HOUSE OF ASSMEBLY

WEDNESDAY 23RD SEPTEMBER 2015

SOCIAL DEVELOPMENT COMMITTEE: COMORBIDITY

Adjourned debate on motion of Hon. G.A. Kandelaars:

That the report of the committee, on comorbidity, be noted.

(Continued from 9 September 2015).

Mr PEDERICK (Hammond) (11:36): I rise to speak on the report that was a referral to the Social Development Committee on comorbidity. It is the 38th report of the committee. I would like to thank all members from this place and the other place who were involved in this committee. I note from the other place we had the Hon. Jing Lee, the Hon. Kelly Vincent—and it was her motion to have this reference—and the Hon. Gerry Kandelaars as presiding member. From this house, I would like to thank the member for Reynell who was a member of the Social Development Committee until February 2015 and the member for Fisher who was appointed to the committee in February 2015, and the member for Torrens.

In relation to the terms of reference for this inquiry—and it was a very interesting inquiry into comorbid outcomes—the Social Development Committee was to inquire into and report on the issue of comorbidity which may refer to a dual diagnosis of both intellectual disability and/or acquired brain injury (ABI) and/or mental illness and/or chronic substance abuse with respect to facilities in South Australia currently treating people with a dual diagnosis, including the Margaret Tobin Centre and James Nash House; the level of training offered to general practitioners, psychologists, psychiatrists and other relevant professionals in the area of dual diagnosis and possible measures to enhance their training; information given to individuals and carers on how to manage a dual diagnosis; programs and supports to aid individuals and carers in managing and living with dual diagnosis; and any other related matter.

We came up with 40 recommendations from this inquiry. The terms of reference for the inquiry into comorbidity concerned intellectual disability, acquired brain injury, mental illness and chronic substance abuse. The committee heard evidence from many individuals and key agencies and, after the initial hearings, the committee adopted a more comprehensive inquiry and considered additional comorbidities. As a consequence, extra symptoms were included in the scope of the inquiry and the report, so it was quite broad. These included traumatic brain injury, as a subcategory of ABI; Asperger's syndrome; autism spectrum disorder; epilepsy; fatal alcohol spectrum disorders; obsessive compulsive disorders; senility; Alzheimer's; and attention deficit hyperactive disorder. As I indicated, the committee was dealing with comorbidities in its very broadest sense.

Comorbidity is a clinical term that generally refers to the co-occurrence of two or more medical issues or more than one physical and/or psychophysical disorder in the same person either at the same time or in some causal sequence. Obviously, comorbidity relates to a complexity of circumstances and every

circumstance represents an increase in vulnerability. The presence of more than one of these can have a major impact on a person's vulnerability.

The committee was informed that the main issues for people who have comorbidities include: the complexity of interactions between the different morbidities and the way they can affect each other; the lack of shared screening and assessment tools to determine the range of issues for an individual client; difficulty for clients in investigating the various treatment and support services because services are not sufficiently developed or coordinated; and difficulty assessing appropriate service pathways in disability, health, mental health, drug and alcohol services and appropriate accommodation.

The committee was informed that some witnesses had concerns with the current screening assessment tools because these tools seem to concentrate on a siloed approach to the delivery of services. So, what seemed to happen is that people all too often fell between the service gaps rather than receiving treatment and support options that provide for the multiplicity of their existing and often complex needs. The services, which include intellectual disability services, health services, mental health services and drug and alcohol services, are all administered and funded separately. There are longstanding practical and historical reasons for the separation of sectors, yet it is widely considered, and it was certainly put to the committee that improving the linkages, communication and collaboration between them, other support services and accommodation providers will help ensure the appropriate and timely delivery of services.

We were informed in the committee about the many different screening and assessment tools to identify, diagnose or assess risk of substance abuse, intellectual disabilities, health or mental conditions, but few collaborative instruments are designed to screen and assess appropriate service responses for people with a range of these conditions. We heard that integrated screening and assessment tools are necessary to provide effective responses and provide a service delivery system that has a 'no wrong door' approach.

With regard to a range of treatments and service responses, we heard from witnesses to the committee. Initially, we heard that people with comorbidity usually do not receive appropriate treatment for the whole range of their conditions. Instead, most of the time they receive treatment for the primary and the more obvious issue and sometimes this leads to circumstances where a client is shuffled between services or just falls through the gaps and the other issues are not dealt with. These comorbidity symptoms and these clients require massive support and treatment interventions and it is a real challenge for the system, the individual, their family carers and support workers, as well as for health and other professionals and support staff. When there is a need for emergency response, additional complications can arise in a crisis.

What we learnt during the hearing is that the current service structure fails to appropriately meet dual or multiple needs. As I indicated before, rather than working collaboratively to bring the skills and resources of the different sectors to bear, there is often a practice of flicking and blaming. To rectify this issue there is a need to develop and operate service delivery systems that can share information and work together to provide treatment and support responses for the multiplicity of needs. What needs to happen is that the service delivery for

every client needs to be undertaken by one service provider to ensure that their primary needs are met and that provider, as the key agency in this instance, also takes responsibility to ensure that all of their needs are met in a holistic way.

We learnt that there were a lot of frustrations and a whole lot of needs, as outlined by people who have been affected with comorbidity or by people in the service sector talking about how there needs to be a full range of responses in regard to this issue out there in the community to assist people who present with these multiple diagnoses. We came up with 40 recommendations to help these people not fall through the gaps, so that they are diagnosed appropriately and that the initial diagnosis is not just the thing that they are dealing with. They need to be looked at with a more collaborative approach, not just in a silo situation.

With the 40 recommendations, we have come a long way to assist people with comorbidity. I hope that the government and others in this sector pick up these recommendations and take them on into the future to help people who have this multiplicity of needs, to give them better health outcomes and a better life in the end. I commend the report.

Motion carried.