered with the support and participation of Aboriginal and Torres Strait Islander people.

8.3   LESBIAN, GAY, BISEXUAL, QUEER, TRANSGENDER AND INTERSEX

We have employed the abbreviation LGBTI used by the Australian Institute of Health and Welfare and note the AIHW's warning that while it cannot describe the full extent of people's genders, relationships, sexualities and lived experiences. [1]

LGBTI people are a significant proportion of Australia's population as approximately 11per cent of Australians identify as LGBTI. [48] LGBTI populations have experienced, and continue to experience significant discrimination, including public antagonism, reduced access to employment and housing, social isolation and verbal and physical abuse, [49] commonly cited in the research literature as "minority stress". [50] [51] Minority stress contributes to divergent health outcomes for LGBTI and non-LGBTI populations, as approximately 20 per cent of Australians experience mental health disorders such as depression and anxiety over their lifetime, compared to 41.4 per cent of lesbian, gay or bisexual people. [52] LGBTI people are also more likely to experience suicide ideation. [53] The disparity is more pronounced for intersex and transgender people: 60 per cent of people with an intersex variation and 41per cent of transgender or non-binary people experienced recent suicide ideation and are up to eleven times more likely to attempt suicide than non-LGBTI people. [52]

While LGBTI people experience higher levels of psychological distress and mental health disorders, the problem can be compounded by substance use. Regular substance use can increase tolerance to the substance and result in psychological or physical dependence. [54] This accords with the view that drug dependence is often a response to 'psychosocial dislocation' noted earlier in this document. [28]

Although much evidence indicates the experience of marginalization contributes to LGBTI people adopting harmful patterns of substance use, LGBTI people also use substances recreationally to celebrate and commiserate, as does the general population. [55] Substance use is normalised in many LGBTI communities as its members congregate and socialise in gay bars and nightclubs where alcohol and other drug use is commonplace. [56] LGBTI people perceive alcohol and drug use to be common among other members of their community [57] [58]: most, (80 per cent) gay and bisexual men report that at least a few of their gay friends use illicit drugs. [59] Additionally, the use of illicit drugs to facilitate sex (known as 'chemsex' or 'party and play') is widespread in LGBTI communities. Gay and bisexual men use meth/amphetamines combined with erectile dysfunction medication to improve sexual performance. [60] [61] Approximately 62 percent of men from the LGBTI community who had used illicit drugs in the previous six months had used substances to enhance a sexual encounter. [62] Chemsex combines sexual activity and drug use and lowered inhibitions while increasing the risk of sexually transmitted infections, [63] which is associated with adverse mental health. [64] [65] Chemsex contributes to the normalisation of substance use in LGBTI communities [66] and regular substance use increases the likelihood of frequent use and thus risks drug dependency. [54]

Overall LGBTI people consume substances at higher rates than their non-LGBTI peers. LGBTI people are almost twice as likely to consume alcohol [67] and lesbian, gay and bisexual people are up to five times more likely to use ecstasy, meth/amphetamines and cocaine. [68] [69] [70] They are also more likely to report ever having tried heroin, ketamine, GHB (gamma hydroxybutyrate) and hallucinogens, although injecting drug use in general is lower among LGBTI people than the general community. [69] [70] There is limited research on substance use and dependency among transgender and intersex populations. Of the studies that do exist, most examine male-to-female transgender substance use. [55] Nonetheless, early evidence suggests that there is a disproportionate use of illicit drugs, particularly methamphetamine and cocaine. [55]

More frequent substance use increases the risk of developing a drug dependency. [54] studies have confirmed higher rates of drug dependency among bisexual and transgender people, particularly for alcohol and stimulants. [55] Between 3 – 7 per cent of LGBTI people are dependent on 'club' drugs (e.g. ecstasy, meth/amphetamines, cocaine, ketamine, amyl nitrite, GHB etc.), compared to 0.5-2.8 per cent in the general population. [71] Bisexual women also have higher rates of dependency for marijuana and cocaine. [55]

The prevalence of mental health disorders among LGBTI people is exacerbated by widespread disengagement and dissatisfaction with mainstream health services. LGBTI people are more likely to experience discrimination while accessing mental and general health services [72] and perceived, anticipatory or experienced stigma can prevent LGBTI people from engaging with health services. Additional barriers to access include concerns about patient confidentiality and perceptions of healthcare providers lacking understanding of the unique needs of LGBTI patients. [73] Medical students and health service providers report a lack of knowledge and skills as one of the major reasons for not raising LGBTI-specific health needs with their patients; and a need for more comprehensive undergraduate medical education and support throughout their careers to improve communication with patients and increase their knowledge of LGBTI health. [74] [75]

Delaying or avoiding health care can exacerbate existing conditions, including mental health and substance use disorders. [76] [77] [78] Given the high risk of negative health outcomes in LGBTI people,

particularly related to mental health and substance use disorders, it is imperative that engagement with the healthcare system is improved. LGBTI people need access to culturally sensitive, targeted and responsive mental health and alcohol and drug education, prevention and treatment. This may include upskilling general practitioners (GPs) and nurses by providing pre-service and ongoing training on responding to LGBTI patients, particularly screening, counselling specific to their needs. This is especially important as some LGBTI people prefer to seek help from GPs, psychologists and LGBTI or HIV health organisations, rather than alcohol and other drug services. [79]

More longitudinal, population-based research is required to accurately evaluate the impact of alcohol and other drug use on LGBTI populations. Early studies largely focused on substance use as a maladaptive coping mechanism in LGBTI communities. [55] Research rarely separates bisexuals from lesbian and gay women and men; and there is a paucity of evidence on transgender and intersex people. [55] Despite the limitations of the data, evidence indicates that there is a need for more responsive and targeted harm reduction and treatment services for LGBTI people in Australia. This necessarily must address the distal and proximal causes of substance use disorders among LGBTI people, including the high rates of mental health disorders and psychological distress.

Recommendation 11: That the Royal Commission recognise the factors unique to the experience of LGBTI people that increase vulnerability to alcohol and other drug use, harms and dependency, including the prevalence of mental health disorders.

Recommendation 12: That the Royal Commission recommend that LGBTI people have access to tailored primary prevention and treatment for substance use and mental health conditions that are designed and implemented in consultation with LGBTI people.

Recommendation 13: That the Royal Commission recommend that preservice and inservice training is required to assist primary health care staff to communicate effectively with LGBTI populations on matters related to alcohol and other drug and mental health problems.

Recommendation 14: That the Royal Commission recommend that further research into alcohol and other drug use in LGBTI populations is required to inform effective prevention, treatment and harm reduction.

9   Prevention of alcohol and drug and mental health problems

Assisting Victorians to avoid early or excessive alcohol and other drug use will reduce personal and social dysfunction, the incidence of mental and physical health problems and the need for complex interventions through the health system, law enforcement and the justice system.

Primary prevention strategies aim to shift the focus "upstream" by working to help people to avoid, reduce or modify drug use, rather than reacting to a subsequent "downstream" problem that requires acute treatment, often in addition to an emergency response. By strengthening and supporting personal and social protective factors the likelihood that young people will engage in problematic AOD use is reduced, thus promoting mental and physical health and improving their life chances [80]. Those factors include young people maintaining positive relations with parents and other family members; enjoying school, completing school or leaving to take up employment pathways; having firm attachment to adult role models outside the home such as teachers, sporting coaches and/or youth leaders; developing future-oriented recreational pursuits; and living in communities with lower levels of drug use.

Families that face the most severe problems require more urgent help. A Victorian government report on the health of children determined that early negative experiences can compromise a child's long-term neurological development, with devastating effects on learning and physical and mental health [81].

Children in abusive families are five times more likely than other children to exhibit behavioural or emotional problems which can compromise their psychosocial development, cognitive capacity and educational development, as measured by a lower attainment in NAPLAN testing in Year 3 [81]. A child who witnesses family violence is on the highest rating of vulnerability and equal to a child who is abused [81]. Involvement in traumatic family events has long term consequences for children who are likely to experience depression, anxiety, low self-esteem and impaired cognitive functioning. Serious family conflict, abuse or violence is a vital public health issue as it has a cascading, intergenerational impact on health and wellbeing and disposes victims and spectators to lifelong physical and mental health problems [81].

Schools promote protective factors and reduce risk factors for young people through their curriculum, and health promotion and pastoral care programs. Effective drug education provides accurate information about drugs, has a focus on social norms, and takes an interactive approach which assists students to develop interpersonal skills. A Cochrane Review found the most effective programs teach social and coping skills to deal with drug taking issues and have a substantial duration of between 10– 20 sessions [82]. Care is needed because education programs have sometimes been followed by increased drug use, possibly because students rejected exaggerated claims of risk as uninformed, and risk-taking students acted out rebellion [83]. Programs that simply provide information on drugs are not effective [82] and neither are presentations by people with drug dependence experience [84]. Australian programs such as the School Health and Alcohol Harm Reduction Project (SHAHRP) and the CLIMATE program have reported reducing drug use and related harm. Students who participated in SHAHRP were 23 per cent less likely to experience alcohol-related harm [85]. The Climate Schools program reduced student binge drinking and cannabis use after 12 months [86]. Schools have access to on-line training and the SHAHRP and Climate resources via the internet through the Positive Choices website directed by the National Drug and Alcohol Research Centre (NDARC).

Schools can provide pastoral care for young people who face difficulties in their personal lives because family dysfunction is a major risk factor. In 2013, one in twelve families with young children (8%) showed signs of unhealthy family functioning [81]. Children in this situation face vulnerability to drug use and drug problems as well as a range of other mental health problems, including developmental delays and restricted educational engagement and achievement. Schools provide a setting and a framework for interventions with those children that can improve mental health and reduce the likelihood of alcohol and other drug involvement, thereby improving their social and educational prospects.

Recommendation 15: That the Royal Commission recommend the Department of Education invest in the training of teachers for the delivery of effective drug education and ensure that all schools are resourced to provide pastoral care services that will assist all students to complete secondary schooling.

9.1   THE ICELAND MODEL – PLANET YOUTH

The value of a long term, broad, community-based prevention program is evident from the experience of Iceland over the past two decades where it has combined community action with policy changes designed to minimise adolescent substance use of all types. A sustained implementation of interlinked, community based health promotion programs has contributed to an impressive reduction in adolescent use of tobacco, alcohol and cannabis [87] while also resulting in improved relationships between parents and children, and the development of communities' social capital [88] [89].

Iceland's Planet Youth primary prevention work builds a social environment that is high in protective factors and low in risk factors and facilitates positive behaviours among parents and young people alike. It reflects the understanding that major determinants of youthful drug use are peer involvement in drugs, the level of parental monitoring and supervision, and the strength of social capital in the local community [88]. It is informed by research findings that protective factors for young people include

involvement in sport and other forms of organised activities, time spent with parents during the week and strong linkages between parents, schools and other local agencies [89].

Planet Youth's approach has young people are actively supported to participate in organised extracurricular and recreational activities, such as sport, artistic endeavors, hobbies, and in supervised work alongside a responsible adult [88] [89]. Parents in Iceland are encouraged to spend substantial time with their adolescent children, to provide emotional support and reasonable levels of monitoring, and to participate in school, social and community events [87].

The changes in Iceland's social environments were accompanied by legislative and regulatory changes designed to lessen access to substances by young people; these included bans on advertising of alcohol and tobacco products, national media campaigns that discouraged adolescent drinking and smoking, a school based anti-smoking campaign, warning labels on cigarette packets and the age of maturity was raised from 16 to 18 years [90].

However, while drug use declined for Icelandic youth generally over the two-decade period, research that compared experimental and control communities found those communities with the interventions for adolescent participation in sport and for closer parental monitoring and supervision of young people saw greater reductions in drug use than did the control communities [90]. This indicates the community action programs, designed, developed and led by the Icelandic Centre for Social Research and Analysis (ICSRA) were successful in lowering alcohol and drug use.

The following graph demonstrates the dramatic decline in adolescent alcohol, tobacco and cannabis use in Iceland from 1998 until 2018 [91].

Positive development over 20 years (10th grade students)

Substance use in Iceland 1997-2018
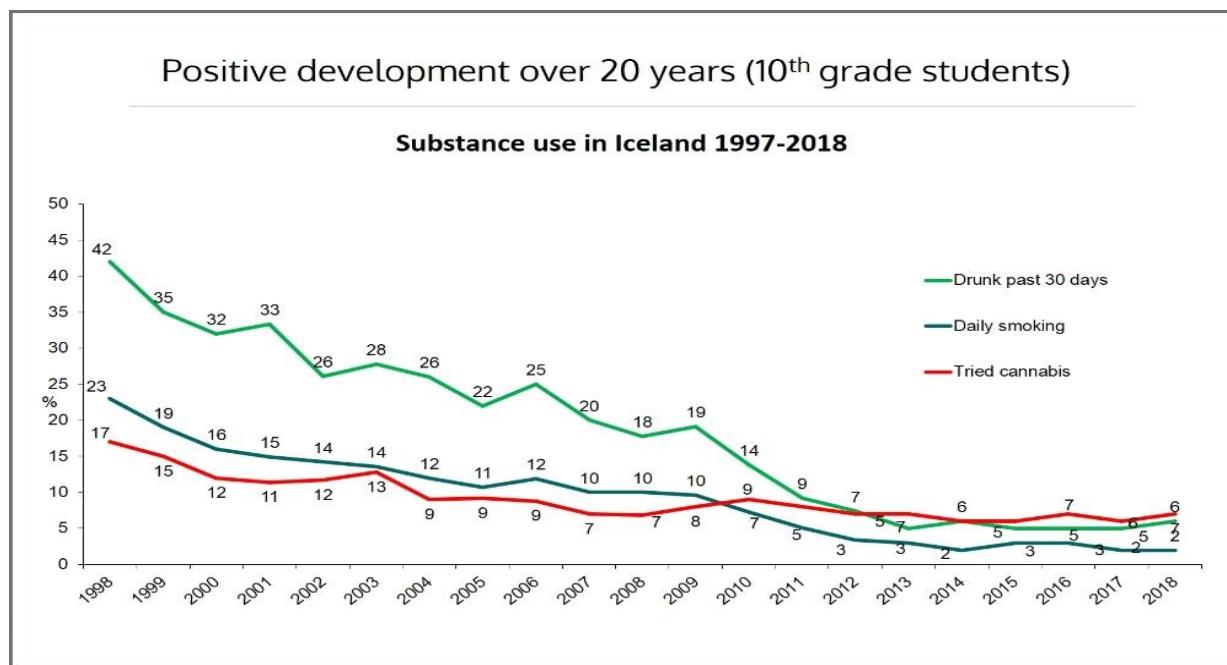
While the European School Survey Project on Alcohol and Other Drugs (ESPAD) found a decline in adolescent drug use in several other European countries, it reported Iceland was the only country that showed successive declines in tobacco and alcohol use in each of five ESPAD surveys in 1995, 1999, 2003, 2007 and 2011 [87].

Significantly, the community led intervention modelled by Planet Youth was also accompanied by dramatic declines in the anti-social behaviours of bullying and theft by 10th graders in Iceland during 1997-2016. [92]

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While the Planet Youth approach takes advantage of Iceland's idiosyncratic demographic, political and social features, it demonstrates that creation of positive social environments that reduce the likelihood of young people engaging in substance use is within the grasp of communities. Around 40 countries have adopted the Planet Youth approach to alcohol and drug prevention.

9.1.1   PLANET YOUTH TRIAL IN VICTORIA

The Alcohol and Drug Foundation is undertaking a 2-year pilot of the Planet Youth approach from June 2019 under the Local Drug Action Team (LDAT) program. This pilot will provide preliminary insights into the potential of this approach for Australian communities. Three Victorian communities are included in this pilot: Hepburn, Northern Mallee and Wycheproof/Sealake. The recommended period in which to evaluate the Planet Youth model is 5 years. The ADF is seeking further investment to expand the pilot sites in Victoria to six communities for a five-year period. This would enable a more robust evaluation in the Victorian context and inform future development of community based alcohol and other drug prevention.

Recommendation 16: That the Royal Commission note the success of the Icelandic Planet Youth model of community-based alcohol and drug prevention and its relevance for the promotion of mental health.

9.2   COMMUNITY PREVENTION PROGRAMS

Community led prevention is emerging as a critical tool in both reducing the burgeoning cost associated with acute treatment services as well as increasing community strength and protective factors. The National Ice Taskforce Report recommended the prioritisation of investment in working with local communities, families and workers to respond to people affected by drugs such as crystal methamphetamine [93]. In this section we outline three community prevention programs that engage the community in alcohol and drug prevention which, by implication, also address the risk and protective factors for mental health conditions.

9.3   THE GOOD SPORTS PROGRAM

Sporting activities are integral to most communities and play a prominent role in maintaining and restoring physical and mental health. Voluntary sporting clubs operate in most towns and suburbs in Victoria and bring together people of diverse backgrounds to share a common interest.

Good Sports is Australia's largest preventative health initiative in community sport and is adopted in more than 9,000 clubs nationally and by 2850 clubs in Victoria (as at July 2019). The core Good Sports module is a three-tier accreditation program which offers sporting clubs free tools, resources and practical support to implement policies for reducing and controlling the use of alcohol within the jurisdiction of the club. Good Sports is proven to reduce problematic drinking: a randomised controlled trial found Good Sports reduced the likelihood of risky drinking at sports clubs by 37 per cent and alcohol-related accidents among club members by 42 per cent (compared to players and supporters of clubs that did not participate in the program) [94].

Good Sports clubs are also supported to address illegal drug issues through the GS Tackling Illegal Drugs module by employing practices and policies to prevent drug use and to effectively manage drug related incidents should they occur. Good Sports clubs can also adopt the GS Healthy Minds module that aims to reduce stigma associated with mental illness, encourage help-seeking, and promote mental health within the club.

Good Sports clubs facilitate social bonding and engagement as well governed clubs attract and keep members. [95] Regular participation in sport provides physical and mental health benefits for players, non-players and spectators by providing regular social contact by people of all ages, genders and social classes, including people who might otherwise endure isolation and loneliness [96]. In many small

towns in Victoria, the local sports club is the social glue that maintains relationships and identity and promotes wellbeing for the whole community.

Recommendation 17: That the Royal Commission recognise the valuable role played by well governed community sports clubs in reducing alcohol and other drug problems and in promoting mental health across Victoria.

9.4   LOCAL DRUG ACTION TEAMS

The Local Drug Action Team (LDAT) program mobilises local groups to form partnerships and respond to alcohol and other drug issues within their community with planned programs and activities based on evidence of effectiveness. LDATs are made up of organisations including schools, local government, local businesses, health services, alcohol and other drug services, youth services among others. LDATs receive an initial grant of $10,000 and develop Community Action Plans which outline evidence-based activities to address alcohol and other drug related issues.

Activities delivered by LDATs reduce risk factors and increase protective factors such as connection to community, school and local sport and recreational clubs; creating a sense of belonging; developing skills and employment opportunities and building resilience in individuals and communities. Those risk and protective factors influence mental health and alcohol and other drug behaviour alike. Specific initiatives and programs include peer support, mentoring, education in schools, supporting teenagers and parents.

Currently (at July 2019) 58 LDATs are operating across Victoria in metropolitan locations and in rural and remote areas that often lack access to community prevention initiatives and programs that are available to people in larger towns and cities. The Local Drug Action Team program is funded by the Australian Government under the National Ice Strategy and is managed by the Alcohol and Drug Foundation.

9.5   COMMUNITIES THAT CARE

The Communities that Care program aims to reduce alcohol and substance use and antisocial and violent behaviour and, at the same time, improve students' academic performance. Evaluation of this program has shown substantial differences on those core outcomes between communities participating in Communities that Care and non-participating communities. [97] [98] The benefits of community-led approaches were also demonstrated in physical health as research by the Global Obesity Centre at Deakin University showed community mobilisation initiatives can reduce obesity among children. Most interestingly, the results included reductions in the prevalence of depressive symptoms. [99] This confirms the value of working on shared protective and risk factors as it can lead to improvements across multiple physical and mental health conditions.

Recommendation 18: That the Royal Commission recommend that the Victorian government support current evidence- informed, community-based prevention programs in Victoria that are addressing relevant risk and protective factors to reduce the prevalence of alcohol and other drug and mental health problems.

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