SUBMISSION TO HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

SUBSTANCE ABUSE IN AUSTRALIAN COMMUNITIES

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THE IMPACT OF SUBSTANCE ABUSE ON MENTAL ILLNESS AND CRIME

INTRODUCTION

The presence of substance abuse in those with major mental disorders greatly increases the probability of violent and other antisocial acts. The increased rates of offending found in those with schizophrenia and major affective disorders is largely accounted for by the minority of such patients who have substance abuse problems. In practice, both preventing initial offending and preventing recidivism in the seriously mentally disordered depends on effectively managing the comorbid substance abuse.

The relationship between substance abuse, offending and mental disorder has considerable impact on forensic mental health services. Forensic mental health is a specialised area within the mental health field. It is an area which must address the special needs of mentally disordered offenders, the justice sector and the community, while providing effective assessment, treatment and management of forensic patients in appropriately secure settings.

In Victoria, the provision of forensic mental health services is the responsibility of the Victorian Institute of Forensic Mental Health, known as Forensicare. Forensicare is governed by a ten member Council accountable to the Minister for Health. In addition to providing specialist clinical services through an inpatient and community program, Forensicare is mandated (under the *Mental Health Act 1986*) to provide research, training and professional and community education.

Services provided by the inpatient program include the newly opened 120 bed secure facility, the Thomas Embling Hospital, and a prison based service providing acute assessment and treatment. The community program focuses on the assessment and treatment of offenders and potential offenders with a severe mental illness, as well as stalkers and victims of stalking, and sex offenders who pose a high risk to the community. A Court Liaison Service also operates.

Forensicare was established to achieve -

. improved quality of services in forensic mental health

. increased levels of community safety

. better community awareness and understanding of mentally disordered offenders

. increased specialist skills and knowledge

. policy advice, service planning and research that contributes to the improved delivery of mental health services.

BACKGROUND

Traditionally, what was known as forensic psychiatry, focussed on providing long term containment of the criminally insane and providing assessments and opinions to courts on an individuals state of mind. The last two decades though have brought an almost total transformation to what is becoming known as forensic mental health services. The management and treatment of the mentally disordered are now just as central to a forensic service as to any other mental health service.

The primary focus of a contemporary forensic mental health service is on providing care to mentally disordered people in contexts connected directly, or indirectly, to the criminal justice system. Forensic mental health services provide treatment facilities to those made security patients by the courts, to prisoners, to individuals for whom the courts have mandated psychiatric treatment and for patients deemed to present an imminent risk of serious offending.

The role of providing courts with an opinion and, on occasion, advice on management, has not disappeared. On the contrary, mental health professionals receive an increasing number of requests and increasingly diverse requests from courts. This is not unexpected, as a significant proportion of the seriously mentally ill (10-20%) find themselves before the courts at some stage. The bulk of the court work of a forensic mental health service is ensuring that people before the courts who need mental health services, or who might benefit from such services, receive forensic services and are effectively managed in the future.

There have also been significant changes in the delivery of forensic inpatient services. Inpatient facilities are no longer primarily psychiatric prisons, but hospitals designed to provide quality care, aimed at the treatment of symptoms and disorder, rehabilitation and eventual reintegration into the community. A forensic inpatient service, as with any other modern mental health service, is but an element in a service which is increasingly community oriented and community based.

The offending of most forensic mental health inpatients and community clients is influenced by their mental disorder (which in turn is quite frequently influenced by substance abuse). The symptoms of the mental disorder are only occasionally the sole explanation of the offending, but are frequently the necessary, if not sufficient, cause. Good treatment with good control of symptoms therefore equates to reducing or removing the risks of reoffending. The level of substance abuse among our inpatients and community clients indicates that appropriate treatment must be incorporated in the overall treatment plan of those with a history of such abuse.

RESEARCH FINDINGS

There is increasing evidence that the co-existence of substance abuse and serious mental disorder not only prolongs the illness and makes treatment more difficult, but also dramatically increases the likelihood of violence.

Three recent studies conducted in Victoria have particular relevance to this issue. The first study found that the presence of substance abuse in those with serious mental illness played a major role in the levels of offending. This study looked at all people convicted in Victorian

higher courts over a three year period (1993-1995 incl)[1]. Those who had a history of substance abuse in public mental health were over seven times as likely to have acquired a conviction than those in the general population, and in convictions for violent offences it was nearly ten times as high.

In those with schizophrenia who did not have a problem with substance abuse, there was only a modest increase in offending. People with schizophrenia however, who also had problems with substance abuse, were over 18 times more likely to have received a conviction for violent offending, and over 28 times more likely to be convicted of homicide. People with severe depression or bipolar illness showed a similar pattern with the risk of offending as that of the general population. Violent offending though skyrocketed when there was co-existing substance abuse. Among people with an affective disorder without substance abuse, violent offences were 2.9 times higher, but the incidence of violent offending was 19 times higher in those with substance abuse.

The above study looked at serious offending. A subsequent study looked at all forms of offending in those with schizophrenia[2]. There was a dramatic increase in offending if the patients also abused alcohol or drugs. In those with schizophrenia who did not abuse substances, their rates of offending were less than half of those who did abuse alcohol or drugs. In those with substance abuse and schizophrenia, their rates of violent offending were nearly 10 times higher than the general population.

In a study of sudden death in Victoria we found that those with serious mental illness who also abused alcohol and drugs had a dramatically increased chance of dying suddenly and prematurely[3]. For schizophrenia the rate of sudden death was twice as high for the substance abusing group. In those with a depressive illness, the rate of sudden death was almost three times higher in substance abusers. These differences are partly accounted for by increased suicide rates, but also involved more frequent death from accident and a variety of illnesses.

THE VICTORIAN INSTITUTE OF FORENSIC MENTAL HEALTH - SERVICE DELIVERY

Inpatient Services

The newly opened Thomas Embling Hospital provides care and treatment facilities for patients from the criminal justice system who are in need of psychiatric assessment and/or acute or continuing care and treatment. The hospital currently has 75 beds in operation, but when fully operational will accommodate 120 patients in seven accommodation units, together with education and recreation facilities. Clinical programs in the hospital consist of –

. Acute Care Program
- consists of 50 beds in three units, and reflects contemporary practice in the delivery of individual and group therapy during the acute phase of a mental disorder. The program

[1] C. Wallace, P.E. Mullen, P. Burgess, S. Palmer, D. Ruschena and C. Browne, 'Serious criminal offender and mental disorder. Case linkage study', British Journal of Psychiatry, 1998, 172. 477-484
[2] P.E. Mullen, P. Burgess, C. Wallace, S. Palmer and D. Ruschena, 'Community care and criminal offending in schizophrenia', The Lancet, 2000, 355, 614-617
[3] D. Ruschena, P.E. Mullen, P. Burgess, S.M. Cordner, J. Barry-Walsh, O.H. Drummer, S. Palmer, C. Browne and C. Wallace, 'Sudden death in psychiatric patients', British Journal of Psychiatry, 1998, 192, 331-336

is directed primarily towards patients from the criminal justice system who are in need of psychiatric assessment and/or acute care and treatment. The program includes ward based individual and group psycho-dynamic, psycho-educational and psycho-social therapies, undertaken within a secure and safe environment.

. Continuing Care Program
- consists of 60 beds in three units, which offer varying levels of support. Patients are assisted to gain and maintain an optimal level of independence and fulfilment, while progressing through the units in a manner which enables their individual needs to be met. The program aims to engage patients and clinicians in a process of collaborative decision making that recognises and utilises existing strengths, preserves good health and creates opportunities for growth and development.

. Women's Care Program
- 10 beds providing psychiatric care and treatment in a safe, supportive and secure environment. The Women's Program is the first of its kind in Australia, and one of the few internationally. The program recognises the dilemmas surrounding the realities of mental illness and the consequences for women, as well as the relevance of the disorder to offending behaviour. The program is responsive and flexible to the individual needs of the women.

Prison-based Service

Comprehensive primary health and specialist mental health care is provided to prisoners at the Melbourne Assessment Prison and mental health services (in the form of psychiatric consultations) to other prisons in Victoria. Services at the Melbourne Assessment Prison are provided 24 hours a day, seven-days a week, and include –

. reception assessment program - a comprehensive Reception Assessment Program operates at the Melbourne Assessment Prison which incorporates custodial and health components. All prisoners are medically assessed on reception and referrals made to a mental health nurse to identify mental illness and prisoners believed to be at risk within the prison system. The program operates Monday to Saturday.

. outpatient services - both mental health and primary health outpatients clinics are provided. A psychiatric outpatient clinic is conducted Monday to Saturday by psychiatric nursing staff and supported by four psychiatric registrar sessions each week. In addition to referrals from reception staff, referrals are accepted throughout the week from prison staff and the medical practitioner at the primary health outpatient clinic. Crisis calls from the previous evening are also followed up and debriefing following serious incidents provided.

  A primary health outpatient clinic is conducted by a Medical Practitioner each week day morning, which is supported by a seven-day a week nursing clinic.

. after-hours crisis intervention program - provided by psychiatric nurses supported by an on call medical officer and psychiatrist, this program operates throughout the prison seven-days a week. This assessment of prisoners and provision of health advice and support, assists prison staff manage difficult situations and behaviours thought to warrant further psychiatric attention.

. Acute Assessment Unit - a 15-bed short stay assessment unit for male prisoners thought to be mentally ill and/or at risk and those prisoners remanded and referred by courts for a psychiatric report. Referrals to the unit are made from the Reception Assessment Program and other male prisons in the state (both public and private). The unit has a high turnover of prisoners with over 520 admissions each year, and a bed occupancy rate of around 95%.

Community Forensic Mental Health Service

The Community Forensic Mental Health Service provides statewide assessment and multidisciplinary community treatment services to high risk clients referred from correctional providers, police, courts, the Adult Parole Board, the Forensicare inpatient facility (the Thomas Embling Hospital), the Acute Assessment Unit at Melbourne Assessment Prison, the Psycho Social Unit at Port Phillip Prison, mainstream mental health services, private psychiatrists and general practitioners.

Three distinct programs are provided –

. Community Forensic Mental Health Program
- providing community based clinical and support services to forensic patients (people who are subject to a court order by virtue of mental impairment) and other high risk clients who have a serious mental illness and significant forensic issues (including stalkers and victims of stalking).

. Psychosexual Treatment Program
- a range of flexible and comprehensive therapeutic interventions are provided that are individually tailored to the various needs of clients. Interventions include both individual and group components. Clients are individually assessed to determine their treatment needs in order to meet treatment goals and decrease their risk to the community.

. Court Services Program
- the program is responsible for providing psychiatric and/or psychological pre-sentence reports to the courts as requested on offenders granted post-conviction bail to attend for preparation of a report (over 150 reports are prepared annually in the community) and a Court Liaison Service. The Court Liaison Service provides psychiatric assessment and advice on people referred by magistrates at two metropolitan Magistrates' Courts. The Service will be extended during the coming year to four country Magistrates' Courts.

PROFILE OF FORENSICARE INPATIENTS AND COMMUNITY CLIENTS

Inpatient Services

An analysis of inpatient admission data for the year July 1998-June 1999 shows a patient profile which is –

Acute care patients - predominantly young, unmarried males, 73% of whom presented with a psychotic disorder (including schizophrenia). Most patients were admitted to the acute

ward for short periods (82% admitted for under 2 months) and 74% of those admitted had a substance abuse problem.

Sub-acute patients - all patients admitted during the year were male and 68% were admitted with a form of schizophrenia. Just over half of those admitted had a substance abuse problem (51%). A slightly older group than acute patients (37% were aged under 40 years, compared to 50% of the acute patients), who were admitted for longer periods than acute patients (58% were admitted for under 2 months).

Continuing care patients - patients were predominantly male (90%) and all were unmarried with few dependents (5% of those admitted had children). The majority of patients admitted had a diagnosis of a form of schizophrenia (85%). 85% of patients had a substance abuse problem. As a continuing care unit, patients were admitted for longer periods than other patients - 45% of patients were admitted for under 6 months and 50% between 6-12 months.

Self-report inpatient admission details

A review of our admission data for the period 1 January - 31 May 2000 confirms a high level of substance abuse among our inpatient population. Although only a brief snapshot, this review reveals a patient population which supports research findings on the prevalence of substance abuse, mental disorder and offending.

During the period, 51 people were admitted as inpatients. Although based on self-report, of the 51 patients admitted, 34 (or 67%) acknowledged recent illicit substance use/abuse as follows –

Patient 1	Cannabis	Amphetam			
Patient 2	Alcohol	Cannabis	Heroin	Amphetam	LSD
Patient 3	Alcohol	Cannabis			
Patient 4	Alcohol	Cannabis	Heroin	Amphetam	Benzodiaz
Patient 5	Polysubst.				
Patient 6	Alcohol	Cannabis	Heroin	Amphetam	
Patient 7	Alcohol	Cannabis	Amphetam		
Patient 8	Alcohol	Cannabis	Heroin	Amphetam	
Patient 9	Alcohol	Cannabis	Cocaine	Amphetam	
Patient 10	Alcohol	Cannabis	Heroin		
Patient 11	Cannabis	Heroin			
Patient 12	Amphetam				
Patient 13	Cannabis	Benzodiaz	Ethanol		
Patient 14	Alcohol	Cannabis	Heroin	Amphetam	Benzodiaz
Patient 15	Alcohol	Cannabis			
Patient 16	Alcohol	Cannabis	Heroin	Amphetam	
Patient 17	Cannabis	Amphetam	LSD	Ecstasy	
Patient 18	Cannabis	Heroin	Amphetam		
Patient 19	Cannabis	Heroin	Amphetam	Benzodiaz	Prolodone
Patient 20	Cannabis	Polysubst.			

Patient 21	Alcohol	Cannabis	Heroin	Amphetam	Cocaine	LSD	Ecstasy
Patient 22	Alcohol						
Patient 23	Cannabis	Heroin	Amphetam				
Patient 24	Alcohol	Cannabis	Heroin	Amphetam	Ecstasy	Mushr'ms	
Patient 25	Cannabis	Amphetam					
Patient 26	Alcohol	Cannabis	Amphetam	Benzodiaz			
Patient 27	Alcohol	Cannabis	Heroin	Amphetam	Cocaine	Benzodiaz	
Patient 28	Cannabis	Amphetam	Heroin				
Patient 29	Cannabis						
Patient 30	Alcohol	Cannabis	Amphetam				
Patient 31	Polysubst						
Patient 32	Alcohol	Cannabis					
Patient 33	Alcohol	Cannabis	Heroin	Amphetam	Benzodiaz		
Patient 34	Cannabis	Heroin					

In addition, there was a very high level of alcohol abuse both in those with drug abuse histories and those without.

Prison-based Service

A Reception Assessment Program operates at the Melbourne Assessment Prison whereby all prisoners received into custody are interviewed by custodial and health staff. Of all prisoners received into custody, approximately 67% are referred to the psychiatric nurse during the reception process for a more detailed assessment. Although the data relating to substance abuse recorded by the psychiatric nurse during this assessment process is based on self-report and is recorded as an entry under each substance (ie. one prisoner may be included in a number of categories of substances listed), the profile that emerges is one of young men (predomionantly under the age of 35) who report a high level of substance use and abuse.

An analysis of the prisoner reception data for the period 1.1.99-30.6.99, shows that during this period 1,199 prisoners were referred to the psychiatric nurse on reception. The recorded substance use of these 1,199 prisoners is as follows –

Admitted recent use of -

.	Heroin	579 prisoners
.	Marijuana	514
.	Speed	156
.	Pills	118
.	Other	46
.	Alcohol abuse	208
	Total reported usage	**1,621**

Community Forensic Mental Health Service

The statistics and admission details obtained on clients attending the Community Forensic Mental Health Service do not cover substance use. Senior clinical staff at our community clinic however estimate that it is likely that over half the clients in the mental health program abuse drugs and/or alcohol.

The substances used tend to be the more “affordable”, (chiefly marijuana, amphetamines and heroin), together with over-the-counter substances such as codeine. Our clinicians report growing examples of clients using prescribed medications as drugs of abuse, particularly benzodiazepines (eg. Rohypnol™, Rivotril™) and anticholinergic agents such as Cogentin™ (prescribed to counter the side effects of anti-psychotic medication, abused for its hallucinogenic effects).

The pattern of substance abuse in the sex offender population (those attending the Psychosexual Treatment Program) is believed to be somewhat lower than the number of people in the mental health program believed to be abusing substances. Treating clinical staff believe however that while the overall proportion would be lower, the number of sex offenders in our program abusing substances would not be inconsequential. Substance abuse among sex offenders is frequently associated with antisocial personality traits.

ISSUES

Mentally ill people are more likely to abuse substances than the general population.

In the population with a serious mental disorder there is an increased vulnerability of lapsing into abuse of alcohol and drugs. This vulnerability frequently arises by virtue of their disorder - impressionability, impaired judgement and impulsivity are not uncommon traits among the mentally disordered. In the case of sex offenders, there is a predisposition to substance abuse through the need to self-medicate social anxiety and enhance sexual performance. Mentally disordered offenders who have a concurrent personality disorder (especially antisocial), are particularly vulnerable to substance abuse, as part of a more general pattern of recklessness, impulsivity and anti-authoritarian behaviour.

The vulnerability of those with a mental disorder also probably reflects, in part, the deprivations and decreasing opportunities for work and normal social activities in those disabled by illness. It may also reflect attempts at self medication to overcome symptoms of illness and self medication to overcome the side effects of medication, particularly the side effects of anti-psychotic drugs.

Contact with the criminal justice field similarly exposes the vulnerability of mentally disordered people A large majority of forensic mental health patients and clients have had substantial contact with the criminal justice system, which generally, as a matter of course, brings them into contact with other substance abusers. These contacts are often retained when they are released into the community. There is also the ever-present danger that the mentally disordered in the criminal justice system, and to a lesser extent in the community, will fall victim to the stand-over tactics of drug dealers.

Substance abuse among the serious mentally ill not only is destructive to them, but potentially increases the risk to the entire community. Managing this problem effectively is therefore a health issue and an issue of crime prevention. There has been considerable research in recent

years of substance abuse among the mentally disordered and a number of promising initiatives in managing this problem. These initiatives have perhaps not yet received the attention and support they deserve, particularly among mentally disordered offenders who are at the highest risk of coming to harm themselves from co-existing substance abuse which places others at risk.

One of the contributors to the failure to address the problem of substance abuse, particularly among mentally ill, may have been the tendency over the past 20 years for the management of substance abuse to be demedicalised. This may have had benefits, but it certainly has had costs.

Substance abuse complicates the assessment of mentally disordered offenders.

Substance abuse by seriously mentally disordered offenders not only complicates their assessment and treatment, but contributes to increased recidivism. The recidivism may be a direct result of substance abuse, or possibly a consequence of a drug-induced relapse of the offender's mental disorder. Whatever the cause, the implications are significant.

Offenders who remain in the community while undergoing treatment and continue to abuse substances are unreliable in their attendance and difficult to assess when they present under the influence of substances. From a clinician's perspective, substance abuse creates diagnostic confusion, often exacerbating mental disorders. Substance abusers are unable to provide clinicians with a reliable history and their capacity to follow the assessing clinician's instructions or advice is generally greatly comprised.

Substance abuse impacts on the treatment of mentally disordered offenders in the community.

The issues inherent in the assessment of substance abusing offenders are similar for both forensic mental health inpatients and clients who are able to remain in the community while undergoing treatment. Community clients though have the opportunity to continue to abuse substances while attending treatment, an opportunity denied to inpatients. The difficulties this poses for treating clinicians cannot be underestimated.

The continued abuse of substances can not only stimulate mental disorders, but can precipitate an acute relapse in people who are in remission and precipitate or aggravate violent behaviour. In addition, as a result of the adverse effects of substances on mental disorders, continued substance abuse hinders compliance with essential treatment. This can lead to further psychiatric deterioration, often culminating in relapse and heightened potential for reoffending.

It is generally accepted that substance abuse and its inherent problems generally incites acquisitive crimes. This is particularly so among the financially disadvantaged sector of the community that so often includes forensic mental health clients. Many forensic mental health clients, by virtue of their mental illness, are prone to being apprehended. Their contact with the criminal justice system, particularly when this results in a custodial sentence, has the potential to disrupt the delivery of appropriate mental health care.

From a client's perspective, the effects of continued substance abuse has a similarly deleterious effect. Procuring drugs frequently takes priority over self care and adequate nutrition, which further comprises control of the mental disorder. Substance abuse creates disruptive and threatening behaviours which can alienate family and social supports, so essential to the stability of an offenders mental condition. These family and social supports are generally already subject to high levels of stress as a result of the pattern of substance abuse, offending and mental disorder.

In terms of service delivery, substance-abusing offenders are further disadvantaged in terms of access to appropriate treatment and care. Critical service gaps exist for this group of people. If such an offender requires hospitalisation for their mental disorder, they are regarded as doubly unattractive to the mainstream mental health system, but virtue of their offender status (frequently involving crimes of violence) and their seemingly intractable drug habits. There is an overall reluctance by mainstream treatment services to admit these individuals. Similarly, the forensic mental health community client is generally not welcomed into mainstream drug counselling services.

The treatment of sex offenders who abuse substances is seriously compromised.

Illicit substances frequently play a significant role in the commission of sexual (and often non-sexual) offences through their disinhibiting effects and exacerbation of any accompanying mental disorder. Substance abuse certainly enhances a sex offenders propensity for assaultative behaviour.

A core component of sex offender treatment is training in behavioural techniques that achieve control over deviant sexual fantasies, urges and acts. The abuse of substances interferes with internal controls and increases the sex offender's propensity for risk taking activities. Impulsivity is enhanced and the offender's capacity to reflect upon the consequences of his/her actions is clouded. Sex offenders who have a concomitant major mental disorder and who abuse substances may therefore experience a deterioration in their mental state, increasing the likelihood of recidivism.

A proportion of serious sex offenders are managed with sexual suppressant hormonal medication. Illicit substances can impede compliance with essential hormonal treatment. They can also diminish or vanquish any control that hormonal agents achieve over deviant sexual urges and acts, further compromising ongoing management and treatment.

There is a serious lack of substance abuse expertise available in Australia.

The impact of substance abuse on mental illness and subsequent offending results comes at a large cost to our community, both in dollar and emotional terms. The National Mental Health Strategy places considerable emphasis on prevention, and substance abuse management among mentally disordered offenders should be considered in the same light. In the case of mentally disordered offenders and substance abuse, the focus needs to be on reducing and preventing offending.

The effective management of substance abuse among offenders with a mental disorder requires a high level of expertise which is not readily available in Australia. Access to training

in contemporary treatment methods should be available to all Australian forensic and mental health professionals and staff from the criminal justice system. It is an issue which needs to be addressed to fill the existing gaps in services and treatment.

RECOMMENDATIONS

1. That the considerable impact that substance abuse has on mentally disordered offenders be noted and methods of overcoming the difficulties be the subject of ongoing discussions and forums.

2. An expert in substance abuse be appointed to work in the forensic mental health field in Australia. Alternatively, funding be made available for an Australian forensic mental health clinician to be trained in substance abuse in the United States. On return to Australia, this clinician to provide training to other professionals in the field.

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