PENINGTON INSTITUTE

Royal Commission into Victoria's Mental Health System

Submission

July 2019

Introduction

Our mission

Penington Institute actively supports the adoption of approaches to drug use which promote safety and human dignity.

We address this complex issue with knowledge and compassion. Through our analysis, research, workforce education and public awareness activities, we help individuals and the wider community.

Our history

Launched in 2014, Penington Institute, a not for profit organisation, has grown out of the rich and vibrant work of one of its programs, Anex, and its 20 years' experience working with people and families directly affected by problematic drug use.

Penington Institute is inspired by and named in honour of Emeritus Professor David Penington AC, one of Australia's leading public intellectuals and health experts.

Our vision

Our vision is for communities that are safe, healthy and empowered to manage drug use.

Our understanding

Drug use trends, drug development and markets historically move faster than research and policy responses. With our outreach to the front-line we are well-placed to know and understand the realities of how drugs are impacting communities – well before the published literature surfaces significant issues.

We combine our front-line knowledge and experience with our analysis of the evidence to help develop more practical research and policy, support services and public health campaigns. Our strong, diverse networks provide an excellent platform for building widespread support for effective initiatives.

Our activities:

We:

- Enhance awareness of the health, social and economic drivers of drug-related harm.
- Promote rational, integrated approaches to reduce the burden of death, disease and social problems related to problematic substance use.
- Build and share knowledge to empower individuals, families and the community to take charge of substance use issues.
- Better equip front-line workers to respond effectively to the needs of those with problematic drug use.

Our purpose is framed by our knowledge that we need to look at more effective, cost-efficient and compassionate ways to prevent and respond to problematic drug use in our community.

Our submission

Penington Institute welcomes the opportunity to make a submission to the Royal Commission into Victoria's Mental Health System, noting particularly the inquiry's themes of 'integration between alcohol and other drugs and mental health services' and 'forensic mental health services'. In our submission, we have been cognizant of initial community feedback to the Royal Commission about the need for 'strong links between mental health services and other health, social, education and justice services' and better integration of support.[1]

In our submission, we respond primarily to the issue raised in Term of Reference 5: how best to support people living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.

Given the evidence base and the gaps between service provision and identified need, our submission focuses on the valuable role that needle and syringe programs and opioid substitution therapy can play in both facilitating integration between the mental health and alcohol and other drugs systems, and in supporting people who live with co-occurring mental illness and problematic drug use.

We focus on the following key points:

1. There is a **high prevalence of co-occurring mental illness and problematic drug use**: a substantial body of evidence shows that people who experience problematic drug use have far higher rates of mental health problems than the general community, although cause and effect remain uncertain. Co-occurrence is frequently associated with both family violence and suicide.
2. Given the high levels of co-occurrence of mental illness and problematic drug use, there should be **greater investment in harm minimisation, with a particular focus on harm reduction**. The evidence shows that both needle and syringe programs (NSPs) and opioid substitution therapy (OST) are effective harm reduction mechanisms. However, both require additional investment in Victoria in order to reach their full potential for harm reduction.
3. Many of the harms associated with drug use, including difficulties with mental health, are related to its illegal nature. While **decriminalising personal acquisition, possession and use of illicit drugs** would not completely remove stigma and discrimination, it has the potential to reduce stigma significantly, by removing some barriers to accessing services and allowing for better support for people who both use drugs and have a mental illness.

Penington Institute makes two primary recommendations to the Royal Commission:

1. Problematic drug use of any kind – of alcohol, prescription drugs or illicit drugs – is known to exacerbate mental health problems. To improve mental health outcomes, problematic drug use must be tackled. If we address drug use properly – using **evidence-based, effective interventions such as needle and syringe programs and opioid substitution therapy** – we will simultaneously improve mental health outcomes for people living with these co-occurring issues.
2. In order to address drug use properly, we need population-level planning to identify need and to allocate drug and mental health services appropriately. The development of a **five-year plan to identify service needs and gaps** will facilitate the implementation of evidence-based practice where it is most needed, and in the most appropriate form for local conditions.

[1] Royal Commission into Victoria's Mental Health System (2019). *Consultation summary*, p. 2.

Our submission is based on both the research evidence and consultations with a range of our key stakeholders. We acknowledge their contributions and are grateful for the valuable insights that they have shared with us.

Context: The prevalence of co-occurring mental illness and problematic drug use

People who experience problematic drug use have a far higher prevalence of mental health problems than the general community:

- Up to **80%** have at least one other psychiatric diagnosis, most commonly mood disorders, anxiety, personality disorders and post-traumatic stress disorder.
- **Quality of life** scores are lower among people who inject drugs than among people with a range of serious and chronic illnesses, including heart disease, spinal cord injuries, chronic pain, neurological illness and stroke; they are also lower than reported by prisoners.
- There is a heightened risk of **family violence** among people who use drugs.

This submission begins with the evidence on the prevalence of co-occurring mental illness and problematic drug use and their differential impacts on vulnerable cohorts in the Victorian community. It is critical to understand the extent and nature of these issues in order to identify appropriate ways to improve support and services for people living with both mental illness and problematic drug use, for their families and for their communities.

People who experience problematic drug use are among the most vulnerable members of the community. In addition to the physical impacts of drug use and its social and economic consequences, there may be significant harms to mental health as well.

A substantial body of evidence shows that people who experience problematic drug use have a far higher prevalence of mental health problems than the general community.[2] Research from both Australia and abroad highlights the levels of co-occurring issues (often termed 'dual diagnosis') in this cohort.

Studies of people seeking treatment for heroin dependence have reported that up to 80% have at least one other psychiatric diagnosis, most commonly mood disorders, anxiety, personality disorders and post-traumatic stress disorder (PTSD).[3]

Results of the Australian Treatment Outcome Study confirmed this high prevalence of co-occurring mental health and drug use issues among 825 current heroin users in Sydney, Adelaide and Melbourne as they entered treatment. The study found high degrees of psychiatric comorbidity, with 49% reporting severe psychological distress, 28% having current major depression and 42% having a lifetime history of post-traumatic stress disorder. Personality disorders were also prevalent, with 72% meeting criteria for antisocial personality disorder and 47% screening positive for borderline

[2] Ross, J., Teesson, M., Darke, S., Lynskey, M., Ali, R., Ritter, A. and Cooke, R. (2005). The characteristics of heroin users entering treatment: Findings from the Australian Treatment Outcome Study (ATOS). *Drug and Alcohol Review*, 24(5): 411-418; Sara, G., Burgess, P., Harris, M., Malhi, G. S., Whiteford, H. and Hall, W. (2012). Stimulant use disorders: Characteristics and comorbidity in an Australian population sample. *Australian and New Zealand Journal of Psychiatry*, 46(12): 1173-1181; Teesson, M., Mills, K., Ross, J., Darke, S., Williamson, A. and Havard, A. (2008). The impact of treatment on 3 years' outcome for heroin dependence: Findings from the Australian Treatment Outcome Study (ATOS). *Addiction*, 103(1): 80-88.

[3] Ross, J., Teesson, M., Darke, S., Lynskey, M., Ali, R., Ritter, A. and Cooke, R. (2005). The characteristics of heroin users entering treatment: Findings from the Australian Treatment Outcome Study (ATOS). *Drug and Alcohol Review*, 24(5): 411-418.

personality disorder. More than one-third (37%) of the study's participants had attempted suicide – more than ten times the prevalence seen in the Australian adult population.[4]

Research has shown that people who experience problematic drug use also have significantly lower subjective wellbeing than is found in the broader community. Dietze and his colleagues examined the self-reported personal wellbeing of a sample of 881 Australians who inject drugs, asking about perceived satisfaction in domains such as health, safety, achievement and personal relationships. Compared with the general population, people who inject drugs reported statistically significantly lower levels of satisfaction. Notably, having a recent serious mental health problem was significantly associated with lower levels of satisfaction in all domains: life achievements, community connectedness, future security, health, personal relationships, personal safety, standard of living and overall personal wellbeing.[5] Similarly, 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.[6]

Studies of co-occurring mental health and drug use issues among clients of needle and syringe programs have shown similar overall results, as well as gender differences in the type of mental illness experienced: women have been found to report higher rates of post-traumatic stress disorder and other anxiety disorders, while men report higher rates of antisocial personality disorder.[7] Research has also shown that comorbidity is associated with greater risk of HIV and other blood-borne virus transmission and greater severity of problems in the medical and family/social domains.[8] 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, as well as lower quality of life. The researchers conclude that:

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[4] Ross, J., Teesson, M., Darke, S., Lynskey, M., Ali, R., Ritter, A. and Cooke, R. (2005). The characteristics of heroin users entering treatment: Findings from the Australian Treatment Outcome Study (ATOS). *Drug and Alcohol Review*, 24(5): 411-418.

[5] Dietze, P., Stoové, M., Miller, P., Kinner, S., Bruno,R., Alati, R. and Burns, L. (2010). The self-reported personal wellbeing of a sample of Australian injecting drug users. *Addiction*, 105(12): 2141-2148.

[6] 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.

[7] 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; Kidorf, M., Solazzo, S., Yan, H. and Brooner, R. K. (2018). Psychiatric and substance use comorbidity in treatment-seeking injection opioid users referred from syringe exchange. *Journal of Dual Diagnosis*, 1-8; Brienza, R. et al. (2000). Depression among needle exchange program and methadone maintenance clients. *Journal of Substance Abuse Treatment*, 18: 331-337.

[8] 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.

> *this population has significant mental health issues and requires a comprehensive package of care…the findings highlight the need to develop more holistic models of treatment within NSP settings, including access to mental health practitioners with expertise in managing personality and co-occurring disorders.*[9]

The most recent *National Drug Strategy Household Survey* published by the Australian Institute of Health and Welfare (AIHW) identifies the strong association[10] between illicit drug use and mental health issues. It shows the high (and increasing) prevalence of psychological distress among users of different types of illicit drugs. High or very high levels of psychological distress were reported by 25.7% of people who had used any illicit drug in the previous month and 22.2% of those who had used any kind of illicit drug in the previous year, compared with 9.7% of those who had not used any illicit drug. Distress was especially pronounced among people who had used meth/amphetamine: high or very high levels of psychological distress were reported by 43.6% of people who had used meth/amphetamine in the previous month and 37.2% who had used these drugs in the previous year – more than three times the 11.2% of people who had not used meth/amphetamine in the previous year who reported such considerable distress.[11]

Similar figures are seen in the proportion of people who have been diagnosed or treated for a mental illness. Among people who had used any illicit drug in the previous month, 29.2% had been diagnosed or treated for a mental illness. Among those who had used any illicit drug in the previous year, 26.5% had been diagnosed or treated for a mental illness, compared with 13.9% of people who had not used any illicit drug in the previous year. The relationship between drug use and mental illness was again most pronounced among people who had used meth/amphetamine: among those who had used these drugs in the previous month, 46.1% had been diagnosed or treated for a mental illness as had 42.3% of people who had used in the previous year. Among people who had not used meth/amphetamine, 15.5% had been diagnosed or treated for a mental illness.[12]

Data from the Victorian Coroners Court highlight the 'intersection between mental ill health and drug dependence, and in particular, how each can exacerbate the other to contribute to external cause death'.[13] In its submission to the 2017 Parliamentary Inquiry into Drug Law Reform, the Coroners Court compiled a summary of deaths for the period 2009 to 2016. Across three major types of deaths, the analysis found the following:[14]

- A detailed study of 838 Victorian overdose deaths occurring between 2011 and 2013 was undertaken in collaboration with researchers from Turning Point. A major finding to emerge from the study was that 49.6% of deceased had both clinically documented drug dependence

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[9] Gibbie, T.M., Hides, L.M., Cotton, S.M., Lubman, D.I., Aitken, C. and Hellard, M. (2011). The relationship between personality disorders and mental health, substance use severity and quality of life among injecting drug users. *Medical Journal of Australia*, 195(3): S16-S21, p. S19.

[10] The AIHW notes, however, that its findings do not establish a causal link between the two: it can be difficult to isolate the degree to which drug use causes mental health problems, and the degree to which mental health problems give rise to drug use, often in the context of self-medication. Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW.

[11] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 8.11.

[12] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 8.12.

[13] Coroners Court of Victoria (2017). *Submission to the Victorian Parliamentary Inquiry into Drug Law Reform*, p. 2.

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

and a diagnosed mental illness (other than a mental illness relating to substance misuse). Among these 416 overdose deaths where comorbidity was found, 135 (32.5%) of the deceased had a history of mental illness and drug dependence lasting more than ten years.

- A pilot analysis of Victorian Suicide Register data for the period 2010-2011 established that 32.9% of all deceased were drug dependent proximal to their deaths, while 45.8% had evidence of substance misuse. Among this drug-dependent cohort, 55.3% of deceased also had a co-occurring diagnosed mental illness (other than a mental illness relating to substance misuse).
- A pilot analysis of 64 intimate partner homicide incidents, using data drawn from the Victorian Homicide Register, showed that 30 of the offenders (46.2%) had a history of substance misuse as well as a diagnosed mental illness at the time of the fatal incident. In contrast, only 16.9% of the deceased (11 people) had both a substance misuse history and diagnosed mental illness.

The co-occurrence of mental health and drug use issues can therefore lead to harm not only to the individual in the form of overdose and suicide, but to intimate partners as well. The Royal Commission into Family Violence noted the heightened risk of family violence among people who misuse drugs and/or alcohol:[15]

> *A serious problem with illicit drugs, alcohol, prescription drugs or inhalants leads to impairment in social functioning and creates a risk of family violence. This includes temporary drug-induced psychosis.*

Particularly among recidivist perpetrators, data from the Crime Statistics Agency indicated that repeat family violence offenders were more likely than others to be depressed or to have used drugs.[16]

Consultations with Penington Institute stakeholders also identified the close nexus between substance misuse, mental ill-health and family violence. Family violence is widespread among men who access alcohol and other drug (AOD) services, and family violence victimisation is commonly seen among women with substance use and mental health co-occurrence.[17] In the context of the Victorian Government's response to the Royal Commission into Family Violence, an integrated and holistic response to co-occurring mental illness and drug use is therefore critical.

Penington Institute's consultations revealed that co-occurring mental health issues are common among clients of Victoria's NSP services. Aboriginal secondary NSP[18] services note that 'most of our people' have problems with drugs and alcohol, mental health or both: among clients, 80 to 90% have

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[15] Royal Commission into Family Violence (2016). *Report and recommendations, Volume I*. Melbourne: Victorian Government, p. 104.

[16] Royal Commission into Family Violence (2016). *Summary and recommendations*. Melbourne: Victorian Government, p. 10.

[17] Stakeholder interview, AOD Family Violence Advisor, 13 June 2019.

[18] In Victoria, there are two main types of NSP – primary and secondary. Primary NSPs are funded by the state government to dispense sterile injecting equipment and deliver other supports and services. There are 20 primary NSPs in Victoria, which tend to be located in areas with active street drug markets or high rates of injecting drug use. Primary NSPs dispense about 53% of injecting equipment in Victoria. Secondary NSPs are not funded by government (except to cover the cost of the equipment dispensed). They are often located in community health centres, hospital emergency departments, pharmacies and drug treatment and youth agencies, and provide sterile equipment as an adjunct to their main functions. There is considerable variation in the skills and knowledge of people who work in secondary NSPs: most are staffed by a receptionist without a background in health or harm reduction.

substance abuse or 'social and emotional wellbeing' issues, based on historical trauma.[19] Similarly, primary NSPs in Melbourne see 'a lot' of clients with co-occurring mental health and drug use issues, although many would not have had a formal diagnosis. Among this group, 'anxiety and depression are huge' (although the more serious mental illnesses, such as schizophrenia, are not), and a 'large percentage' show evidence of 'accumulated trauma,' particularly relating to the overdose deaths of friends.[20]

The combination of mental health issues and problematic drug use is particularly concerning due to the potential impact on treatment outcomes: co-occurrence can lead to poorer outcomes in drug treatment[21] and can be challenging to address in terms of providing appropriate and individualised services. Moreover, the presence of a mental illness – specifically the presence of anxiety and depression – has been found to be associated with dependence, with injectors who have poly-drug dependence being more likely to experience these mental health disorders.[22]

Some of the harms associated with co-occurring substance use and mental health issues are identified by the Centre of Research Excellence in Mental Health and Substance Use:[23]

> *The high prevalence of comorbidity means that AOD workers are frequently faced with the need to manage complex psychiatric symptoms, which may interfere with their ability to treat the clients' AOD use. Clients with comorbidity present to treatment with a more complex and severe clinical profile, including poorer general physical and mental health, greater drug use severity, and poorer functioning. It is not only AOD workers who must cope with the increased burden associated with comorbidity. The presence of comorbid mental health conditions can place an enormous strain on clients' families and others close to them, both emotionally and financially.[24]*

The extent and complexity of harms are illustrated in Figure 1.

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[19] Stakeholder interview, regional health service provider, 28 May 2019.
[20] Primary NSP provider roundtable, 4 June 2019.
[21] Teesson, M., Mills, K., Ross, J., Darke, S., Williamson, A. and Havard, A. (2008). The impact of treatment on 3 years' outcome for heroin dependence: Findings from the Australian Treatment Outcome Study (ATOS). *Addiction*, 103(1): 80-88.
[22] Darke, S. and Ross, J. (1997). Polydrug dependence and psychiatric comorbidity among heroin injectors. *Drug and Alcohol Dependence*, 48(2): 135-141.
[23] Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A. and 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: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales, p. 14.
[24] Citations omitted.

Figure 1: Harms associated with co-occurring substance use and mental health issues

Source: Marel et al. (2016), p. 14

The high levels of co-occurring mental health problems experienced by people involved with problematic drug use – especially among those who inject drugs – are thus indications of the complexity of this population and of the need for a comprehensive, integrated service response that addresses both substance use and mental health issues.[25]

Armed with an understanding of the prevalence of, and harms associated with, co-occurrence of problematic drug use and mental health issues, the need to improve support for people living with both – and their families and communities – is clearly an urgent one.

Question 1: What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

People who use drugs experience significant **stigma and marginalisation**. The implications of these can be profound, including increased vulnerability and susceptibility to mental ill-health.

Criminalisation of drug use contributes to stigma by colouring society's judgment of people who use drugs – dependency is seen as a choice or a **moral failing, rather than as a chronic illness**.

[25] 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.

Penington Institute advocates both **public education** (about the prevalence of drug use in the community and the link between drug use and mental health issues) and the **consideration of decriminalising personal acquisition, possession and use of illicit drugs** as key strategies for reducing stigma and discrimination among people with co-occurring mental health and drug use issues.

People involved with problematic drug use are among the most marginalised groups in the Victorian community. Levels of stigma are particularly high among those who inject. Although there are no data available, it is likely that even higher levels of 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:[26]

> *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 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."*

Comparing the efforts that have been applied to reduce stigma around mental health in its submission to the NSW inquiry into the drug 'ice', the NSW Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted that 'there is much work to be done in the area of substance use disorders to move towards a similar place of destigmatisation and acceptance'. Reducing stigma is important to encourage people into treatment; stigmatising people who use drugs reduces the likelihood that those who need care will actually seek it. The College recommends:[27]

> *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.*

Penington Institute's stakeholders also noted the differential stigma associated with drug use compared with mental illness, even in the health care sector: drug use is seen as a moral failure and personal choice, while mental illness is beyond a person's control. This 'moralisation of drugs where it's inherently bad' 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 stigma associated with drug use means that individuals are held responsible for their health issues

[26] Pew Charitable Trusts (2017). *The case for medication-assisted treatment*. Fact Sheet. Although the document focuses on meth/amphetamine, it is relevant to illicit drugs more broadly.
[27] 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.

and life circumstances, which 'denies the confluence of social forces that structure our every day and our health'.[28]

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.[29]

Questions in the 2017 *Australian Survey of Social Attitudes* investigated the extent to which a representative sample of the Australian public would discriminate against other groups of people; injecting drug use was the attribute most likely to be stigmatised by participants (86%), with 28% indicating that they would 'often' or 'always' behave negatively towards people who inject drugs.[30]

Many of the stakeholders consulted during preparation of this submission noted the inequity of the health system's response based on the stigma associated with drug use:

> *What other reason would there be for prescribers to choose quite happily to treat someone's diabetes or heart disease or COPD [chronic obstructive pulmonary disease] but not want to treat their opioid dependence?*[31]
>
> *They get their diabetes medication for a month for free but for their opioid dependence it costs them $150 a month and upwards. It's not fair – it's actually a human rights issue.*[32]
>
> *There are inequity issues – universal healthcare means access to everyone, regardless of their social determinants of health.*[33]

Marginalisation among this cohort – and ensuing increased vulnerability – is largely caused by the criminalisation of drug use, including the negative impact of incarceration. Stakeholders see the criminalisation of drug use as contributing to stigma by colouring society's judgment of people who use drugs – dependency is seen as a choice or a moral failing, rather than as a chronic illness.

As key strategies for reducing stigma and discrimination among people with co-occurring mental health and drug use issues, Penington Institute advocates both public education and the consideration of decriminalising personal acquisition, possession and use of illicit drugs.

Public education

The organisation Release in the United Kingdom runs a campaign entitled 'Nice People Take Drugs' that aims to dislodge stereotypes about the kinds of people who use drugs.[34] Removing the 'us versus

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[28] Primary NSP provider roundtable, 4 June 2019.
[29] 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.
[30] Cama, E., Broady, T., Brener, L., Hopwood, M., de Wit, J. and Treloar, C. (2018). *Stigma Indicators Monitoring Project: General public*. Sydney: Centre for Social Research in Health, UNSW Sydney.
[31] Stakeholder interview, person with experience of the opioid substitution therapy system, 4 June 2019.
[32] Stakeholder interview, practice pharmacist, 6 June 2019.
[33] Stakeholder interview, pharmacist with experience in AOD services, 13 June 2019.
[34] Release is the UK's centre of expertise on drugs and drugs laws. See: https://www.release.org.uk/nice-people-take-drugs

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* afford 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,[35] it increased among people aged 40 to 49 and 50 to 59.[36]

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.

As one stakeholder said, 'people fear what they don't understand'.[37]

Decriminalisation

While decriminalisation of drug use would not completely remove stigma and discrimination, it has the potential to reduce stigma significantly, by removing some barriers to accessing services and allowing for better support for people who both use drugs and have a mental illness.

Victoria Police data show the high number of recorded offences related to drugs. For the year ending March 2019, 32,397 drug offences were recorded; of these, 80.4% (26,051 offences) were drug use and possession, 14.7% were drug dealing and trafficking and 4.4% were cultivating or manufacturing. Cannabis was the most common drug among the use and possession offences, accounting for one-third (34.0%) of these offences. Methylamphetamine accounted for 25.5% of drug use and possession offences, while prescription drugs accounted for 15.3%.[38] Clearly, then, the use and possession of cannabis represents a substantial proportion of all drug-related offences recorded. This is of particular concern when considering that the Global Commission on Drug Policy,[39] in its recent report examining the scientific evidence on the harms of psychoactive substances, placed cannabis eighth, behind both alcohol (in first place) and tobacco (in sixth).[40] Similarly, an Australian study based on the research expertise and practice wisdom of 25 local experts resulted in alcohol being scored as the most harmful

[35] 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.

[36] 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.

[37] Stakeholder interview, practice pharmacist, 6 June 2019.

[38] Crime Statistics Agency (2019). *Drug offences by drug type*.

[39] The Global Commission on Drug Policy is an independent body comprising 26 members, including 14 former heads of state or government and four Nobel Prize laureates.

[40] Global Commission on Drug Policy (2019). *Classification of psychoactive substances: When science was left behind*. Geneva: Global Commission on Drug Policy.

substance overall in terms of harm to self and others, with tobacco ranking fifth. Cannabis was ranked 13th.[41]

Decriminalisation is an important element in reducing stigma and discrimination against people with both mental health and drug use issues, as well as stigma directed towards their families and communities.[42] The vulnerable nature of this cohort and the impact of criminalisation have been identified by the Release organisation:[43]

> *There is a link between trauma exposure (including childhood physical/sexual abuse, PTSD) and substance misuse. Current drug policies are criminalising people who have already suffered greatly, thereby exacerbating their trauma. The criminalisation of people with problematic drug use, particularly those who use drugs in an attempt to self-medicate, amounts to the criminalisation of trauma itself for many people. This approach is cruel and arguably immoral, as well as an inefficient use of time and resources in the criminal justice system.*

This view was echoed in Penington Institute's stakeholder consultations:[44]

> *Those who are less equal and more vulnerable face much greater disadvantage and therefore have much greater stress. Repeat trauma – trauma on trauma – just amplifies mental health [issues]. Drug use is often about coping…drug use that people would call self-medication is often to do with loneliness, anxiety, depression and a disconnect.*

The NSW Bar Association has recently called for consideration to be given to the decriminalisation of personal acquisition, possession and use of illicit drugs, with increased focus on treatment and harm reduction measures, and encouragement of diversionary measures for minor matters that remain criminalised. They suggest that such an approach would allow the implementation of a comprehensive public health approach, and would involve the following components:[45]

- The continued application of criminal sanctions for drug producers, traffickers and suppliers.
- Decriminalisation of personal acquisition, possession and use of all currently illicit drugs.
- The use of civil orders to deal with personal acquisition, possession and use of all currently illicit drugs through a comprehensive framework of community-based tribunals.
- The expansion of harm reduction measures and drug treatment services.

Decriminalisation of drug possession and use, and investing in public health responses, can lead to broad social benefits, including:[46]

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[41] Bonomo, Y. et al. (2019). The Australian drug harms ranking study. *Journal of Psychopharmacology*, 33(7): 759-768.

[42] Decriminalisation will not solve all problems associated with stigma and discrimination as addictions to legal drugs such as alcohol and prescription opioids can also lead to stigma. For those people who suffer from mental health issues and addiction to legal substances, decriminalisation is unlikely to be directly helpful (although, arguably, reductions in stigma around illicit drugs could flow to legal drugs as well).

[43] Release (n.d.). *Briefing Paper for upcoming parliamentary debate: The human and financial costs of drug addiction*. London: Release, pp. 1-2.

[44] Primary NSP provider roundtable, 4 June 2019.

[45] NSW Bar Association (2019). *Submission to the Special Commission of Inquiry into the Drug "Ice"*. Sydney: NSW Bar Association.

[46] Release (n.d.). *Briefing Paper for upcoming parliamentary debate: The human and financial costs of drug addiction*. London: Release, p. 2.

- improved public health;
- reduction of the harms of drug use;
- reduction of the stigmatisation and marginalisation of vulnerable populations;
- reductions in the spread of infectious diseases; and
- reductions in homelessness and improved access to basic services.

Decriminalisation also has the potential to address structural barriers experienced by people living with mental illness and drug use. When people are swept into the criminal justice system on the basis of illicit drug use, finding stable accommodation and employment with a criminal record becomes extremely difficult. The case of Courtney Herron – without a job or home and struggling with addiction and mental illness – is a tragic example of the impact of the illicit nature of some drug use.

Results from the 2016 *National Drug Strategy Household Survey* show increasing public support for non-punitive, harm minimisation measures designed to reduce problems associated with illicit drug use. More than one-third (35%) of respondents in 2016 supported legalisation of cannabis, up from 26% in 2013.[47] Only one-quarter (26%) felt that cannabis should be a criminal offence.[48] Almost half (47%) felt that someone found in possession of a small quantity of cannabis should receive a caution, warning or no action, with 27% supporting referral to treatment or an education program. Support for referral to treatment or education was also seen for heroin (47%), methamphetamine (46%), hallucinogens (45%) and ecstasy (39%).[49]

Strong support was also reported for reducing problems associated with injecting drug use: about two-thirds of the population aged 14 or older supported rapid detoxification therapy (69%), methadone/buprenorphine maintenance programs (68%), treatment with drugs other than methadone (67%), needle and syringe programs (67%) and the use of naltrexone (66%). Just over half (55%) supported both regulated injecting rooms and the availability of take-home naloxone.[50]

Given the vulnerability of people with co-occurring substance use and mental health issues, and the harms associated with their status, additional investment in education, prevention, treatment and harm reduction is sorely needed. Decriminalisation of drug use would reduce stigma for people with co-occurring substance use and mental health issues and would ease access to appropriate support.

Question 3: What is already working well and what can be done better to prevent suicide?

People who use drugs are extremely vulnerable to suicide.

NSP providers can play a key role in preventing suicide. Enhancing the ability of NSPs and their staff to **identify mental health issues** among their clients – including suicidal thoughts – and **strengthening referral pathways** to clinical mental health services will allow better use of this point of contact in enhancing the mental health of this cohort.

[47] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 9.27.
[48] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 9.18.
[49] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 9.32.
[50] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 9.24.

Improved NSP provision is critically required in **regional and remote** areas as a way of addressing the high rates of suicide in non-metropolitan parts of the state.

People who use drugs are extremely vulnerable to suicide – there are often blurred lines between intentional and unintentional overdose.

The Australian Treatment Outcome Study of 825 current heroin users found extremely high rates of attempted suicide. More than one-third (37%) of the study's participants had attempted suicide – more than ten times the prevalence seen in the Australian adult population.[51]

Data from the Victorian Coroners Court also highlight how the co-occurrence of substance use and mental health problems can contribute to suicide risk. Its analysis of Victorian Suicide Register data for the period 2010-2011 found that one-third (32.9%) of all deceased were drug dependent proximal to their deaths, while almost half (45.8%) had evidence of substance misuse. Among this drug-dependent cohort, 55.3% also had a co-occurring diagnosed mental illness.[52]

While better integration between the AOD and mental health systems will improve services to people with co-occurring problems, NSP providers can also play a key role in preventing suicide. Enhancing the ability of NSPs and their staff to identify mental health issues among their clients – including suicidal thoughts – and strengthening referral pathways to clinical mental health services will allow better use of this point of contact in enhancing the mental health of this cohort. 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.

Improved NSP provision is critically required in regional and remote areas as a way of addressing the high rates of suicide in non-metropolitan parts of the state. Stakeholders have identified young Aboriginal men as a particularly vulnerable group for suicide: they are injecting drugs but are not accessing treatment, leaving them open to intentional or unintentional overdose. But this is not necessarily a sign of a 'mental illness': Aboriginal people have 'ongoing historical despair, loss of culture and identity and their roles within the community, particularly men and the ongoing grief and trauma'. There is regular 'misdiagnosis' and services that are 'not dealing with the underlying causes of those issues – we're putting band-aids over those issues'. According to one stakeholder, 80 or 90% of their clients have issues with substance abuse or social and emotional wellbeing, which has historical causes; the focus for this cohort should therefore be on wellbeing.[53]

For many Aboriginal people who live with co-occurring substance use and social and emotional wellbeing problems, access to improved care is hampered not only by a lack of services in regional areas, but by a severe lack of any culturally safe services. The various systems do not accommodate Aboriginal people's needs: western conceptualisations of diagnosis and management do not necessarily work with Aboriginal people.[54]

Within this western lens, AOD services often refer an Aboriginal person back to the local Aboriginal organisation: they see them as the 'too hard basket'. AOD providers do not have the capacity or

[51] Ross, J., Teesson, M., Darke, S., Lynskey, M., Ali, R., Ritter, A. and Cooke, R. (2005). The characteristics of heroin users entering treatment: Findings from the Australian Treatment Outcome Study (ATOS). *Drug and Alcohol Review*, 24(5): 411-418.
[52] Coroners Court of Victoria (2017). *Submission to the Victorian Parliamentary Inquiry into Drug Law Reform*.
[53] Stakeholder interview, regional health service provider, 28 May 2019.
[54] Stakeholder interview, regional health service provider, 28 May 2019.

knowledge to 'unpack the issues' with this cohort, so clients tend to be 'handballed' back. But Aboriginal services are not clinical service providers – 'we can't deal with these things on our own'.[55]

Partnerships with clinical services are key to improving services for Aboriginal people who use drugs and have wellbeing issues. Aboriginal social and emotional wellbeing needs to be addressed alongside and in partnership with a clinician who is properly trained in culturally safe practice, using appropriate assessment tools.[56]

More broadly, space needs to be made for the Aboriginal worldview of substance use and wellbeing to be incorporated to allow Aboriginal people to heal themselves. 'Putting an Aboriginal lens' on issues means that historical and social and emotional wellbeing are a key part of recovery. This approach needs to be incorporated into the mainstream system and workers need to be educated around Aboriginal culture and cultural safety. Doing this appropriately would involve moving away from a token Aboriginal liaison officer to having an Aboriginal social and emotional wellbeing staff member working alongside a clinician who is assessing clients using Aboriginal assessment tools. It would also involve space for cultural healing practices as a mechanism to allow people to recover by reconnecting to culture.[57]

Question 4: What makes it hard for people to experience good mental health and what can be done to improve this?

NSPs present a valuable **opportunity** to address the complex interactions between drug use, poor mental and physical health, socio-economic exclusion and crime.

While they offer significant potential, 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.

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 systems.

Additional **funding** and support are required to ensure that NSPs are better able to identify and respond to client needs, to link clients with appropriate services, and to support those who may fall through the gaps.

Opioid substitution therapy offers a powerful mechanism for harm reduction; better access would help address growing rates of prescription opioid misuse and overdose. But despite its proven effectiveness, the cost of associated **dispensing fees presents a key obstacle** to the therapy fulfilling its potential to reduce harm among people who use drugs.

[55] Stakeholder interview, regional health service provider, 28 May 2019.
[56] The Aboriginal Stay Strong Assessment is a specialised Aboriginal mental health assessment tool that has been proven to work well with Aboriginal people. However, it is only being used by one Aboriginal organisation in Victoria.
[57] Stakeholder interview, regional health service provider, 28 May 2019.

Needle and syringe programs 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.[58] Properly resourced, NSPs can address the complex interactions between drug use, poor mental and physical health, socio-economic exclusion and crime.

Often the only interface between people who inject drugs and the healthcare services, and acting as a central hub and gateway for many clients to access a range of services and interventions, NSPs are uniquely placed to address people's full range of needs. NSPs have the potential to address not only injecting drug use but other types of drug use as well. People who use drugs tend to be poly-drug users – using more than one type of drug as their circumstances or the availability of drugs change. By offering services to people who inject drugs, NSPs are actually supporting people who also use a range of other drugs, both legal and illicit.

Although poor mental health may not be a direct consequence of drug use, it is a significant and persistent issue among people who inject drugs. A high prevalence (69%) of psychiatric disorders was found among a sample of people in Melbourne who inject drugs, with depression and anxiety commonly reported.[59]

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.[60] Staff at a busy NSP saw their role as 'catch[ing] people falling through the cracks'. They expressed despair that 'the mental health system doesn't exist for our clients' – there is significant resistance among mental health workers to admit or even see their clients due to drug use issues. Instead, for this cohort, 'their inpatient care is prison'.[61]

Stakeholders expressed frustration at the inability of services to respond promptly to mental health crises. For example, a primary NSP provider described the case of a client who was experiencing a range of serious physical and mental illnesses – she weighed no more than 45 kilograms, had chronic diarrhea and bleeding from the rectum, suffered from severe schizophrenia and was floridly psychotic. The NSP called police and ambulance services regularly in an attempt to have her admitted to hospital for her physical illnesses, but it took three months of efforts for her finally to be admitted. She was so unwell that the NSP staff 'thought we were going to lose her'. Ultimately, she required four blood transfusions and remained in hospital for two months.[62]

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[58] 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.

[59] Wain, D., Aitken, C., Devin, H., Lubman, D., Hides, L., Gibbie, T., Wong, L., Gregson, S. and Hellard, M. (2005). *Prevalence of psychiatric disorders and associations with drug use among clients of a needle and syringe program and primary health centre*. Melbourne: Burnet Institute. See also Rowe, J. (2003). *Who's using? The Health Information Exchange (St Kilda) and the development of an innovative Primary Health Care response for injecting drug users*. Melbourne: The Salvation Army Crisis Service.

[60] 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.

[61] Stakeholder interview, primary NSP providers, 26 June 2019.

[62] Primary NSP roundtable, 4 June 2019.

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.

Clients interviewed for the project indicated that they accessed NSPs for a range of reasons. Of the 41 people interviewed, the majority (98%) indicated that they used NSPs to access health and welfare information, while just over half (54%) indicated that they accessed NSPs for referrals to other health and welfare services.[63] In other words, there appears to be a mismatch between the range of services that NSPs are providing and their clients' reasons for visiting the service.

The NSP program itself faces a range of constraints that undermine systematic fulfilment of its aims and objectives. Hours are highly variable and often insufficient to meet client demand. The physical set-up of NSP locations can compromise discretion and curtail client access to the full range of services. There are gaps in knowledge, skills and confidence in a range of essential tasks among the NSP workforce due to inconsistent training, which may affect the ability or willingness of some staff to engage clients effectively and assist them in achieving the best health outcomes. Some staff may even believe that elements of the NSP program are not part of their role. Lack of knowledge of other available services, and referral pathways to them, is a particular concern for people with co-occurring issues. But so, too, is staff capacity to manage overdose and the potentially challenging behaviour of some clients with mental health problems. In the absence of reliable data on NSP clients, there are gaps in understanding of polydrug use and the complex interaction of drugs and mental health.

Almost 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:[64]

> *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, stakeholders told us that 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

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[63] 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), p. 12.
[64] Victorian Department of Human Services (2010). *National Needle and Syringe Programs Strategic Framework 2010-2014*, Melbourne: DHS, p. 25.

mental health systems – is an obvious way to improve integration between the two. More than a decade ago, Penington Institute identified how additional funding should be offered to NSPs to take advantage of their unique position as a gateway to health services for people who inject drugs:[65]

> *Additional funding and support are required to ensure that NSPs are better able to identify and respond to client needs, to link clients with appropriate services, and to support those who may fall through the gaps. There is a critical need to:*
>
> *1. Identify and assess ways to improve the reach and penetration of service delivery to the injecting drug user population, and in particular, identified priority groups including young people, Indigenous injectors, and people from culturally and linguistically diverse backgrounds.*
>
> *2. Provide financial assistance and incentives for NSP staff to access a range of available workforce development and training opportunities, particularly where many NSP staff members work on a casual basis.*
>
> *3. Establish a number of positions through high client contact NSPs (regardless of whether they are primary or secondary NSP outlets) with responsibility for developing, maintaining and fostering partnerships and linkages with a range of organisations, and who are appropriately trained to co-ordinate and participate in case management meetings, and to support clients through the health and welfare service system.*
>
> *4. Review and identify ways to better capitalise on the synergies between NSPs and other harm reduction services, and ways to better align these services to respond to, and meet the needs of, injecting drug users.*
>
> *5. Identify and pursue strategies for realigning and integrating NSP services within the overall service delivery framework and mandate of host agencies as an integral frontline component of responses to address drug-related issues and the needs of IDUs [injecting drug users].*

Were additional funding provided, and gaps addressed, Victoria would be able to offer better access and more responsive services to a particularly vulnerable group, ensuring that:[66]

- 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.

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[65] 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), p. 122.
[66] 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.

The value of NSPs was expressed succinctly by staff at a busy NSP office: discussing a particularly disadvantaged client who had been released from prison with no resources, no opportunity for employment, no housing and with both mental health and drug use issues, they quoted the client as saying, 'this is the only place I feel safe'.[67]

In the same way that NSPs serve a critical function in harm reduction for people who inject all types of drugs, opioid substitution therapy (OST) has a vital role to play among people who have dependency problems with opioids, both legal and illicit. And in the same way that the NSP program has not achieved its full potential to reduce harm, so too the OST program has encountered various constraints in fully realising its aims.

The illicit use of opioids such as heroin, and pharmaceutical opioids such as morphine and oxycodone, is a serious health and social problem. Opioid users are more likely to experience mental and physical health problems, social and economic disadvantage, and poorer levels of overall wellbeing.[68] There are also social costs associated with opioid addiction, such as poverty, family disruption, harm to the welfare of children and contact with the criminal justice system.

The OECD notes that the opioid crisis is not only a health crisis: it has social and law enforcement dimensions, and economic and social conditions, such as unemployment, housing, exclusion and stigma are also linked to the issue. Its report on problematic opioid use calls for a better approach, with governments establishing co-ordinated networks to facilitate access to integrated services for people with opioid dependencies. The OECD framework for responding to opioids focuses on three key systems:[69]

- Health system interventions: including prevention, treatment, harm minimisation and health financing issues that are designed and implemented mainly in the health sector.
- Social policy: covering housing, employment and recovery support services for people with opioid use disorders and their families.
- Legal system and law enforcement: interventions around international co-operation, customs, and the criminal justice system, including police and investigation

OST offers a powerful mechanism for harm reduction; better access would help address growing rates of prescription opioid misuse and overdose. It is an evidence-based, cost-effective public health strategy for managing opioid dependence.[70] It has been shown to effect a range of positive outcomes among people with opioid dependencies, including reductions in opioid use, blood-borne virus transmission, overdose and acquisitive crime. It provides a regular, consistent and long-acting opioid dose that allows people the opportunity to regain control of their lives, leading to improvements in health and wellbeing. A long-term OST program enables individuals to improve their physical and mental health, resume employment and/or education and strengthen their relationships with family, friends and the wider community. It also greatly reduces people's risk of fatal overdose.

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[67] Stakeholder interview, primary NSP providers, 26 June 2019.

[68] Ross, J., Teesson, M., Darke, S., Lynskey, M., Ali, R., Ritter, A. and Cooke, R. (2005). The characteristics of heroin users entering treatment: Findings from the Australian Treatment Outcome Study (ATOS). *Drug and Alcohol Review*, 24(5): 411-418; Dietze, P., Stoové, M., Miller, P., Kinner, S., Bruno,R., Alati, R. and Burns, L. (2010). The self-reported personal wellbeing of a sample of Australian injecting drug users. *Addiction*, 105(12): 2141-2148.

[69] OECD (2019). *Addressing problematic opioid use in OECD countries*. Paris: OECD Publishing, p. 28.

[70] McNally, S., Milner, R., Turnbull, T., Ryan, J. and Crooks, L. (2018). *Poor access to pharmacotherapy will jeopardise eliminating hepatitis C in Australia*. Melbourne: Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM).

Analysis of data from British Columbia, Canada has shown the impact that OST can have on overdose deaths: between April 2016 and December 2017, there 2,177 overdose deaths, but an estimated 590 were averted by OST. In the absence of take-home naloxone, overdose prevention services and OST, overdose deaths would be 2.5 times higher.[71]

Despite the proven effectiveness of OST in treating opioid addiction, there is one key obstacle to the therapy fulfilling its potential to reduce harm among people who use drugs: costs to the patient.

Community pharmacies, which comprise the largest proportion of pharmacotherapy 'dosing sites' in Australia (85%), are commercial enterprises that charge consumers a fee to cover their costs of dispensing OST. Dispensing fees for OST average around $5 per dose, although they can reach as high as $10.[72] This differs substantially from arrangements for other prescription medications, for which the Commonwealth provides a dispensing fee to the pharmacy on a 'per script' (rather than 'per dose') basis. Other Australian health consumers who receive medication for chronic and/or lifestyle-related illnesses such as diabetes, smoking-related illness and high cholesterol are not required to pay for their medication to be dispensed. This situation is discriminatory and inequitable: people on OST should be provided the same access to medication as other Australians with chronic health issues.[73]

For many people with opioid dependence, the issue of cost and the 'consumer pays' model is the major impediment and barrier to treatment. The evidence shows that OST dispensing fees are a major barrier to treatment retention and represent a 'significant financial burden particularly for the 65-75% of pharmacotherapy clients on fixed incomes or welfare support'.[74]

Research with 120 OST patients in Victoria found that many faced significant hardship in dealing with dispensing fees, leading to a range of negative outcomes. Some of the key findings of the report were that:[75]

- People on OST often prioritise the payment of dispensing fees over basic necessities, including food and accommodation.
- OST patients on low incomes are compelled to rely on emergency relief services to meet food and accommodation needs.
- A significant minority of consumers engage in crime to meet co-payments.
- Co-payments often contribute to a deterioration in the relationship between dispensing pharmacist and patient.
- The accumulation of debt through the inability to pay dispensing fees is a primary reason for the involuntary discontinuance of treatment.
- Co-payments are the single greatest obstacle to retention in OST.
- The withholding of OST encourages illicit heroin and/or other opioid use.

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[71] Irvine et al. (2019). 'Modelling the combined impact of interventions in averting deaths during a synthetic-opioid overdose epidemic'. *Addiction*, first published 5 June 2019, doi.org/10.1111/add.14664. The analysis estimated that a total of 3,030 overdose deaths were prevented by the combination of take-home naloxone (averting an estimated 1,580 deaths), overdose prevention services (averting 230 deaths) and OST (known there as opioid agonist therapy).

[72] Lord, S., Kelsall, J. and Kirwan, A. (2014). *Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention*. Melbourne: Centre for Research Excellence into Injecting Drug Use, p. 2.

[73] Penington Institute (2015). *Chronic unfairness: Equal treatment for addiction medicines?* Melbourne: Penington Institute.

[74] Lord, S., Kelsall, J. and Kirwan, A. (2014). *Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention*. Melbourne: Centre for Research Excellence into Injecting Drug Use, p. 2.

[75] Rowe J. (2008). *A raw deal? Impact on the health of consumers relative to the cost of pharmacotherapy*. Melbourne: RMIT and the Salvation Army.

- Involuntary discontinuance of treatment is invariably followed by a return to problematic heroin use.

The evidence clearly shows the detrimental impact that OST co-payments have on consumers and how these fees can contribute to the experience of economic hardship and continuing engagement in criminal activity. Reducing or eliminating co-payments by government funding of dispensing fees would ensure that pharmacotherapy is viable and sustainable for pharmacists and affordable for their clients.

All of the stakeholders consulted for this submission who have been involved with OSTs decried this cost issue as the biggest challenge – an 'enormous barrier' to improving the effectiveness of OST programs.[76] Paying even $30 each week is a large sum for someone who is unemployed. Further, the service is not part of the PBS and does not contribute to one's safety net. All these factors severely constrain the reach of the program and reflect a lack of recognition that this is an ongoing illness.

Financial concerns are also an obstacle to the pharmacists themselves. The dispensing fee does not cover the costs to the pharmacists in running the OST program; there is no business case for a pharmacy to offer a service that is not profitable. One stakeholder noted that OST provision is a 'government-run program relying on the good will of providers'.[77] The lack of profitability means that there are not enough providers in rural and regional areas in particular, with significant workforce shortages as well – clients have been known to travel 100 kilometres to access a doctor or pharmacist. Unless the funding model changes, the decreasing number of prescribers of OST will continue to reduce. Such service shortages could directly result in increased drug use. The introduction of Safe Script – which is likely to identify many more people who are dependent on opioids – will only compound the lack of availability of OST providers.[78] As one stakeholder commented, 'a perfect storm is coming'.[79]

Question 5: What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Given the evidence that people experiencing social and economic vulnerability are more likely to use illicit drugs, and the known link between illicit drug use and mental health issues, we recommend taking a broader view of risk, focussing more on **social and economic vulnerability**, rather than identifying specific at-risk demographic groups.

Nonetheless, there are particular issues facing specific demographic groups that highlight the importance of understanding the differential impact of substance use. Services for vulnerable groups need to be properly **integrated** to ensure that people are receiving the full suite of support that they need. The prevalence of a **triad of 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.

[76] Stakeholder interview, person with experience of the OST system, 4 June 2019; stakeholder interview, practice pharmacist, 6 June 2019; stakeholder interview, person with experience in AOD services, 13 June 2019.
[77] Stakeholder interview, person with experience of the opioid substitution therapy system, 4 June 2019.
[78] Stakeholder interview, person with experience of the opioid substitution therapy system, 4 June 2019.
[79] Stakeholder interview, person with experience in AOD services, 13 June 2019.

Better integration between the various systems can be achieved through the following strategies:

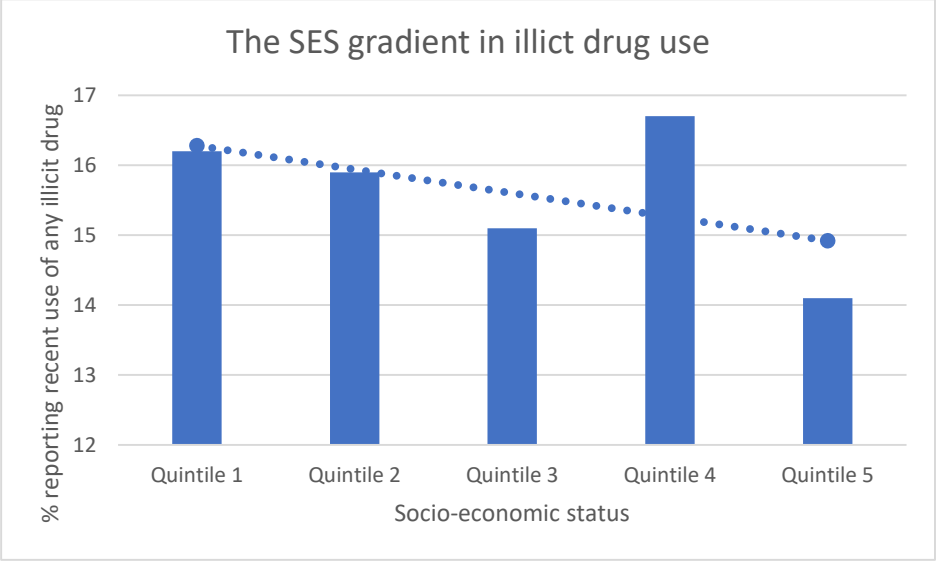
- Workforce training
- Co-location of services
- Use of multi-disciplinary teams

People who use drugs are particularly susceptible to mental health difficulties. Data from the *National Drug Strategy Household Survey 2016* show that high or very high levels of psychological distress are reported among 25.7% of people who have recently used drugs, compared with 11.7% of all survey respondents.[80]

The survey identifies several population groups that have higher risk of experiencing harms associated with drug use, including people living in remote and very remote areas, socio-economically disadvantaged people, those who are unemployed, Aboriginal Australians, people identifying as homosexual or bisexual, people with mental health conditions or high/very high levels of psychological distress and pregnant women.

While identifying those groups most at risk is useful for the development of targeted responses, it may obscure the underlying common threads among the groups. Among many of these cohorts, the underpinning risk factor is most likely economic and social vulnerability. Using data from the *National Drug Strategy Household Survey 2016*, Figure 2 illustrates the relationship between socio-economic status and illicit drug use.

Figure 2: The relationship between socio-economic status (SES) and illicit drug use



Source: National Drug Strategy Household Survey 2016 (Table 8.3)

Note: Quintile 1 is the most disadvantaged and Quintile 5 is the least disadvantaged.

The data show that illicit drug use is found in all socio-economic groups, from the most advantaged to the least. However, it is those in the least advantaged group who are most vulnerable to harms

[80] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 5.8.

associated with illicit drug use – they are least likely to have access to effective supports and services and are most at risk for entering the criminal justice system and ending up incarcerated.

The RANZCP identifies the link between disadvantage and drug use:[81]

> *While it would be simple to assume that drug use leads to poverty and other psychosocial problems, the clustering of significant substance use issues in areas with high levels of poverty and marginalisation, suggests that the core problem is actually more complex than drug use as the causative driver.*
>
> *Scarcity and poverty both affect decision making and impulsivity, leading to problems with delaying gratification or inhibition of risky behaviour, including drug use. There is also evidence that scarcity of resources changes attention and the ability to focus on differing demands. While we would like to say that behaviour is predictable and that it is simple to influence people to healthier choices, the reality is that in poor/marginalised communities, choices of behaviour are not always directly linked to increasing health or safety.*

The RANZCP notes the importance of harm minimisation taking a more health-focused approach and broadening its remit to consider social inclusion, social disadvantage, unemployment, homelessness, Aboriginal and Torres Strait Islander peoples, income support, child protection and the justice system. It recommends:[82]

> *Any meaningful strategy seeking to address problem drug use, including methamphetamine, must contemplate the broader social determinants of health and drug use, and seek to reduce social inequality and lack of opportunity. Focussing on drug use behaviours alone cannot hope to provide any cohesive or comprehensive solution.*

These interactions among mental illness, drug use and broader socio-economic vulnerability are also implied in the Law Institute of Victoria's submission to the Royal Commission into Victoria's Mental Health System:[83]

> *The Commission must look to develop an integrated service model that ensures consumers are supported by 'wraparound' services outside of purely mental-health based assistance, including housing, employment, disability, and drug and alcohol services. Wraparound support plays a critical role in preventing mental illness – which, with appropriate treatment, may be only a short-term circumstance – from escalating into family breakdowns, criminal offending, homelessness, or hospitalisation which may irreversibly change the course of an individual's life.*

Given the evidence that people experiencing social and economic vulnerability are more likely to use illicit drugs, and the known link between illicit drug use and mental health issues, we recommend

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[81] 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.
[82] 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.
[83] Law Institute of Victoria (20 May 2019). *Submission to the Royal Commission into Victoria's Mental Health System*. Melbourne: LIV.

taking a broader view of risk, focussing more on social and economic vulnerability, rather than identifying specific at-risk demographic groups.

Nonetheless, there are particular issues facing specific demographic groups that highlight the importance of understanding the differential impact of substance use.

Men

Research evidence and drug service data suggest that men are more likely to inject drugs than women. Men consistently make up a greater proportion of service users[84] and drug-related deaths compared with women.[85] Men are more likely to use alcohol excessively, more likely to engage in illicit drug use and more likely to be hospitalised for AOD-related reasons.[86] Men who use and/or inject drugs often experience additional risk factors or face challenges that are likely to exacerbate their drug use and related harms. In Australia, for example, use of methamphetamine is highest among males aged 20-39 in low socio-demographic groups.[87]

Other factors, such as a history of incarceration, further increase the likelihood of substance use and drug-related death. While this is true for both men and women, men are far more likely to be incarcerated than women and currently comprise 92% of Australia's prison population.[88] It is therefore important that a focus on this group is not lost in the consideration of other at-risk, yet often substantially smaller, populations; efforts to support access to other priority populations should not result in decreased access for those who make up the bulk of substance users and bear the majority of harms.

Women

Women are particularly vulnerable to co-occurring substance use and mental health difficulties. Although women are less likely than men to use illicit drugs,[89] their pathways to drug use are very different. Women are far more likely to have experienced early victimisation and childhood trauma, and are more likely to turn to illicit drugs as a self-medication mechanism for coping with the mental health issues caused by unresolved trauma. Women are more likely to experience major depression as a co-occurring disorder with their illicit drug use, but may be less likely to seek treatment. While the relationship between illicit drug use and mental health is bi-directional and complex for both men and women, the need for an integrated system response for women is particularly acute.

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[84] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW; Australian Institute of Health and Welfare (2018). *Alcohol and other drug treatment services in Australia: 2016-17*. Canberra: AIHW.

[85] Penington Institute (2018). *Australia's Annual Overdose Report 2018*. Melbourne: Penington Institute.

[86] Connolly, B. (3 June 2019). *Men more likely than women to face substance use disorders and mental illness*. Available at: https://www.pewtrusts.org/en/research-and-analysis/articles/2019/06/03/men-more-likely-than-women-to-face-substance-use-disorders-and-mental-illness

[87] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW.

[88] Australian Bureau of Statistics (2018). *Prisoners in Australia, 2018*. Canberra: ABS.

[89] Data from the *National Drug Strategy Household Survey 2016* show that 45.6% of males reported lifetime use of any illicit drug, compared with 39.8% of females: Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 5.9.

Lesbian, gay, bisexual and transgender Victorians

Research has found 'considerably higher' rates of drug use among LGBT people than among the general population, with experiences of discrimination tied to drug use as a way to cope with feelings and experiences of mental distress, such as anxiety, depression and social isolation.[90] The 2011 *Private Lives 2* (PL2) survey of LGBT Australians found that rates of drug use among these communities were higher than the national average for all drug types other than heroin. The rate of cannabis use was particularly high (24.2%) – more than twice the national average for the general population (10.3%). Table 1 shows that rates of recent use of other drugs (in the past 12 months) were also many times higher than the national average.

Table 1: Proportion of PL2 respondents who reported having used drugs for non-medical purposes in the last 12 months, by drug type

Drug type	PL2 %	General population %^
Illicit drugs (excluding pharmaceuticals)		
Cannabis/marijuana	24.2	10.3
Ecstasy	12.3	3.0
Meth/amphetamine	9.0	2.1
Cocaine	7.1	2.1
Hallucinogens	4.6	1.4
Ketamine	2.8	0.2
GHB	2.3	0.1
Kava	0.9	-
Heroin	0.3	0.2
Other illicit drug	0.2	-
Any illicit drug excluding pharmaceuticals	31.5	-
Pharmaceuticals		
Pain-killers/analgesics*	20.6	3.0
Tranquillisers/sleeping pills	12.6	1.5
Steroids	0.9	0.1
Barbiturates	1.3	-
Other pharmaceutical	2.5	-
Any pharmaceutical	26.7	-
Other drugs		
Amyl Nitrate/poppers**	0.9	-
Other drug not specified	0.3	-

^General population estimates are extracted from the 2010 National Drug Strategy Household Survey report and includes those aged 14 years and above (AIHW, 2011).
*Considered to be an overestimate – it is likely that a number of respondents did not consider the disclaimer "for non-medical purposes."
**Considered to be an underestimate (Amyl Nitrate/poppers was not included in the list of drugs in the survey) - The proportion above reflects the number of respondents who recorded 'Amyl Nitrate' under 'other (please specify)'

Source: Leonard, Lyons and Bariola (2015), p. 33; AIHW (2017), Table 5.4

[90] Leonard, W., Lyons, A. and Bariola, E. (2015). *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Melbourne: Australian Research Centre in Sex, Health and Society, p. 32.

Regional Victorians

People living in regional Victoria bear a disproportionate burden of drug harms. Data on the rate of drug-induced deaths in Australia show that the rate of death in metropolitan Melbourne in 2016 (7.4 deaths per 100,000 estimated resident population) was lower than in the rest of Victoria (8.0 deaths per 100,000).[91] The ABS notes a change of profile in drug induced deaths from that of younger people overdosing from heroin, to middle aged people dying from misuse of prescription drugs in a polypharmacy setting. The impact of misuse of pharmaceuticals is keenly felt in rural and regional areas: analysis for *Australia's Annual Overdose Report 2018* found that 35.6% (or 48 out of 135) of accidental drug-related deaths in regional Victoria in 2016 were caused by pharmaceutical opioids, compared with 23.8% of similar deaths in metropolitan Melbourne.[92]

Despite these higher rates of harm, regional Victorians often face additional social or economic barriers to accessing health and support services. People in regional communities find it more difficult to access harm reduction services such as needle and syringe programs, alcohol and drug treatment programs, and solution-focused justice system responses such as the Melbourne and Dandenong Drug Courts (as both have a limited geographic intake area). Further, when overdoses or other drug-related emergencies occur, regional communities face additional wait times for emergency care to arrive.

For those living in rural and regional areas, the lack of availability of treatment options for those experiencing co-occurring mental health and drug issues is particularly concerning.

Stakeholders from rural and regional areas highlighted the additional difficulties faced by people in their areas who are living with both problematic substance use and mental illness. With small populations, services are sparse so book out weeks in advance, with some people having to drive long distances to access the support they need. Resources often have to be shared: one stakeholder spoke of driving two hours to deliver naloxone to a client of another town's provider.[93] Privacy is an issue in rural and regional areas as residents of small communities are more likely to know each other and be more aware of each other's movements. This can lead to increased concerns about stigma and reluctance to seek help.[94]

The gaps that exist at the intersection of drug treatment and mental health services mean that many people experiencing co-occurring drug and mental health issues are unable to access treatments that effectively address their needs: mental health services may not have the capacity to address drug dependency, and drug and alcohol services do not have the capacity to treat mental illness. While difficulties in access are found in metropolitan areas, they are particularly acute in rural and regional parts of Victoria.

Aboriginal Victorians

A third layer of disadvantage is felt among Aboriginal people who live in rural and regional areas who experience co-occurring substance use and mental health issues. In addition to difficulties accessing services due to the lack of local facilities, there are both cultural and social obstacles for this group

[91] Australian Bureau of Statistics (2018). *Causes of Death, Australia, 2016*. Canberra: ABS.
[92] Penington Institute (2018). *Australia's Annual Overdose Report 2018*. Melbourne: Penington Institute, p. 46.
[93] Stakeholder interview, person with experience of the opioid substitution therapy system, 4 June 2019.
[94] See, for example, Wood, P., Opie, C., Tucci, J., Franklin, R. and Anderson, K. (2018). "A lot of people call it liquid handcuffs" – Barriers and enablers to opioid replacement therapy in a rural area. *Journal of Substance Use*, 24(2): 150-155.

due to the imposition of western conceptualisations of, and responses to, mental illness being imposed on Aboriginal communities.

Current and former 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.[95] 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.[96]

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 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.[97]

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:[98]

- 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.

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

[96] 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.

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

[98] 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.

- 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.[99]

One stakeholder from a rural part of Victoria identified forensic clients as presenting multiple challenges. Many prisoners who are released are required to engage with mental health as part of their parole, but the few psychiatrists available in the area will not see them until they have ceased taking drugs. There is a lack of understanding that self-medication for underlying mental ill-health is widespread among released prisoners: about two-thirds of this person's clients use drugs to cope with their mental health issues. These clients struggle even to see a doctor – with their complex and extensive histories, doctors in the area are not keen to accept them as patients. With these clients unable to access the support and services they need, 'most of them are reoffending'.[100]

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

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.[101]

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.[102] It is also a missed

[99] 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.

[100] Stakeholder interview, rural secondary NSP provider, 13 June 2019. This stakeholder ended the interview by summing up her current work with rural forensic clients: 'it's actually horrific to work in…it's really sad'.

[101] Justice Health and Forensic Mental Health Network (2015). *Network Patient Health Survey*. NSW Health.

[102] 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,

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'.[103] 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.[104]

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 OST; and
- improved referral to aftercare and community treatment services.

Part of through-care provision should be the ready availability of naloxone 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[105] should be more easily available, at no cost, and with a greater diversity of products, including intranasal naloxone to facilitate wider use.

The need for integration

Given the vulnerabilities of these different communities, it is critical that responses to drug harms are tailored to local needs and demographics, are readily accessible and are driven by the community. In particular, services need to be properly integrated to ensure that people are receiving the full suite of services that they need.

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.

[103] Anex (2010). *With conviction: The case for controlled needle and syringe programs in Australian prisons*. Melbourne: Anex.

[104] Victorian Auditor-General (2013). *Prevention and management of drug use in prisons*. Melbourne: VAGO.

[105] Naloxone is a medication that can temporarily reverse opioid overdose. It has no potential for abuse.

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 NSP clients have been found to report at least one diagnosable psychological disorder or anti-social personality disorder.[106]

During consultations, Penington Institute's stakeholders noted a range of problems for their clients in accessing services that could address both mental health and substance use issues in an integrated and co-ordinated fashion. They expressed frustration at the inability of services to respond promptly and appropriately to mental health crises among people who use drugs. Lack of integrated services, lack of effective referral pathways, and lack of knowledge of appropriate ways to address co-occurring drug use and mental health issues were also cited as problems.

In order to address inequity in mental health outcomes among these and other vulnerable communities, better access to services that are integrated more effectively is critical to improving outcomes. Research describes the problem of disconnected and poorly co-ordinated services as systemic and commonplace. For example, a 2010 report on housing, mental health and drug treatment services in Australia identified a multitude of ongoing barriers to effective integrated care arrangements for people whose mental illness is contextualised by co-occurring issues such as drug misuse, homelessness or both.[107] A follow-up report in 2013 noted:[108]

> *Despite the fact that the homelessness, drug and alcohol, and mental health service systems are separate, they share many of the same clients and address similar problems among clients. Homelessness services, for example, provide support to clients who also have drug and alcohol, and mental health needs. Therefore, the homelessness, drug and alcohol, and mental health service systems interact. Service integration and effective working relationships between services across the homelessness, drug and alcohol, and mental health systems is, a priori, critical in achieving good outcomes for clients wherever they may be located.*

While there is broad agreement on the need for better integration of the mental health and AOD system, there has been limited effort in defining precisely what 'integration' of systems actually means. Flateau et al. (2013) note that the two highest levels of integration are co-operation and

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[106] 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.

[107] Flateau, P., Conroy, E., Clear, A. and Burns, L. (2010). *The integration of homelessness, mental health and drug and alcohol services in Australia*. Melbourne: Australian Housing and Urban Research Institute.

[108] Flateau, P., Conroy, E., Thielking, M., Clear, A., Hall, S., Bauskis, A., Farrugia, M. and Burns, L. (2013). *How integrated are homelessness, mental health and drug and alcohol services in Australia*? Melbourne: Australian Housing and Urban Research Institute, p. 1.

collaboration. They offer a definition of service integration[109] that is directly relevant to efforts to improve system responses to people with co-occurring substance use and mental health issues:[110]

> *Cooperation involves services across the region having an active program of communication and information sharing, while collaboration involves services working closely with each other to guide and modify their own service planning.*

Integration also refers to client integration, which may be seen as the second pillar of an effective response to people living with both problematic substance use and mental illness: [111]

> *Client-level integration focuses on the experiences and perceptions of clients as to whether they face a seamless system of care and support in which needs are met, irrespective of who provides assistance to them. Client integration can be conceptualised in one of two ways: (1) how clients perceive the service system, and whether it works seamlessly in their eyes to meet their needs in a timely appropriate fashion; and (2) how clients experience the service system, and whether it works seamlessly in actual practice to meet their needs in a timely appropriate fashion.[112]*

The research found that service integration is higher within the same domain (for example, within the AOD domain) rather than between domains (for example, across AOD and mental health), and that there remain significant barriers to accessing services, including cost, long waiting lists and difficulties negotiating the service system.

Penington Institute's stakeholders identified better integration between the AOD and mental health systems as a fundamental and critical need. Multiple examples were provided of instances where clients with co-occurring substance use and mental health problems 'fell through the cracks' – where people could not access the support they needed as AOD services lacked the capacity to deal with the mental health issues, but clinical mental health services lacked the capacity to deal with the AOD issues.[113]

One stakeholder noted that 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 services, and family violence victimisation is commonly seen among women with substance use and mental health co-occurrence. The stakeholder provided an example of a female client who was suffering from PTSD after experiencing decades of family violence (including two hospitalisations), and who had a long-term history of alcohol abuse as a coping mechanism to deal with the violence. It was the trauma caused by the family violence that was underpinning her problematic alcohol use and PTSD. In the stakeholder's experience, this is 'not an uncommon story'. However, women who are victim survivors of family violence are more likely to

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[109] While the report discusses *service* integration rather than *system* integration per se, it nonetheless offers valuable insight into the value of integration when working with people who have co-occurring needs.

[110] Flateau, P., Conroy, E., Thielking, M., Clear, A., Hall, S., Bauskis, A., Farrugia, M. and Burns, L. (2013). *How integrated are homelessness, mental health and drug and alcohol services in Australia*? Melbourne: Australian Housing and Urban Research Institute, p. 4.

[111] Flateau, P., Conroy, E., Thielking, M., Clear, A., Hall, S., Bauskis, A., Farrugia, M. and Burns, L. (2013). *How integrated are homelessness, mental health and drug and alcohol services in Australia*? Melbourne: Australian Housing and Urban Research Institute, p. 5.

[112] Emphasis in original.

[113] Primary NSP provider roundtable, 4 June 2019.

disclose their experiences when they are *not* accessing specialist family violence services; they are more likely to open up in the context of either AOD or mental health services.[114]

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).

For stakeholders, better integration between the various systems can be achieved using a range of strategies.

Workforce training

Most stakeholders identified workforce training as a primary way for facilitating integration between the AOD and mental health systems. Clinical staff working in mental health 'don't have confidence in their knowledge' of AOD issues, while those working in the AOD sector likewise lack adequate understanding, experience and expertise in mental health issues.[115] Staff need to be trained specifically in dual diagnosis and its ramifications.[116]

Spending one or two days at a workshop is insufficient to equip staff with the knowledge that they will need in practice. Instead, several stakeholders suggested that secondments would be a useful way to provide the exposure that can facilitate deeper understanding at the intersection of substance use and mental health. Such exposure could also help reduce the judgment and fear that some clinicians experience around drug issues – one stakeholder who invited a mental health worker to visit the NSP was told 'I thought it would be really scary'.[117]

A Clinical Nurse Educator suggested that secondments would empower psychiatric nurses and AOD workers to see that working at the intersection of AOD and mental health is something that they do every day. Secondments would help staff to recognise co-occurring problems, to avoid feelings of fear with this cohort and to refrain from seeing these clients as 'not my job'.[118]

Training in communication and empathy for pharmacists, doctors, mental health clinicians and NSP and AOD staff may also be valuable to improve services for people with co-occurring mental health and drug use issues. For example, a stakeholder suggested that pharmacists have neither the time nor the expertise to deal with people's complexities, or do not feel comfortable or equipped to ask about their mental health status: 'here's your dose, see you later'.[119] Treating clients more appropriately can help retain them in treatment and allow for better linkages with other services.

Co-location of services

Stakeholders emphasised the value of embedding AOD services as a core part of the primary healthcare system. 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

[114] Stakeholder consultation, AOD Family Violence Advisor, 13 June 2019.
[115] Stakeholder interview, primary NSP provider, 6 June 2019.
[116] Stakeholder interview, rural secondary NSP provider, 13 June 2019.
[117] Stakeholder interview, primary NSP provider, 6 June 2019.
[118] Stakeholder interview, Clinical Nurse Educator, 6 June 2019.
[119] Stakeholder interview, practice pharmacist, 6 June 2019.

that employ both AOD workers and mental health counsellors offer a way to strengthen referral pathways.

Other stakeholders discussed the value of mental health units – both inpatient and in the community – employing a full-time AOD worker and for AOD services (including primary NSPs) to employ a full-time mental health clinician. This would allow drug and mental health services to be provided at the same time: 'it's so opportunistic – if you can't take advantage of that opportunity right at that moment, you just lose it'.[120]

A stakeholder who works at the boundary between the AOD and family violence systems discussed the value of co-location of services. The AOD Family Violence Advisor role, implemented across the state following the Royal Commission into Family Violence, allows this stakeholder to spend one day per week located within a family violence service provider to offer guidance and information about AOD and how best to respond to affected clients. For her, the co-location model 'provides such rich opportunities' to improve understanding, reduce stigma and offer a more holistic and co-ordinated service.[121]

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.

One stakeholder who works with forensic clients in an AOD capacity emphasised the particular value that a team-based approach would provide for this client group. For her, having mental health and community corrections around the table with her would give her the information she needs to be able to respond appropriately and effectively to her clients. The lack of information sharing around these clients can actually be dangerous – 'how do you know what you're working with?'[122] – so a multi-disciplinary approach, working as one organisation, would ensure appropriate support and service provision for all of a person's needs to achieve the best possible outcome.

Another stakeholder with forensic experience recommended the model used in the Victorian Drug Court, where all the relevant services are brought around the table with the person who is serving the Drug Treatment Order to develop, implement and monitor a package of support that is tailored to each person's individual needs and circumstances.[123]

There remain, however, several obstacles to the integration of the various systems. The requirement to cease drug use prior to entering mental health treatment was raised by stakeholders as a key barrier

[120] Stakeholder interview, primary NSP provider, 6 June 2019.
[121] Stakeholder consultation, AOD Family Violence Advisor, 13 June 2019.
[122] Stakeholder interview, rural secondary NSP provider, 13 June 2019.
[123] Stakeholder consultation, AOD Family Violence Advisor, 13 June 2019.

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.[124] Each of these represents a significant barrier to proper system integration.

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. These need to be considered alongside considerations of how best to integrate the AOD and mental health systems.

One example of community-led integration is underway in the regional town of Mansfield, Victoria.

In July 2014, the town of Mansfield held a forum attended by more than 250 people to discuss ice use and to seek information and advice on responding to the increasing problem of ice in their community. The meeting was chaired by a local GP with recent experience of handling local drug users, including withdrawal of the drug in the local hospital. He was supported by the local Shire youth worker, the local Senior Police Sergeant and a local solicitor with court experience with drug users. Professor David Penington AC was an invited speaker. Also present was a badly damaged recovering ice user from a neighbouring town who had successfully completed a rigorous program in a private rehabilitation service. He was sitting with his mother, who was able to recount her lack of any support as she watched her son slide into deep ice dependence, stealing money and becoming severely mentally impaired. She talked about how the family became fearful of violence and about her son's large debt to a criminal gang supplying drugs to his town. She feared the consequences of notifying him to anyone, as it raised fears of arrest and incarceration, with a prospect of a life of crime following release.

In the wake of the forum, Mansfield determined that a new, local model was needed to tackle drug use. Adopting a person-centred, primary health system response, Mansfield District Hospital and the town's two General Practice groups have been funded to develop a locally-controlled intervention to respond to the problems of illicit drug use in the community. The model aims to allow those in need to access appropriate support and services as quickly as possible to minimise or prevent problematic drug use.

A three-year trial of a community-led model was launched in Mansfield in 2018, focusing on early intervention via case management and treatment. The trial has employed a Community Health Nurse who specialises in drug and alcohol support/rehabilitation and client case management. The model of care will be governed by key community stakeholders, including Mansfield District Hospital, the GPs, local government, lawyers, police and any other strategic service providers or key people within the community.

The model is person-centred, community-controlled and holistic with a strong primary health and family focus. This will enable the community to:

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

- know what is happening and be able to respond or intervene early before drug use becomes an even greater problem;
- provide assistance to busy GPs to make it possible for them, in partnership with a Community Health Nurse, to make the necessary decisions in managing drug users;
- provide better and immediate access to specialist services if needed;
- ensure that the client's family is kept fully informed at every stage;
- acknowledge and understand that there are underlying and social factors that contribute to someone's drug use and that solutions must address a range of factors, including mental health, employment, housing or isolation; and
- embed all support within the community in a co-ordinated way, including other community welfare and recreational institutions in addressing both prevention and rehabilitation issues.

The model's success will depend on strong partnerships across the many local professions and agencies and the investment in a dedicated co-ordinator (Mansfield District Hospital). Liaison with regional alcohol and drug services will be key (Gateway Health and, for those with co-occurring mental health issues, North East Border Mental Health Service), as will additional support and referral into specialist drug withdrawal or rehabilitation service in Melbourne if required.

The Mansfield trial will be evaluated to determine whether it would be appropriate for development in other rural areas where problems from 'ice' and other drugs continue to mount.

Question 6: What are the needs of family members and carers and what can be done better to support them?

Family members and carers of people who use drugs and also suffer from mental health problems need to be able **to understand what is happening** to their family member and how best to support them.

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**.

Family members and carers of people who use drugs and also suffer from mental health problems need to be able to understand what is happening to their family member and how best to support them. Educational resources are critical for providing facts about drug use and harm reduction, including how to access available services and how to support loved ones.

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.

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 case study in education: Penington Institute's online resource for young people at risk of ice use, their friends and their families

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*.[125] At the time there were no online resources for young people that provided calm, evidence-based, non-judgmental information.

Young people have embraced digital and social media, engaging with these extensively in all aspects of their lives. Many use this medium to access information about drugs – as evidenced by numerous online 'drug forums' where people exchange information and experiences.

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.

The resource is structured around four sections, each tailored to a specific target audience (young people or their friends or family):

- The facts about ice – the forms it comes in, its effects, how it is used, problems with more frequent use.
- Ice and health – the potential impacts of ice on a person's mental and physical health.
- Ice and life – the potential impacts of ice on a person's work and study.
- What can I do? – links and help line numbers plus information about how and when to talk to a young person about their ice use.

The aim of *Understand Ice* was to contribute to the reduction of adverse consequences of ice use among young people aged 19-24 years by:

1. Encouraging young people to consider the impact that their ice use was having on them and help them manage the impacts of their use.
2. Giving young people support and advice on things they could do if they recognised that their ice use was becoming a problem.
3. Providing harm reduction information that gave people the information and knowledge with which to reduce the harms of their ice use, in the event that they chose to continue to use.
4. Linking them in with information, advice and referral if they wanted to take action about their ice use.

Over two years, Penington Institute ran an extensive education campaign across regional and rural Victoria and metropolitan Melbourne to promote the *Understand Ice* resource, using the latest social media promotional tools and advertising as well as more traditional channels such as media relations activities and print advertising.

[125] www.understandice.org.au

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.

There are many opportunities for education-based interventions focused on preventing and reducing the harms associated with drug use. However, the continued funnelling of resources into ineffective and at times harmful responses to drug use not only diverts resources away from education interventions but can also actively inhibit their effectiveness. Harm reduction- and prevention-focused interventions improve the wellbeing of people who use drugs by empowering them to take better care of themselves, access available services and have positive interactions with others. At the same time, education for families and friends helps to reduce fear and anxiety by providing them with knowledge, understanding and practical advice on how to support their loved ones.

Unlike families of people with a physical illness such as cancer, families of people who use drugs do not have access to broad-based public support networks. Due largely to the stigma associated with drug use, the death of a family member through overdose is not afforded the same level of public sympathy or the same clear mechanisms through which family and friends may grieve.

International Overdose Awareness Day attempts to offer families a forum for public grief. Through the 'tributes board' on its website,[126] as well as with local events and activities that are held for people to come together to remember loved ones, family and friends are able to commemorate those who have lost their lives or suffered injury through overdose. The large number of tributes and events that are held around the world is testament to people's need to be able to talk about the impact of overdose on their lives. This process would be easier for families and friends if there were less stigma associated with drug use – stigma that is associated with its criminalisation.

Question 7: What can be done to attract, retain and better support the mental health workforce, including peer support workers?

The **quality** of the NSP workforce is integral to a more effective mental health system in Victoria. Given the complex needs of NSP clients, the capacity of NSPs to address these conditions needs to be supported and increased.

Staff need to have the requisite understanding, skills and competencies in both AOD and mental health to meet clients' service needs. This requires both **ongoing workforce development and increased funding** to expand access to NSP services.

Given the potentially critical role that NSP providers can play in supporting people living with both problematic drug use and mental illness, the quality of the NSP workforce is integral to a more effective mental health system in Victoria.

The National NSP Strategic Framework identified workforce development – especially among secondary NSP providers – as a 'significant challenge':[127]

[126] https://www.overdoseday.com/tribute/

[127] Victorian Department of Human Services (2010). *National Needle and Syringe Programs Strategic Framework 2010-2014*, Melbourne: DHS, p. 16.

> *People who staff secondary and pharmacy NSPs do not undertake NSP duties as their main role. These workers may not have had the opportunity to obtain NSP qualifications or training and therefore may not be aware of the public health benefits of the program; the importance of making clients feel comfortable in accessing the service; or may be unable to provide referral or other services when required. Training and education for workers in secondary NSPs and pharmacies is critical to the success of the Program.*
>
> *The workforce staffing individual NSPs need to have an appropriate level of knowledge about the effects of injecting drug use on health and wellbeing and be skilled to provide NSP services confidently and effectively.*
>
> *The Program experiences considerable workforce turnover on an annual basis. Investment in training must be constant to address the orientation and further training needs of new personnel.*

The high turnover may be due to lack of adequate remuneration, to the undervaluing of NSP staff or to 'burnout' as staff work at the coalface with people who have complex and challenging lives.

The critical component of the NSP is the people who comprise the staff of individual provider locations. Especially for NSP clients who also have mental health problems, staff need to have the requisite understanding, skills and competencies to meet clients' service needs.

The vast majority of NSP providers do not receive funding to employ specialist NSP staff members. In the absence of such a role, there is often inadequate recognition and acceptance by staff of their responsibilities for service delivery in the NSP context and, more broadly, the purpose of, and need for, NSPs.

Professional development opportunities such as training are crucial to ensure that all staff have an accurate understanding of the purpose of, and philosophy underpinning, NSPs and of their role in providing NSP services. While some staff might be active in providing sterile injecting equipment, others may not perceive the additional aspects of NSP service delivery, such as providing information and education or referrals, as being part of their role.

Organisational support is also needed to ensure that staff feel supported in their roles and to improve how staff understand their role within an NSP. Compared with NSP outlets that are not well supported, those which are well supported tend to have fewer problems with staff not perceiving NSP service delivery as part of their role (19.5% of supported NSPs compared with 36.4% of those which indicated room for improvement in organisational support, and 60% of those which reported no organisational support).[128]

NSP staff themselves have identified their need for more training:[129]

> *Providing information and support and referral to assist individuals to mitigate injection-related harm requires a high level of knowledge about the practice of injecting as well as the many physical and mental health problems associated with this practice. This entails a skilled and educated workforce to carry out harm*

[128] 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. 25-26.
[129] Thomson, N., Leitch, D. and Ryan, J. (2015). *Taking stock: Injecting drug use and the Victorian Needle and Syringe Program*. Melbourne: Penington Institute, p. 14.

reduction activities and interventions. Service providers reported a need for more training and workforce development delivered in innovative ways to the sector.

Further, NSP service providers have also noted a lack of guidance about best practice service delivery, such as the absence of service benchmarking or Key Performance Indicators (KPIs) in the NSP sector. The adoption of benchmarks or KPIs would assist in empowering and professionalising the NSP sector.

Penington Institute is currently undertaking a sector-wide training audit and needs analysis to identify specific technical and administrative training needs among NSP providers. Part of our role is to provide training to NSP staff to help professionalise the workforce and give staff the skills they need to succeed in their roles. Penington Institute also produces the monthly Anex Bulletin,[130] designed specifically for the NSP workforce, as a mechanism for translating current research and issues and informing staff of recent developments in their field.

Research clearly shows that NSPs are an invaluable service in terms of the support they can provide to a highly marginalised, disadvantaged and unwell population that may be reluctant to access mainstream health care. However, given the complex needs of this population — including injecting-related injury and disease and chronic mental and physical health issues — the capacity of NSPs to address these conditions needs to be supported and increased. This requires both ongoing workforce development and increased funding to expand access to NSP services. Good access to NSPs requires a range of models of provision including fixed site, outreach, syringe dispensing units and online services. This multi-modal approach can respond to the diversity of people who inject drugs, providing specialist services at fixed sites, but also being proactive in supplying at risk groups such as young people or other populations that have low rates of use of fixed site NSPs.

Question 8: What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

A significant barrier to people's social and economic participation is the **stigma** created by the criminalisation of their substance use.

The criminalisation of illicit drugs frustrates the goals of the *National Drug Strategy*, which has an overarching goal of minimising the harms associated with drugs and drug use.

While **decriminalising personal acquisition, possession and use of illicit drugs** and **adopting a health response** would not completely remove stigma, it would help to reduce stigma significantly, thereby facilitating access to appropriate services and support and allowing people to increase their participation in the social and economic life of their communities.

A significant barrier to people's social and economic participation is the stigma created by the criminalisation of their substance use. By being pushed to the edges of society and cast out of communities, people with co-occurring drug use and mental health issues have very poor rates of social and economic participation. Part of this is the lack of basic human dignity that often afflicts people who are in dire circumstances, with no stable accommodation, no employment and with co-

[130] http://www.penington.org.au/anex-bulletin/

occurring mental health and drug use issues. One stakeholder called the group the 'most disenfranchised and marginalised' in our society who are often classified as 'too hard' to deal with, and asked, 'how can you help someone's mental health issue if you're not taking care of basics like housing?' For this stakeholder, one of the primary strategies in providing better support would be to give people their dignity back by allowing them to be 'clean and fed': the provision of showering and laundry facilities would allow people to feel more comfortable accessing services, and would reduce the likelihood of service providers turning people away due to cleanliness problems.[131]

The criminalisation of illicit drugs frustrates the goals of the *National Drug Strategy*, which has an overarching goal of minimising the harms associated with drugs and drug use. The harms associated with illicit drug consumption and dependence to individuals, families, communities and society are well known. Having a wholly unregulated supply of a range of illicit drugs that are easily accessible is clearly a primary driving factor of illicit drug-related harms.

Contact with the criminal justice system is itself harmful both to society and to individuals. The criminal justice system is costly to the state and harmful to the individual. People with illicit drug dependence, who are already at a higher risk of experiencing problems such as mental ill-health, poverty, poor physical health, unemployment and low quality of life, are unlikely to benefit from criminal charges. In fact, a criminal conviction and possibly incarceration will exacerbate the significant challenges they already face.

While decriminalising personal acquisition, possession and use of illicit drugs and adopting a health response would not completely remove stigma, it would help to reduce stigma significantly, thereby facilitating access to appropriate services and support and allowing people to increase their participation in the social and economic life of their communities. This approach is consistent with the recent unanimous support for decriminalisation of personal drug use and possession, as confirmed by the United Nations Chief Executives Board, which represents the 31 UN agencies.[132]

Question 9: What areas and reform ideas should the Royal Commission prioritise for change?

The primary priority for reform is appropriate **funding for evidence-based harm reduction**.

Data show that many people want to see drug use addressed through **public health strategies** rather than via the criminal justice system.

Given that both NSPs and OST have been shown to be effective harm reduction initiatives, both need adequate funding to be able to fulfil their potential. Additional funding would facilitate the implementation of best practice approaches, **holistic support and integrated care** to support Victorians who are living with both mental illness and drug use.

For Penington Institute, the primary priority for reform is appropriate funding for evidence-based harm reduction.

[131] Stakeholder interview, primary NSP provider, 26 June 2019.
[132] http://www.dpnsee.org/cms/files/2019/03/UN-Chief-Executives-Board-Minutes-1901.pdf

Harm reduction is one of three pillars of the harm minimisation approach, along with demand reduction and supply reduction. But government investment in each of the pillars is far from balanced in Australia, with two-thirds spent on supply reduction: an examination of government drug policy expenditure in 2009-10 showed that the largest proportion of expenditure was on law enforcement (64%), followed by prevention (10%), treatment (22%), harm reduction (2%) and other (1%).[133] These figures represent an increase in the Federal budget for law enforcement from 55% in 2002-03, but a *decrease* in harm reduction expenditure from 3% since that time.[134]

Yet, judging by research on public attitudes commissioned by Penington Institute in 2009, Victorians are in favour of greater balance between taxpayer funding on law enforcement measures and harm reduction interventions. When asked the question 'if the government had $100 to spend on addressing problems associated with illegal drugs, how much do you think they should spend on each of the following?', analysis found that the preferred division for a majority of respondents was as follows:[135]

- Police, courts and imprisonment for people who use or produce illegal drugs: $20
- Educating people to prevent commencement of illegal drug use: $30
- Treatment programs that aim to reduce or end use in people using illegal drugs: $20
- Programs to reduce harms to individuals and the community resulting from illegal drug use: $20

These figures indicate that many people want to see drug use addressed through public health strategies rather than via the criminal justice system. Penington Institute advocates that a greater proportion of funding be allocated to harm reduction initiatives.

More recent data from the *National Drug Strategy Household Survey* confirm these findings, showing that people allocated more to treatment and education combined and less to law enforcement to reduce illicit drug use. In 2016, while law enforcement alone received the highest proportion of the allotted $100 ($36.00), education was almost identical ($35.20), while treatment received $28.80. But the proportion of money allocated to law enforcement was statistically significantly lower in 2016 than in 2013, while the proportions for both education and treatment were significantly higher.[136]

Given that both NSPs and OST have been shown to be effective harm reduction initiatives, both need adequate funding to be able to fulfil their potential. Return on investment analysis for Australian NSPs has shown that for every dollar spent on NSPs, more than $4.00 will be returned in savings to the health system, with NSPs being 'highly cost saving' over the longer term.[137]

Additional funding would facilitate the implementation of best practice approaches, holistic support and integrated care to support Victorians who are living with both mental illness and drug use.

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[133] Ritter, A., et al. (2013). *Government drug policy expenditure In Australia 2009-2010*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.
[134] Moore, T. (2005). *What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia*. Fitzroy, Victoria: Turning Point Drug and Alcohol Centre.
[135] Anex (2009). *Anex Community Research Project - Summary of Findings*. Melbourne: Anex.
[136] Australian Institute of Health and Welfare (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW, Table 9.33.
[137] Department of Health (2009). *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia 2009*. Canberra: Department of Health, p. 8.

Question 10: What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

In the short term, there is a need to address a **lack of adequate data** on the relationship between mental illness and drug use. Known **barriers to support**, such as the requirement for people to cease their drug use prior to accessing mental health treatment and the dispensing fee associated with OST, must be addressed.

In the longer term, the stigma associated with drug use needs to be reduced. The best way to reduce stigma is to **treat drug use as a health issue** rather than a criminal justice issue, which would allow it to be treated on equal footing alongside mental health issues.

Allocating **more funding to harm reduction** and less to law enforcement, and **decriminalising personal acquisition, possession and use of illicit drugs**, would both facilitate this shift in paradigm and would have substantial benefits for supporting people with mental illness.

There are both short-term and longer-term changes that can be made to support lasting improvements to Victoria's mental health system.

In the short term, there is a need to address a lack of adequate data on the relationship between mental illness and drug use. While prevalence data are available, there are yet to be robust data on the nature and prevalence of different causal relationships and pathways between the two. Data are also needed on the differential impacts of different types of drugs on different types of mental illness, and on the potential for some illicit drugs to assist with intractable mental health problems (such as the use of ecstasy to treat PTSD). A more nuanced understanding of the co-occurrence of drug use and mental illness is needed if we are to ensure nuanced policy and targeted support.

The known barriers to support must be addressed in the short-term. The requirement for drug use desistance prior to accessing mental health treatment and the dispensing fee associated with OST are two examples of obstacles that significantly restrict the availability of support for people living with both drug use and mental illness. These sorts of obstacles should be dealt with quickly to facilitate lasting reform.

In the longer term, one of the key issues hindering better support for people living with co-occurring drug use and mental illness is the stigma associated with their dependency. The best way to reduce stigma is to treat drug use as a health issue rather than a criminal justice issue, which would allow it to be treated on equal footing alongside mental health issues. Allocating more funding to harm reduction and less to law enforcement, and decriminalising personal acquisition, possession and use of illicit drugs, would both facilitate this shift in paradigm and would have substantial benefits for supporting people with mental illness.

Data on overdoses show the increasing problem of prescription drug abuse. It may well be that the distinction between licit and illicit drugs is becoming meaningless – that it is the licit prescription drugs that are causing more harm to our communities. If this is the case, then we need to shift our thinking away from the licit/illicit dichotomy to a view of all types of drugs that is based on harm. This shift would facilitate a health-driven response to drug use and would offer greater opportunities for supporting people living with both drug use and mental illness.

Question 11: Is there anything else you would like to share with the Royal Commission?

Penington Institute advocates not only for a clear understanding of how AOD funding is currently allocated within the three policy pillars of harm reduction, but also for **evidence of the benefits or return on investment** for each dollar spent within those areas.

We recommend that the Australian Government Productivity Commission establish a broad-ranging **inquiry into the effectiveness and efficiency of illicit drug use policies** and responses in Australia, including their impact on private sector productivity.

Penington Institute advocates not only for a clear understanding of how AOD funding is currently allocated within the three policy pillars of harm reduction, but also for evidence of the benefits or return on investment for each dollar spent within those areas.

The disparity between government spending on law enforcement and funding provided for other measures to address drug use signals a need for rigorous economic evaluation of this approach. The Australian Government Productivity Commission is best placed to undertake a thorough examination of the effectiveness, or otherwise, of Australia's illicit drug use policy and practice. This applies particularly to the allocation and return on investment of resources, as well as the extent to which the use of both licit and illicit drugs is contributing to the overall burden of drug-related harms in our communities.

A Productivity Commission investigation of spending in the area of drug use will ensure that drug policy and programs are funded on the basis of the evidence about interventions that are both effective and cost-effective, rather than being emotionally and ideologically driven. As such, we recommend that the Australian Government Productivity Commission establish a broad-ranging inquiry into the effectiveness and efficiency of illicit drug use policies and responses in Australia, including their impact on private sector productivity.

Conclusion

On the basis of both the research and our consultations, Penington Institute makes two primary recommendations to the Royal Commission:

1. Problematic drug use of any kind – of alcohol, prescription drugs or illicit drugs – is known to exacerbate mental health problems. To improve mental health outcomes, problematic drug use must be tackled. If we address drug use properly – using **evidence-based, effective interventions such as needle and syringe programs and opioid substitution therapy** – we will simultaneously improve mental health outcomes for people living with these co-occurring issues.
2. In order to address drug use properly, we need population-level planning to identify need and to allocate drug and mental health services appropriately. The development of a **five-year plan to identify service needs and gaps** will facilitate the implementation of evidence-based practice where it is most needed, and in the most appropriate form for local conditions.