Senate Select Committee
on
Mental Health

Submission by the
Gold Coast Drug Council Inc.

30th January 2006

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Section One

Submission to the Senate Select Committee

1.0 Overview

The Gold Coast Drug Council (GCDC) is a Not For Profit, Charitable organization which provides drug & alcohol services to residents of the Gold Coast and South East Queensland.

Over the last 5 years the GCDC has become a specialist providers of residential and out-client services for younger people who often have co-occurring mental health disorders (often known as Dual Diagnosis). Co morbidity of mental disorders and substance use disorders is widespread and often associated with poor treatment outcomes, severe illness and high service use. It has long been established that substance abuse can greatly exacerbate mental health problems (Allwell, Goldsmith, Osborne & Rolfe,). The term “dual diagnosis” or “co morbidity” refers to the co-existence of a substance misuse disorder with a mental health problem, as adopted by the Dual Diagnosis Consortium (1998).

As a result of our experience, we believe that we can provide valuable information on some of the current issues facing young people with mental health problems.

2.0 Key Issues for the Region

In terms of the broader picture in our immediate community on the Gold Coast, the following factors have a significant effect on Mental Health Services now and in the future:

Public Sector Mental Health Staffing – under-funding of staff across the acute sector, including Mental Health Services has been widely and publicly documented by the Forster Inquiry. Both the Forster Inquiry and the Productivity Commission have identified that Queensland has below average Medical Staffing when compared to the Australian norm. In Queensland we have 3.3 Registered Nurses per 1000 population and on the Gold Coast only 2.4 per 1000 population. According to Benchmarks set by Greg Hardsy we only have 70% of the staff needed for the current acute healthcare sector. Historical under funding of healthcare across Queensland, including Mental Health services remains a continuing problem for the Gold Coast.

Medical Cover – there is insufficient Medical staffing across the mental health sector. The Doctors currently available largely work within the acute hospital sector. This leaves little or no medical cover for services in the community, resulting in clients only receiving medical attention when they become emergencies.

Inability Of Services To Meet Current Demand - Mental Health Services currently cannot meet client demand on the Gold Coast. Our experience over the last year is that public sector Mental Health services are increasingly referring many of their most

complex and demanding clients to us for treatment, as public sector services are unable to support these clients in a mainstream service model. Even Private hospitals will not admit psychotic patients. As a Provider, we also have limited client capacity and the complexity of clients requires greater ratios of staff to clients which we find increasingly difficult to support with the limited funding available.

Growth In Service Demand – The Gold Coast as a Region has one of the fastest growing populations in Australia. Population growth on the Gold Coast is estimated at 30% by 2016. For young people this will mean an increase of 50,000 young people under 21 during this period. Of particular importance will be growth in the Gold Coast/Brisbane corridor, where population at places such as Coomera is predicted to grow at twice the Queensland average. Mental Healthcare provision for the Gold Coast Region is currently lagging behind the Queensland norm. This situation will be exacerbated quickly as the population grows.

Lack of Dual Diagnosis Service Specialists – The DPECs estimate of 80% of registered mental health service clients having substance use problems is consistent with epidemiological studies in the field (Regier et al, 1990; Fowler et al, 1998) which report lifetime prevalence rates of co morbid psychiatric and substance use disorders of 47%, and current substance usage among 87.1% of mental health service users (Fowler et al, 1998, p.447). For males in particular, substance use disorders account for a major proportion of the disease burden due to mental disorders; 33% of their mental health DALYs are due to substance use disorders, with alcohol abuse accounting for 59% of this figure (Mathers *et al*, 1999). Psychiatric co-morbidity is especially common among populations in which substance abuse is high, such as prisoners, the unemployed, and homeless (Timms & Balázs, 1997). These ‘dually disordered’ clients are particularly prone to suicide, noncompliance with treatment, social alienation, and risk-taking behaviour. Attempts at ‘self-medication’ with alcohol or drugs to alleviate depression and anxiety are common (Addington & Duchak, 1997);alternatively, substance use can itself lead to depression, anxiety, and psychosis (Baigent et al, 1995).

Overall, clinical care of clients with dual disorders is inadequate (Drake & Noordsy, 1995; Sitharthan et al, 1999), and costs disproportionately more than other mental health treatments (Jerrell et al, 1994; Jenner et al, 1998). In fact, these clients have often been excluded from treatment altogether (Ridgely et al, 1990; Kivlahan et al, 1991). In comparison to either disorder alone, the current impact of dual diagnosis is marked by reduced functioning, difficulties accessing treatment services, and resultant poorer treatment outcomes for each disorder. Service criteria for treatment of mental illnesses often explicitly excludes those with serious substance use disorders; the converse is true in substance abuse treatment services. The burden on carers and families of people with dual disorders, and the cost of attempting to effectively access health and social services commonly reaches totally unacceptable proportions. People with dual disorders have been described as the “fringe dwellers” of the mental health and substance treatment service frameworks (Mence, 1997); despite their prevalence, dual disorders have yet to be acknowledged as ‘core’ business by any mainstream

health services.

The national problems outlined above have become increasingly visible and prevalent in recent years, particularly with the shift of mental health and substance abuse treatment services from institutional to community-based service models (Drake & Wallach, 2000). Of particular concern has been a rise in the general availability (and, arguably the potency) of an ever-increasing variety of licit and illicit drugs, which has had especially damaging consequences for those most at risk, including the mentally ill.

Evaluation of GCDC clients indicates that 72% of clients suffer some form of dual diagnosis. Depression, anxiety, and psychotic disorder are the most frequently recorded psychiatric diagnosis. Psychotic disorder appears to be more prevalent amongst the younger age group (17 – 21 age group), and female clients appear to have a higher probability than male clients of suffering this disorder. Furthermore, it has been found at the GCDC that there is a definite increase in dual diagnosis among amphetamine users. Of importance here is the notion that younger clients are seeking treatment earlier, reinforcing the idea that services need to provide quality care for this age group.

One local imitative of the GCDC is the Gold Coast Youth Alcohol and Other Drugs Working Party (auspiced by the Youth At Risk Alliance). In July 2002 the working party conducted training on a variety of drug related topics for workers in the youth industry. One of these topics was dual diagnosis. Discussion with service providers in relation to this training indicated that services were experiencing difficulties in getting the needs of their dually diagnosed clients met. One report from the Supported Accommodation and Assistance Programs (SAAP) in 2002 indicated that 40% of young people referred to SAAP report co-existing mental health issues and drug/alcohol dependencies. In addition, it was reported that the Gold Coast Health District was one of the most under-resourced areas in South East Queensland. High population growth, high itinerant population and very high seasonal demand were cited as significant issues for this region, but a lack of additional resources was noted (Rowlands, 2002). Support resources remain scarce despite the Gold Coast City Council reporting that young people with mental health issues and young people with disabilities and substance abuse issues are a specific group with unmet accommodation and treatment needs (Rowlands, 2002).

Currently there are few services in the Gold Coast Region equipped to either identify clients or provide support for clients with mental health or co-occurring disorders.

3.0 Gaps in Mental Health Service Provision

The management of mental health disorders requires collaborative working arrangements between agencies, as clients can easily fall between gaps in services. Service gaps on the Gold Coast, which we believe are evident from our experience includes:

- lack of experience and expertise of health professionals, including General Practitioners who are often the first point of call for clients and/or their families. GPs often have limited experience and there is also little assistance available to them from mainstream services. As a result clients can easily be mis-diagnosed or fail to be referred to appropriate services.
- acute shortage of Bulk Billing Doctors who have experience in this field
- reliable and holistic assessment of cases – the difference between primary and secondary diagnosis can be minimal and difficult to ascertain in early presentation and clients can suffer if they are denied early access to treatment
- lack of Medical staffing - there is little or no access to specialist mental health Doctors/Psychiatrists in the community. This results in clients not receiving adequate care and treatment before their symptoms become acute enough for admit to hospital
- long waiting lists - clients who are referred will often have to wait a significant length of time (3/4 weeks) before they can access mainstream mental health services. Many clients will end up being admitted as emergencies before they can be seen on the waiting list
- there is little or no support or advice available for families & friends who are often supporting the client at home
- lack of simultaneous and coordinated assessment, case management and treatment between mental health services and other drug and alcohol services
- complexity of disorders which can include multiple diagnoses and therefore require collaborative treatment planning. There is often a lack of multi-disciplinary approaches due to services operating independently
- funding complexities which are often not conducive to dealing with the complex management and treatment options required
- non admission of suicidal and “at risk” clients
- some services require a client be “treatable” as a requirement for treatment. This often results in those diagnosed with personality disorders being excluded due to the difficulty of these diagnoses
- difficulties when clients admitted to accident and emergency departments of hospitals are referred back to the community services, and then readmitted to the hospital – a cyclic process begins and appears to never end
- no adequate provision of services to maintain clients in their communities and prevent relapse. This would include supported social & activity networks; housing support; re-skilling & training; employment support. Clients often only re-gain access to services when they have relapsed
- a fundamental lack of financial incentives for organisations to develop the expertise and staffing ratios required to deliver specialist services. The GCDC has developed its own specialist services with minimal funding.

4.0 Proposals for Change

Currently Mental Health Services are delivered on an illness model, with services focused on prioritizing emergencies and acute service requirements. This model reflects the health sector more generally, but is not appropriate or cost effective for services that are accessed by 1 in 3 people over their lifetime, with some requiring on-going support for most of their lives.

The current acute model of care is self-sustaining and self-limiting as clients waiting to receive services often relapse without assistance and continually cycle through the acute system, without having the support to ever develop a truly sustainable lifestyle.

Mental Health services need to move to a Recovery Model of care. This model of care would reduce the burden on the acute sector, by enabling it to more adequately support the most complex clients. This model of care would be characterized by:

- development of psychiatric community based hubs which would provide an holistic approach to the treatment and support of clients
- holistic treatment for clients would include:
    - disorder specific clinical models for managing the symptoms of chemical dependence and mental and personality disorders
    - physical interventions for managing physical problems related to the target problems
    - cognitive therapy for changing irrational thoughts that drive the target problems
    - affective therapy for changing unmanageable feelings that drive the target problem
    - behavioural therapy for changing self-defeating behaviours that drive the target problem, and
    - social/situational therapy for changing lifestyle factors that drive the target problem
    - relapse prevention – this is a cognitive behavioural therapy, based on the theory that learning processes play a critical role in the development of behavioural patterns
- development of multi-disciplinary teams at the psychiatric community based hubs, which would include Bulk Billing Doctors/ Psychiatrists; GPs and nurses providing general medical care; Psychologists; together with access to a range of other agencies at the hub to support the client e.g. Centrelink; Housing; Dept of Families; Education & Training
- options for alternative models of employment and funding for Doctors to encourage them into the mental health sector e.g. employment loadings, sessional contracts. This should also include specialist mental health Doctors working in the community which would take pressure off the acute sector. Many clients would never enter the acute system if they received adequate care in their own communities. Solving this

problem would require State and Federal Government working together to ensure Medical roles in this sector were sufficiently attractive

- early identification and assessment of clients with mental health problems through the provision of training to community organizations; public sector services and General Practitioners
- easy to access; speedy and accurate advice and support services for clients, families & friends and other agencies – putting people in touch quickly with services that can help them
- family support options for clients with families, to avoid family separation and homelessness as a result of unemployment
- daily activity programs to address living skills; employment; nutrition; social networks & training etc …
- support officers to provide on-going support and contact with clients living with on-going mental health problems which aim to prevent relapse. These individuals do not necessarily need to be specialist mental health staff, but need to be people who have the practical skills to help make service connections for clients and identify early when clients need additional help
- development of a strong and vibrant volunteer network for the mental health sector
- development of appropriate Supported Accommodation which would support the needs of people with mental health problems. It could also offer “Step Down” support for those coming out of hospital. The Richmond Report on De-Institutionalisation identified Supported Accommodation and Connectedness as the No.1 priority.
- development of Specialist Residential Units to provide holistic treatment and support for clients e.g. Minors, Youth, Dual Diagnosis. For example, young people aged 12-16 who are using drugs, but not addicted may have primary issues such as ADHD, Depression or Autism – services for all client groups need to be tailored to their maturity and experience
- a career pathway for workers in the mental health sector which provides training and development as well as recognition for skills and experience.

This model of care would require an investment of funding, but would lead to a more efficient and cost effective service in the longer term with less demand on acute services.

5.0 Work in Progress

The Gold Coast Drug Council has for many years been providing services for young clients (aged 16 – 29) with a dual diagnosis. These include clients who are particularly high risk users (e.g. psychosis, bipolar disorder) as well as those with more common conditions such as anxiety or depression. We also accommodate multiple co-morbidities and mental health disorders, as often the use of 1 substance increases the chance that others will be used.

The GCDC has found that for clients with mental health problems a range of treatment options need to be available to maximize effectiveness. Some people respond to

standard treatments for each disorder or even brief interventions, in other cases longer support is needed. Some people need pharmacological treatment and effective programs take into account inclusiveness, flexibility and individual tailoring.

As a result of this specialization, we have developed a team of staff, including nursing staff, counselors, psychologists and welfare workers, together with the support of a Medical Team including a specialist General Practitioner and a Professor of Psychiatry, which provide an holistic model of care for Dual Diagnosis clients. The GCDC is currently the only Therapeutic Community on the Gold Coast which admits co-morbid clients for residential and outclient care

While the Gold Coast Hospital has a specialist worker for similar work (a Clinical Nurse), this position only deals with cases from the hospital system. The only community position on the Gold Coast is our Youth Dual Diagnosis Co-coordinator who provides treatment and support for the 12-25 age group. Obviously one worker can only provide a limited service for this age group and is completely overwhelmed by the demand for client services and requests for support from other agencies.

The GCDC is supported by both State and Federal grants, but many of these do not provide for cost increases year on year and all are fixed term agreements. Recruiting and retaining staff in this environment is a continual challenge. For example, the Youth Dual Diagnosis Worker position has been filled by three different professionals since August 2004, as the salary available for this position is not sufficient to compete with similar roles in the public sector.

As a result of the expertise we have developed, we are now experiencing the referral of the most complex clients from Mental Health services as well as the wider community. In 2004/5 the Mirikai Residential Therapeutic Community Programme bed cost was @ $21,000 p.a. Other States such as Victoria and New South Wales have benchmarked their costs for particular client beds, with the cost of an equivalent bed in New South Wales and Victoria running @ $30,000 per year, with this funding including a component related to complexity. Queensland Health have repeatedly confirmed that they do not intend to benchmark costs for specific services or to provide financial incentives for specific client groups. Without financial recognition for the complexity of clients supported, it may simply not be possible to provide the environment and staff to deliver these services safely into the future.

The GCDC has also been lobbying for funding to support Doctor time for this specialist group of patients. As there is currently no recognition for the complexity of specialist services, or the staff expertise required to deliver these services, there are currently no potential sources of funding at either a State or Commonwealth level for specialist staff, including Doctors & Psychiatrists. If this issue is not addressed, providers of complex and specialist services will not be able to continue into the future.

This leaves organizations such as the GCDC with difficult service and financial decisions to make in the coming years. We know that there is a real and unmet need for

the services we provide, as mainstream healthcare services are already unable to support these clients. We also believe that to fund full running costs of $30,000 a bed for these clients is cost effective in the medium term.

Organisations delivering these services to complex clients need to be provided with sufficient funding to provide the level and quality of service needed. If providers such as ourselves pull out, these clients will simply have no where else to go.

Section Two

1.0 History : Gold Coast Drug Council Inc.

The Gold Coast Drug Council Inc., also known locally as Mirikai (formerly the Drug Referral Centre), is a registered charitable institution. It was established in 1971 as the first alcohol and drug service on the Gold Coast and received a land grant from the Gold Coast City Council in1981 to develop services in West Burleigh. Since that time we have developed into a centre for education, prevention, assessment, referral and detoxification.

We offer a growing number of programs, such the Mirikai Therapeutic Community Residential Program, the Personal Support Program (PSP), Drug Court, QIDDI, Youth Outreach service, Family Therapy service and OASIS supported accommodation programme. The Gold Coast Drug Council continues to develop its services to meet new needs and in recent years has developed special therapeutic and medical expertise to manage and treat clients with both addictions and mental health disorders (referred to as “dual diagnosis”).

The Gold Coast Drug Council also provides a 24 hour telephone information and referral service for person wanting assistance to address drug-related problems. We handle thousands of telephone calls and enquiries each year.

The Gold Coast Drug Council was Quality Accredited by the Institute of Healthy Communities Association (IHCA)for the first time in 2001.This was a significant achievement, as it was the first residential rehabilitation facility in Australia to receive a 3-year accreditation. It remains one of the few Non-government Drug and Alcohol Organisations to be accredited in South East Queensland. In 2004, following an in-depth review of the organisation and it’s services, the Gold Coast Drug Council was re-accredited for a further 3 years, until July 2007.

We are proud to work in partnership with many local, state and federal organisations and agencies. Locally, we are active members of the Youth at Risk Alliance, District Health Council and Regional Ministerial Community Forum. We also work closely with the local Universities; other community organisations and government agencies to support and improve services for people on the Gold Coast.

At a national level we are an active member of the Australian Therapeutic Communities Association (ATCA).

Our Mission Statement

To be recognised by the public, professional groups, clients and funding bodies as an exemplary model of a responsive and cost effective community based alcohol and drug organisation, particularly in the area of providing high quality services for younger drug using persons who are experiencing significant problems in interpersonal and social functioning.

Our Priority
To utilise prevention, early intervention and specialised treatment in order to minimise the harm related to the use of licit and illicit drugs within the Gold Coast Region.

Our Philosophy
We believe that the reasons for drug use are both social and psychological. Therefore the Mirikai program has been designed to incorporate flexibility so that we can best meet the problems and progress of the individual resident.

We strongly believe in consumer and community participation. We believe that the consumers both primary and secondary, should be involved in the development, design and evaluation of the program for all clients. Because we are ultimately responsible to the community, we will use all avenues available to us to facilitate community participation in the conduct of our programs.

Our programs can assist our target group to strengthen their decision to stop taking their drug(s) of dependence, and to deal with the underlying reasons for drug use.

Our programs offer clients practical skills that can help their behaviour to become more self-regulatory, and enhance their choices in making major lifestyle changes in order to minimise the harm of their drug(s) of dependence.

2.0 The Mirikai Therapeutic Community Program

The Gold Coast Drug Council is probably best known for it's Mirikai Residential Therapeutic Community Program. Mirikai, a local Aboriginal meaning "a place of peace" is a specialist alcohol and other drug treatment programme that works on a Therapeutic Community model. It's goal is to enhance the capacity and commitment of clients to achieve, as well as maintain an optimal level of personal and social functioning free from harmful drug use.

Clients are aged 16-29 years old and have complex problems associated with their drug use, including mental health problems. Clients can be referred from health, welfare and community organisations, or they may self-refer. The maximum number of residents at any one time is 40.

Mirikai is a residential programme with each stage taking between six to eight weeks to complete. Successful completion of each stage is a necessary pre-requisite for progress onto the next. The last stage, re-entry to the community through one of the commitment houses lasts around six months, depending on the individual. For clients with a dual diagnosis, tailored educational and social activity programs have been developed to support them through the programme.

Programme Stages
Assessment and Admission – during the first three weeks after arrival, all residents will be thoroughly assessed. This includes examination by a medical practitioner, with residents requiring detox placed in a appropriate and safe setting. The programme

works closely with other services such as mental health services, hospitals, dentists, sexual health services, Centrelink and legal services to meet each individuals specific needs.

Safety Net – this is a six week intensive living and life skills programme consisting of basic health and hygiene, self esteem, anger management, communication skills, relapse prevention, stress management, therapy and sports programme.

Treatment – during this stage of the programme, 6 to 8 weeks, there is a strong emphasis on teamwork and developing the ability to trust others. Residents learn how to have positive relationships and to change their belief systems. They begin to learn how to be responsible for their actions by helping other people, and maintaining the daily running of the programme.

Re-entry – in this stage, there is an emphasis on work based future planning. Residents live in a commitment house (supported accommodation) to test these new found skills before moving back into the community.

3.0 Our Services

The Gold Coast Drug Council Inc. offers services on a residential and out-client basis. Services include:

Residential Programs
Mirikai Therapeutic Community Programme
Outreach Accommodation Support and Integrated Services (OASIS)
Drug Court Programme
Drug Court Supported Accommodation Program (MISO)

Outclient Programs
Personal Support Program (PSP)
Drug Court Outclient Program
Queensland Illicit Drug Diversion Initiative (QIDDI)
Youth Outreach Program
Youth Dual Diagnosis Support Program
Family Therapy Program

Out-client Services
Family & Friends Support Group
Earlybirds Support Group
Stop Pot
Supervised Urinary Testing (UT)
Health Education
Drug Awareness Course
Visits and Presentations

A leaflet outlining the services available is attached for information.

During 2004/5, the Gold Coast Drug Council saw a 27% increase from 2003/4, in the number of clients supported and treated by our services.

Last year, 889 clients from across the Gold Coast and South East Queensland accessed our services. Of these clients, 66.26% were male and 33.74% were female; 35.53% identified themselves as having a previous psychiatric history; 37.18% identified themselves as having a criminal history and 37.63% had children.

Our clients ranged in age from 12 to 60. Our Youth services supported clients aged 12-25; most of our residential clients were aged under 30, whilst our remaining out-client services offered support to a large number of adults of all ages.

In terms of clients client's identified drug of choice, this has increasingly been changing over recent years with an increase in the use of amphetamines as both the primary and secondary drug of choice for clients seeking treatment. This change has significant implications for the delivery of treatment and rehabilitation services. In 2004/5, over 55% of all clients identified themselves as Poly-Users.

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