Transitions between AOD & MH:

Potentials of the Mental Health Royal Commission

THIS IS AN INTERACTIVE PDF:
Images with this symbol are hyperlinked to the actual resource / document

Gary Croton

VDDI- Hume Border

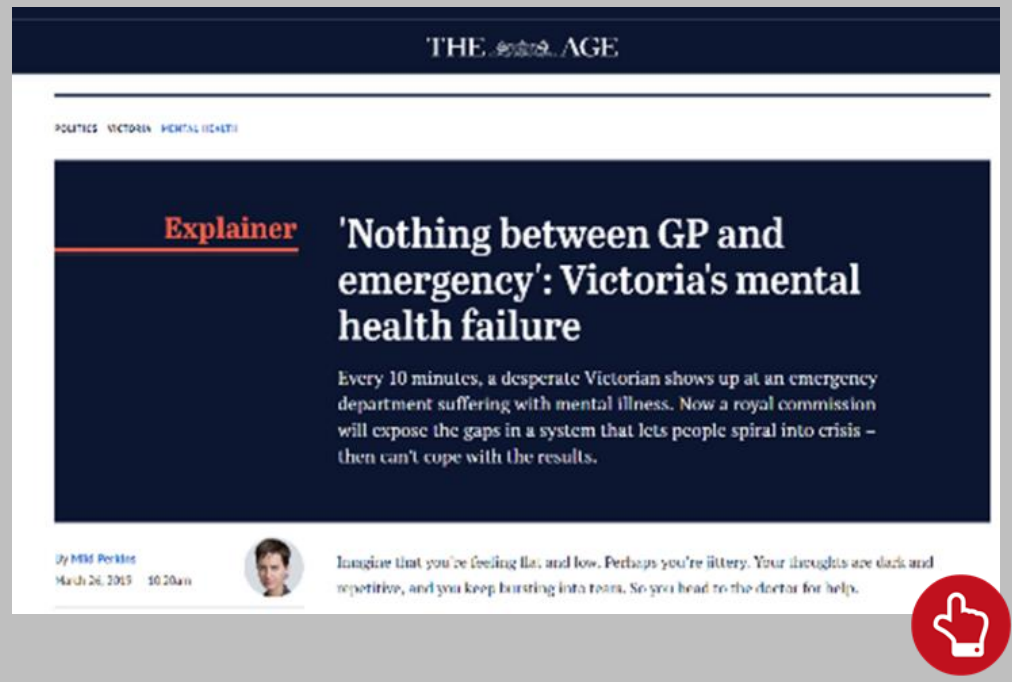
Auspice: Albury Wodonga Health

This session:

- **About the Royal Commission**
- **Landmarks: Transitions between AOD and MH**
- **RC recommendations**

Victoria's Mental Health Royal Commission

Drivers:


THE AGE

Explainer

'Nothing between GP and emergency': Victoria's mental health failure

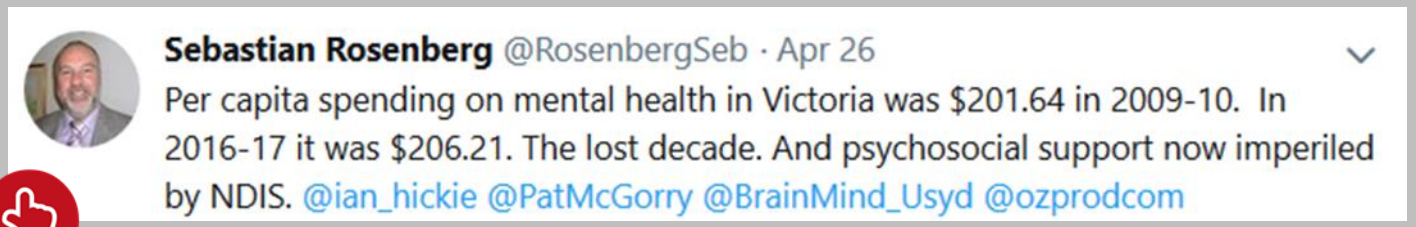
Every 10 minutes, a desperate Victorian shows up at an emergency department suffering with mental illness. Now a royal commission will expose the gaps in a system that lets people spiral into crisis – then can't cope with the results.

The Age Explainer:

- $ - lack of investment
- ***Least per person on MH in Oz***
- ***13% below national average***
- ***2016-17 per capita MH spend: WA: $304 / VIC: $206***

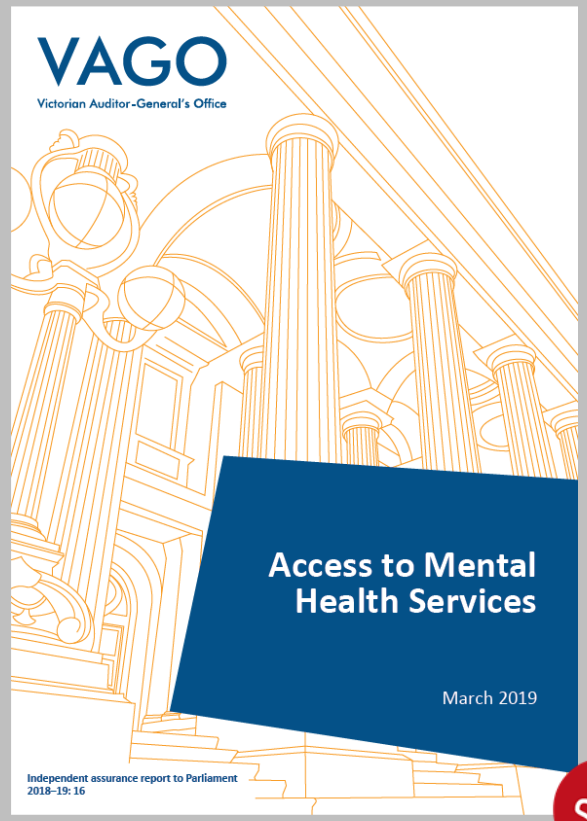
- Access to MH: **40 % below national average**
- *'State's psych. wards far beyond capacity'*

- 'Shortage of Community MH = people in crisis showing up at hospital EDs'


Sebastian Rosenberg @RosenbergSeb · Apr 26

Per capita spending on mental health in Victoria was $201.64 in 2009-10. In 2016-17 it was $206.21. The lost decade. And psychosocial support now imperiled by NDIS. @ian_hickie @PatMcGorry @BrainMind_Usyd @ozprodcom

Drivers:



'Until the system has the capacity to operate in more than just crisis mode ….'

Drivers:

- ‘**missing middle**’ – too unwell for headspace /unable to access clinical MH
- **De-institutionalization:** ‘*correct in principle but … not enough investment in community MH*’
- 20 years ago Vic had highest, per-capita, MH funding - system steadily eroded, resources diverted to strained E.Ds.
- **Community MH completely overwhelmed** - virtually nothing between GP and ED
- Last year’s state budget $705 mill to MH but **most directed to acute services / pointy end** where ***chaotic EDs & psych wards*** try to cope with demand.

Timelines:

Announced Oct 2018

Victorian Premier Daniel Andrews promises royal commission into mental health

Updated 24 Oct 2018, 8:06pm

PHOTO: The Premier said the royal commission would save lives. (ABC News: Stephanie Anderson)

Victorian Premier Daniel Andrews has promised to hold a royal commission into mental health if his Government is re-elected next month.

Mr Andrews made the pledge at the Men's Shed in Kyneton, north-west of Melbourne, saying a royal commission would bring mental health out of the darkness and into the "blinding light".

He said the inquiry would change lives and save lives.

"We don't have the best mental health system we can possibly have," he said.

RELATED STORY: Where do you go when you're afraid you'll kill yourself?

RELATED STORY: A thousand mental health jobs to be lost in Victoria, lobby group fears

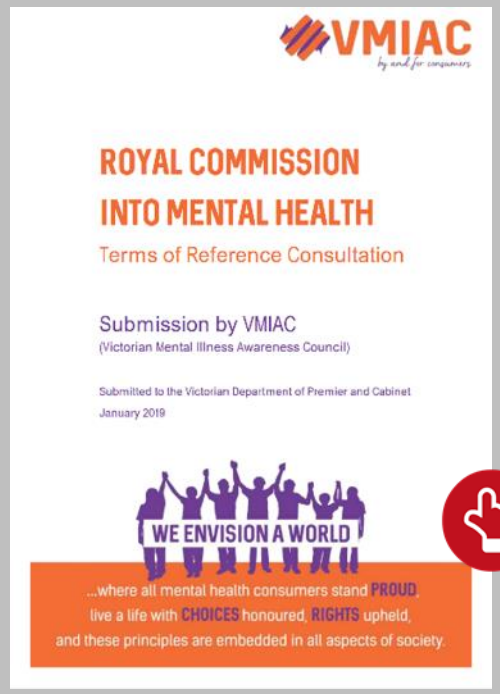
Key points:

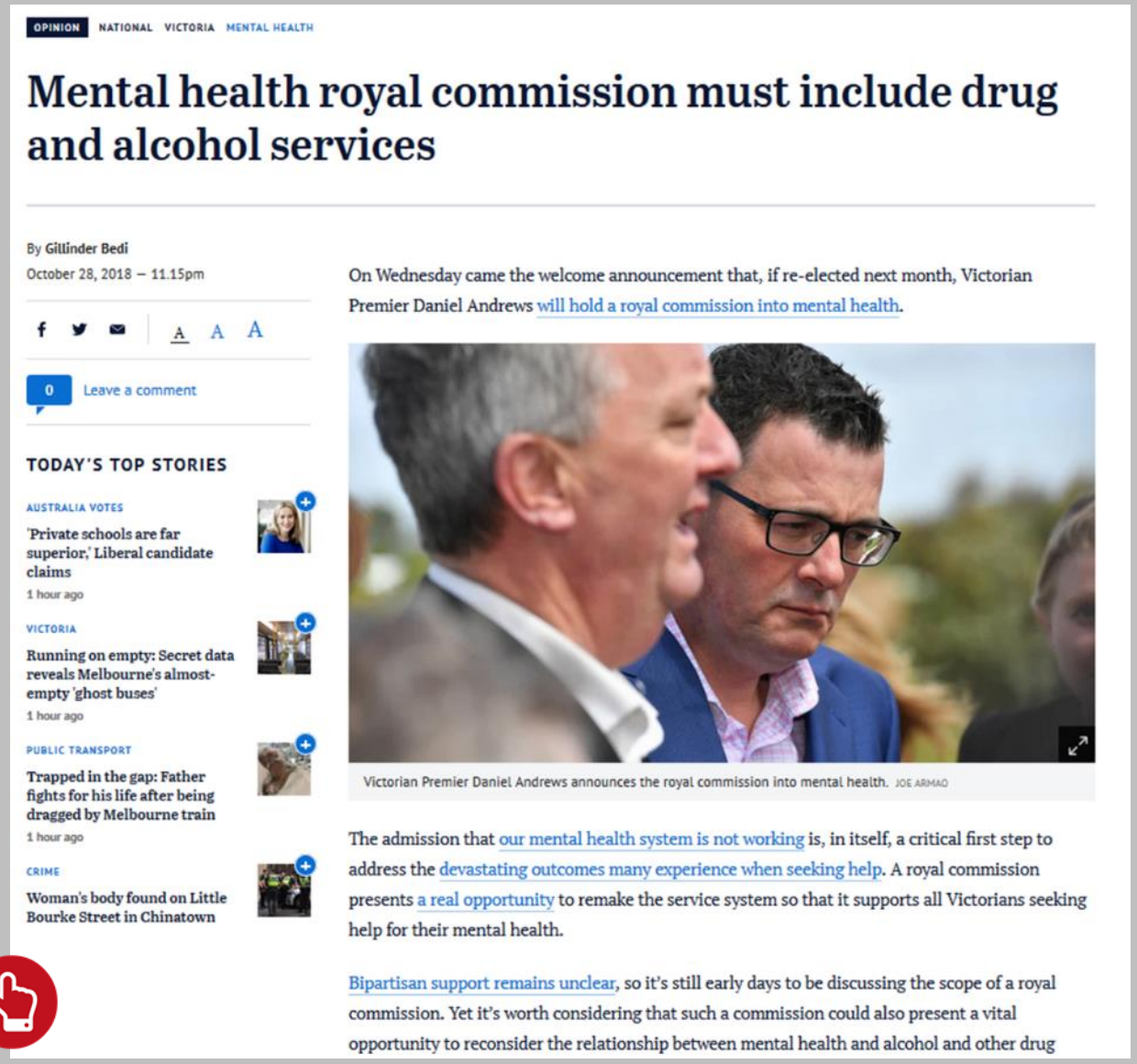
- One-in-five Victorians will experience a mental illness this year, Government says
- Premier promises to implement all of the royal commission's recommendations
- Mental health expert urges bipartisan support for the royal commission

Timelines:

Dec 2018 – Jan 2019:

- Community consult on ToR
- **>8000 submissions!**

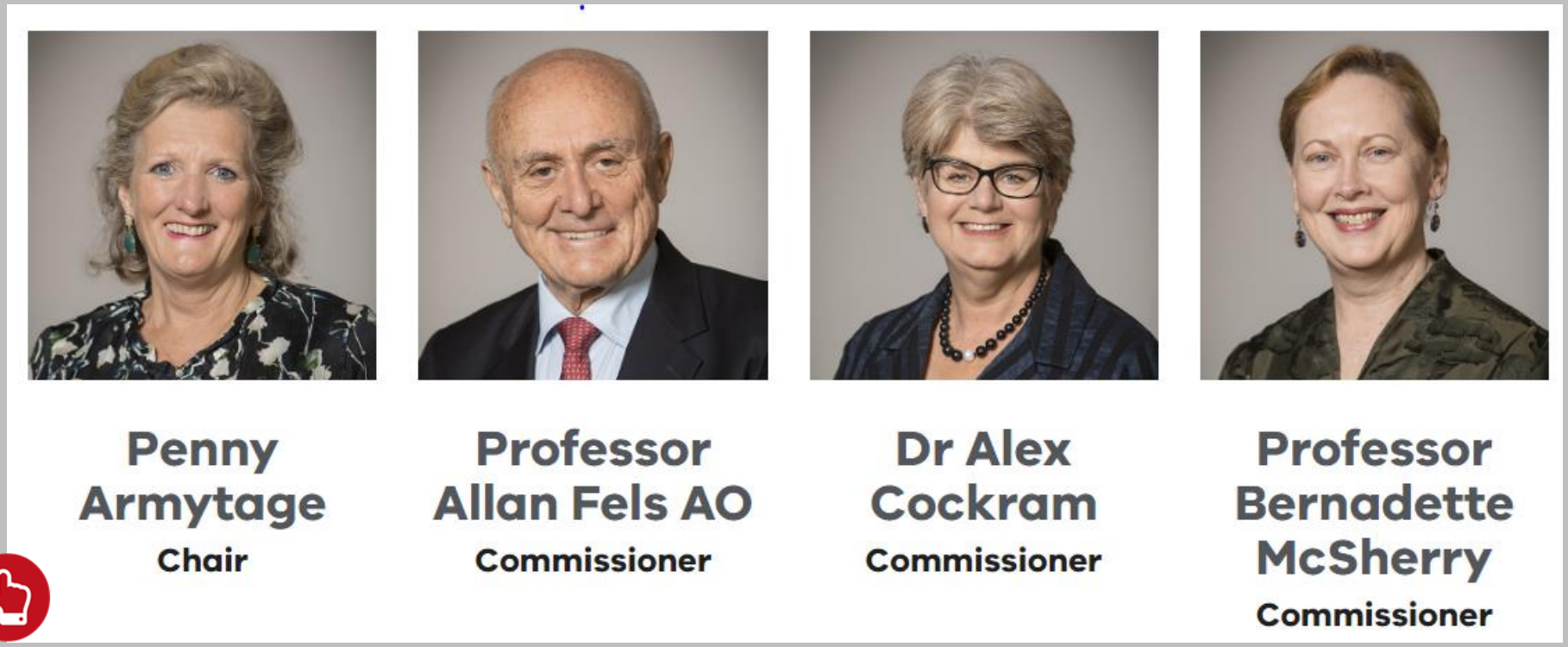




Timelines:

Feb 2019:

- ToR released
- Commissioners appointed



Ahead:

- *April - May 2019* **Community consults**
- *From April 2019:* **Call for submissions to ToR** (written, online, audio, video)
- ***July 5th 2019:*** **Written submissions close**

- *Mid 2019* **Online discussion forums / Surveys**
- *June to July 2019:* **Hearings**

- *November 2019:* **Interim report**

- *From early 2020:* **Discussion papers released**
  Submissions on discussion papers
  Targeted roundtables / Online forums / Surveys / Hearings

- *October 2020:* **Final report**

Terms of Reference:

How to…

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

- ..deliver the **best MH outcomes** & **improve access to & navigation of** Victoria's MH system for people of all ages.

- .. best support the **needs of family members & carers** of people living with mental illness.

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

- **..best support those in the Victorian community who are living with both mental illness & problematic alcohol &drug use, including through evidence-based harm min approaches.**

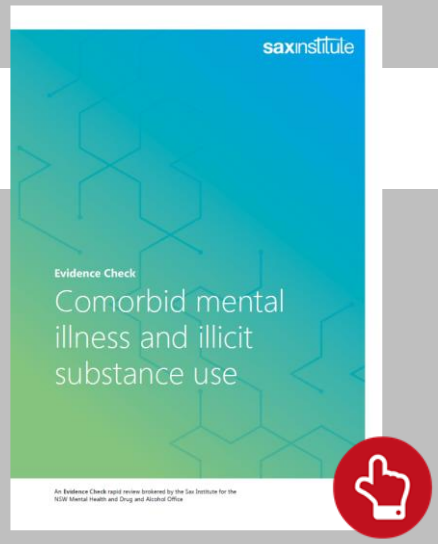
Transitions between AOD & MH

Existing Guides / Landmarks

Why does it matter?

1. Prevalence

- ‘90% MH in SUD services ….’
- ‘71% SUD in MH services….’



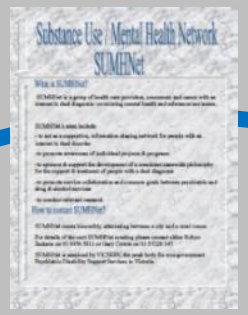
2. Harms

3. Potential for better outcomes

Victoria's responses to date:

Of all Australian states the longest, largest, investment in better outcomes for people with dual diagnosis

Jesuit Social Services
Building a Just Society
CONNEXIONS



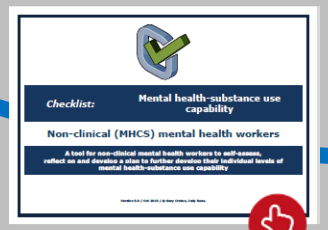
SUMITT
Substance Use & Mental Illness Treatment Team

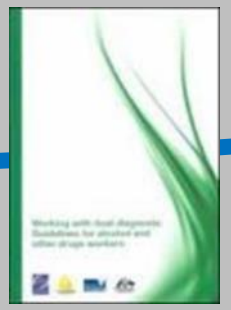
Dual Diagnosis
VDDI

21 MST DDx positions

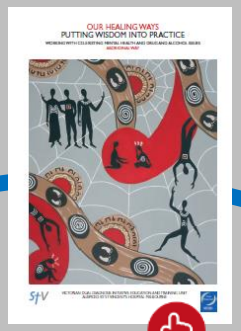
5 Youth DDx positions

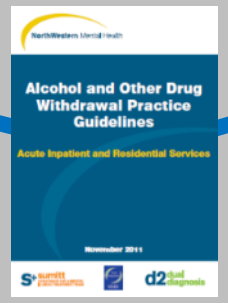
Education Training Unit





BUDDYS
Building Up Dual Diagnosis in Youth Services

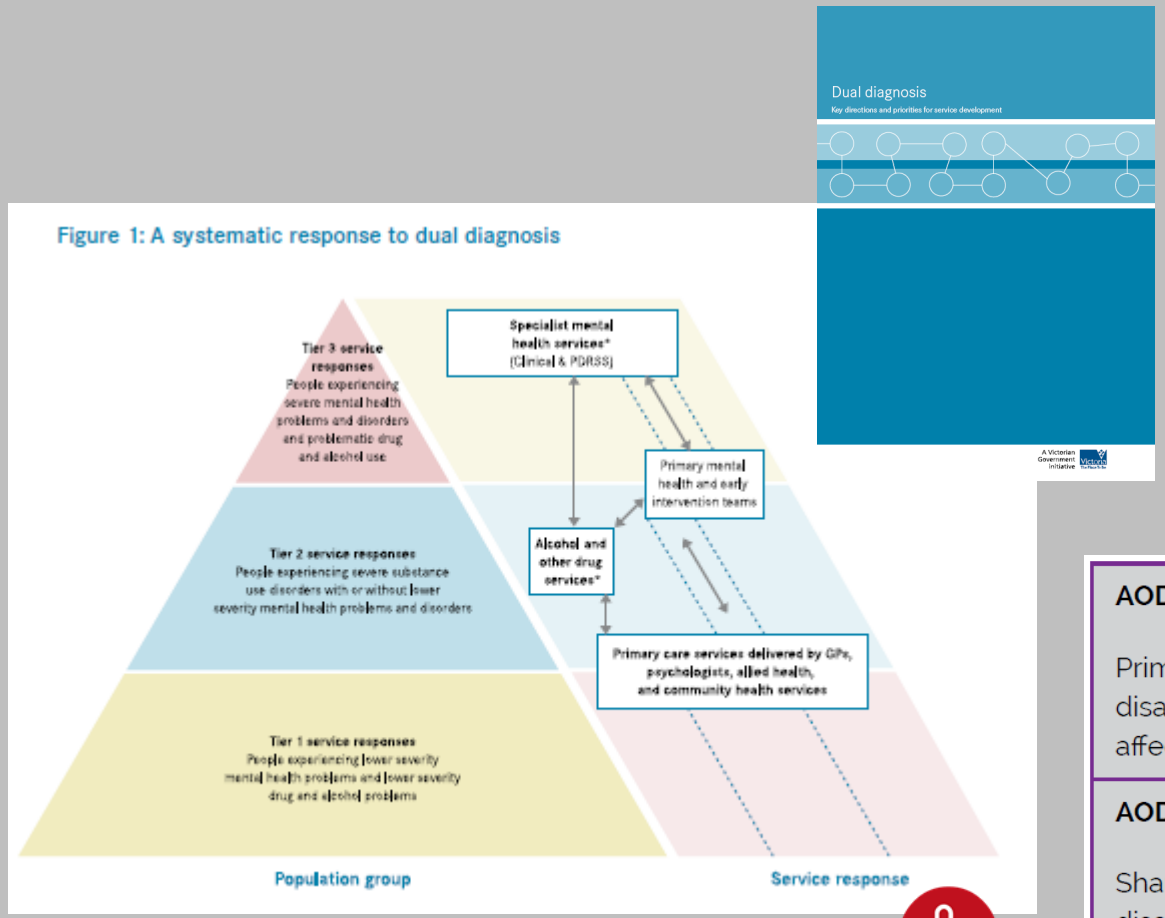


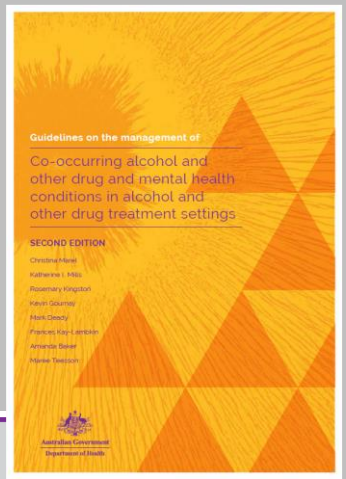


new Mental Health Act

Dual Diagnosis Rehabs

Locus of responsibility of treatment:





AOD services Primarily responsible for people severely disabled by current substance use and adversely affected by mental health problems.	**Mental health services** Primarily responsible for people severely disabled by current mental health problems and adversely affected by substance use.
AOD and mental health services Shared responsibility for people severely disabled by both substance use and mental health disorders. The client should be treated by the service that best meets his/her needs.	**General practitioners** Primarily responsible for people with mild to moderate AOD and/or mental health conditions but with access to specialist AOD and mental health services as required.

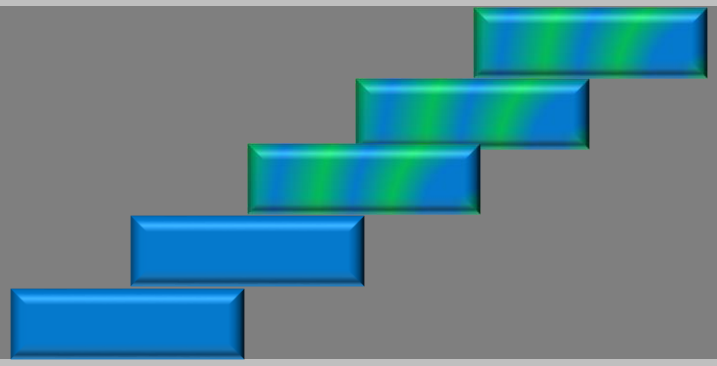
Options for responding to people with AOD-MH:

- Sequential

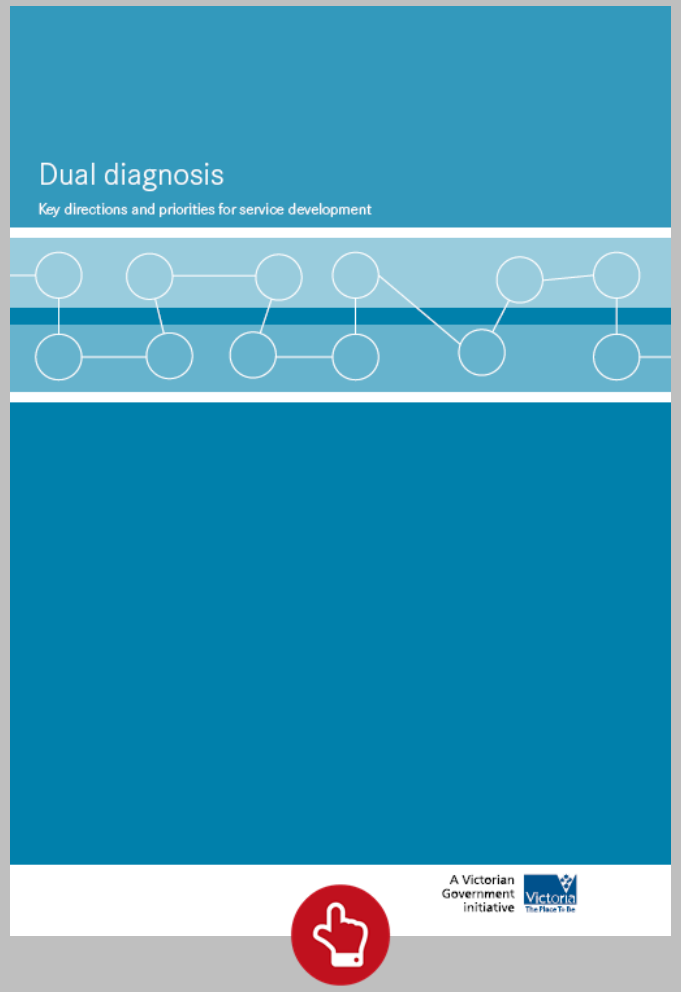
- Parallel

- Integrated

- Stepped Care

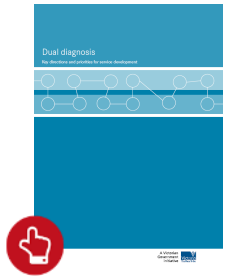


Integrated treatment:



- a clinician treats both client's substance use AND mental health problems
- also occurs when clinicians from separate agencies agree on an individual treatment plan addressing both disorders and then provide treatment.
  (integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client)

Integrated treatment:



a clinician treats both client's substance use AND mental health problems

AOD workers/ agencies

Severe SUD - high-prevalence MH

Anxiety

Depression

Trauma Sxs

Personality Issues

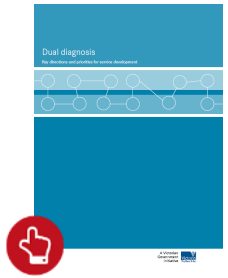
MH workers / agencies

Severe Mental Illness - SUD

Incidental IP Withdrawal

Brief Interventions

Integrated treatment:



a clinician treats both client's substance use AND mental health problems

AOD workers/ agencies		MH workers / agencies
Severe suicidality		Community Withdrawal
Acute Psychosis		SU Dependence
SMI		IDU
Risk		Pharmacotherapies

INTEGRATED TREATMENT

(cross-sector)

…clinicians from separate agencies agree an individual treatment plan addressing both disorders & then provide treatment.

CORE BUSINESS

Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as 'core business' in both mental health and alcohol and other drug services.

NO WRONG DOOR

MH & AOD services establish partnerships & mechanisms that support integrated assessment, treatment and recovery and ensure **NO WRONG DOOR** to treatment and care.'

CHALLENGES:

- Systems / Services / Structures oriented to 'mono-disorders'
- Competitive Tendering
- Separate funding streams
- Training to 'mono-disorders'
- Cross-sector work not recognised or rewarded
- Continual Change /Churn
- Time constraints / Case load pressure
- Systems difficult to navigate (even when you work in them)

Strategies to build AOD-MH transitions/ partnerships / navigable pathways

- Interagency Protocols
- Service Coordination Alliances
- Bus- trips
- Joint education
- Social events
- Stakeholder Breakfasts
- [Randomised Coffee Trials]


ARE WE THERE YET !?!
MATT GROENING

What could the RC recommend towards better outcomes for people with SU-MH?

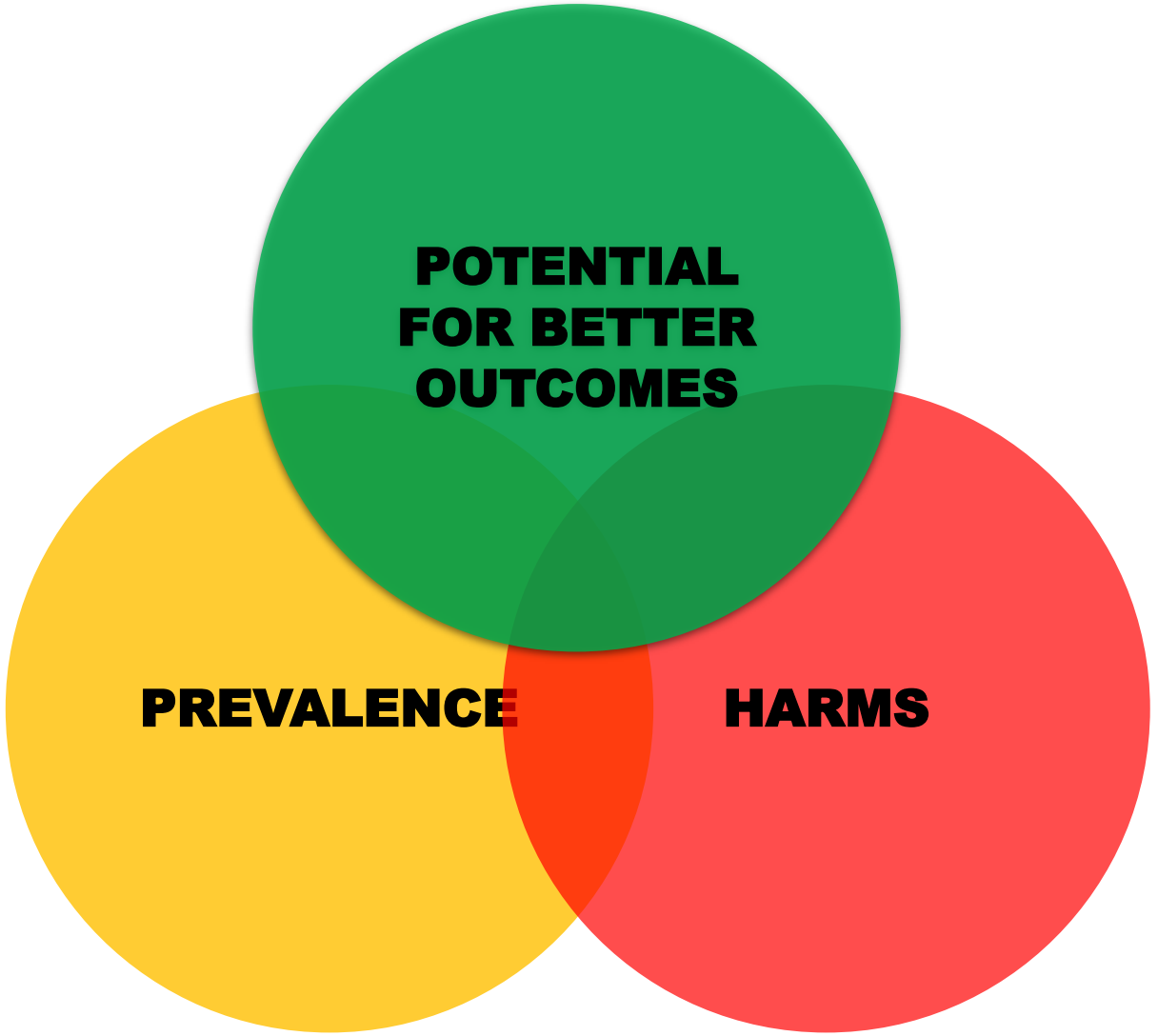
Likely:

- Investment ++
- Moving upstream- less crisis driven.
- More codesign
- More community options
- Increased access
- Rural & remote focus
- Primary MH focus

Menu of possible strategies towards better outcomes

Include AOD system in reforms

- Warranted by AOD:



Concerns that MH may ‘takeover’ AOD

Would fail to recognise:

- different predominant cohorts of people in each sector
- their different treatment needs & preferences
- different strengths & cultures in each setting
- MH services struggle to be effective with MH concerns – unrealistic they be required to respond effectively with people with predominantly-AOD presenting concerns

Concerns that MH may ‘takeover’ AOD

We need a greater range of welcoming, accessible treatment services that flexibly provide integrated treatment to people presenting with differing combinations of and severity of co-occurring mental health and substance use needs and other complex co-occurring needs

These services need to be coherently arranged and meaningfully linked with easily navigable pathways within & between them

Menu of possible strategies towards better outcomes

- **Develop our systems around the expectation that people seeking services will have dual diagnosis and other complex needs**

Comprehensive Continuous Integrated System of Care model
CCISC

- **Vision-driven, system-wide, CQI process**
- **Data driven - financial integrity & value-driven practice are anchored into place simultaneously.**

Menu of possible strategies towards better outcomes

Access & system responsiveness:

- **Co design**
- Build systemic / agency / clinician **capacity to flexibly provide integrated treatment**
- Address **WELCOMING** across MH & SU service systems
- Recognise & explore **culture & lived experience** of **MH and SU workers**
- Reward **systemic flexibility**

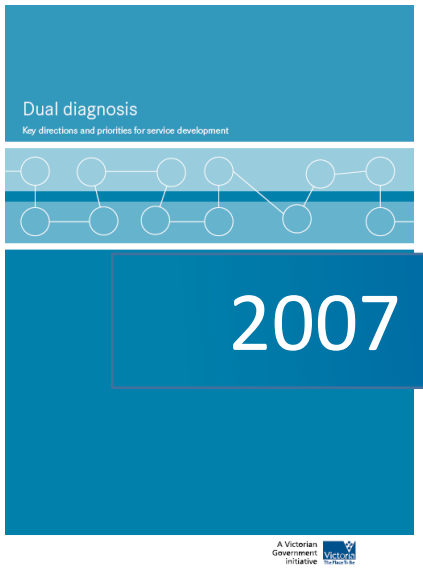
Menu of possible strategies towards better outcomes

Access & system responsiveness:

- **Deconstruct laborious entry processes / rigid, limited, entry criteria**
- Single session therapy models?
- **Funding models-** was block funding more effective? Does competitive tendering contribute to a navigable No Wrong Door service system?
- **Does NDIS work for people with MH-SU concerns / complex needs?**
- Recognise & **reward cross-sector work**

Menu of possible strategies towards better outcomes

- Refresh **cross-sector, dual diagnosis policy / vision statement**
  - **Align data & reporting with vision** of effective, evidence based, responsive systems



2007 → 2019

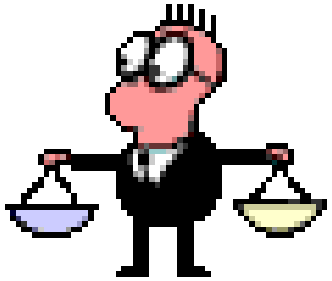
Menu of possible strategies towards better outcomes

- **Stigma**
  - address SU per se stigma AND **compounded, dual diagnosis stigma**
  - @ societal, healthcare system, healthcare provider & self-stigma levels

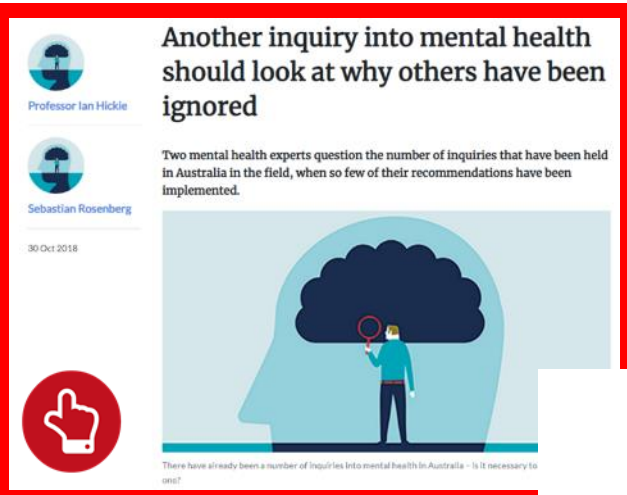
- **Language:** time to move on from '***dual diagnosis***'?
  - **evolution away from diagnostic paradigms**

- **Build systems-wide capacity to record & analyse prevalence**

Will this RC make a difference?

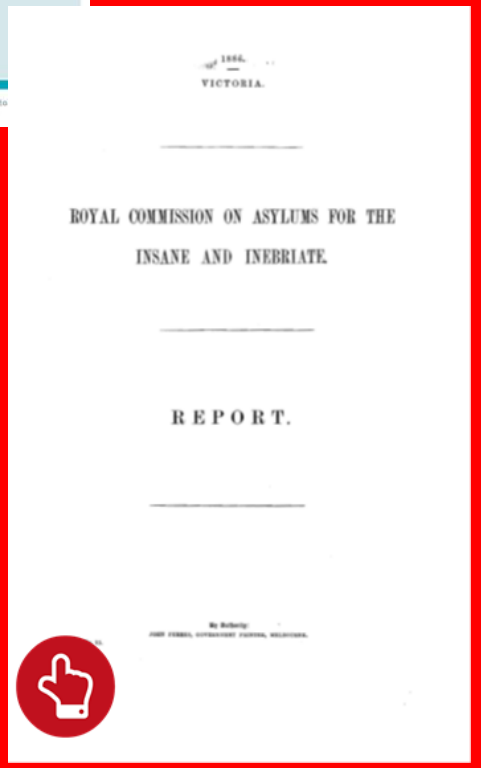


- Since 1993 Aust has **averaged a MH Inquiry every 84 days**

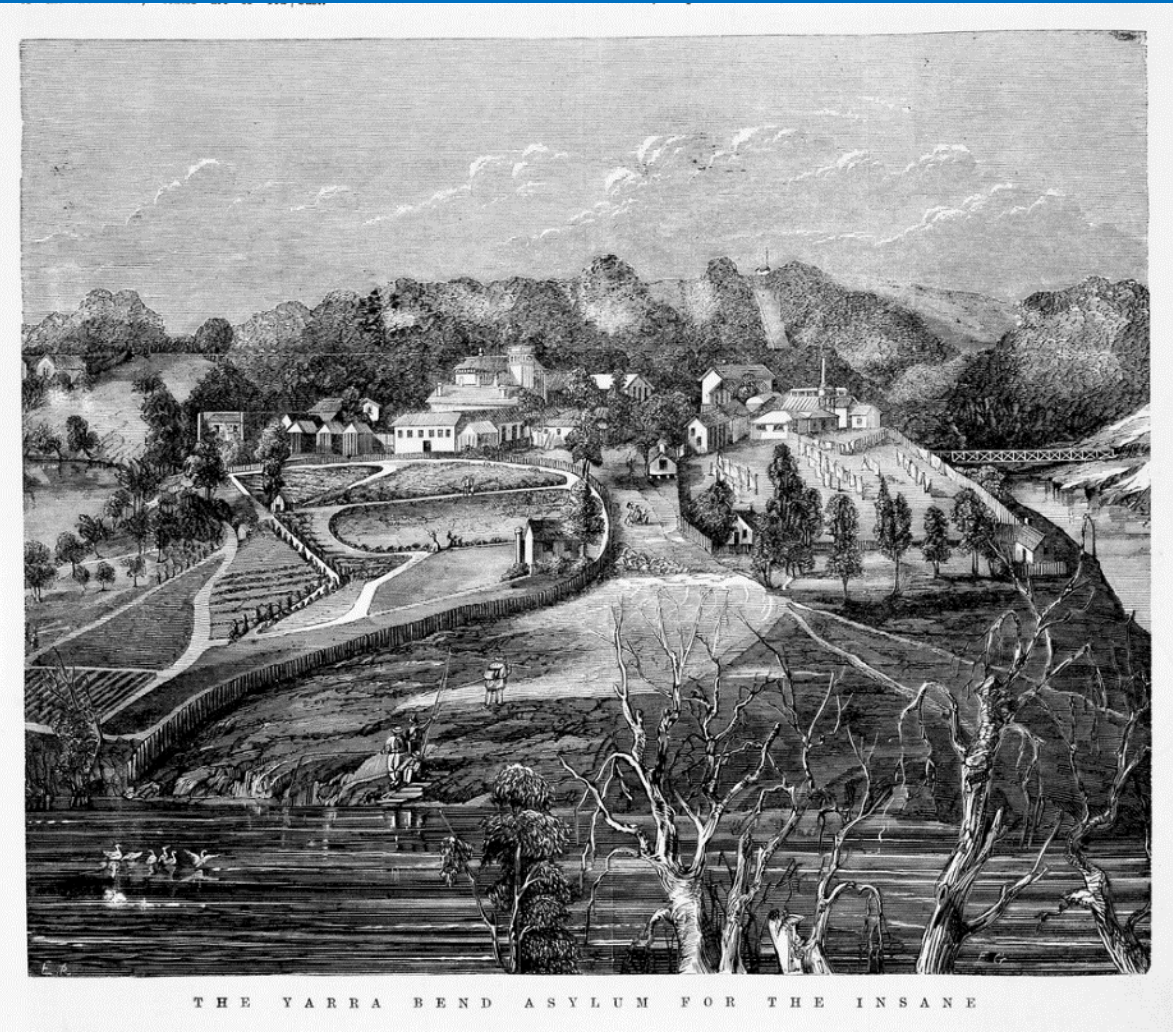


- **2006-12: 32 statutory inquiries into MH** - *Few recommendations implemented…*

- **1886 Victorian Royal Commission on Asylums for the Insane & Inebriate**



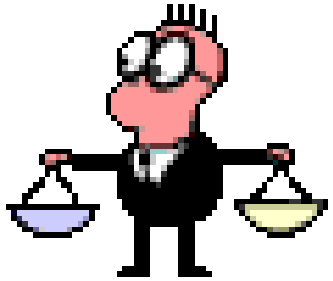
1886 Victorian Royal Commission on Asylums for the Insane & Inebriate



THE YARRA BEND ASYLUM FOR THE INSANE

HORRORS OF THE KEW ASYLUM.

Will this RC make a difference?



- Victorian Government committed to implementing every recommendation
- Funding in advance of RC findings
- 1886 Victorian Royal Commission on Asylums for the Insane & Inebriate
- Burdekin Report 1993
- ***BREAKING IN NZ!***

GOVERNMENT INQUIRY INTO
Mental Health and Addiction
Oranga Tāngata, Oranga Whānau

$1.9bn $0.5bn "missing middle"

VAADA's RC input:

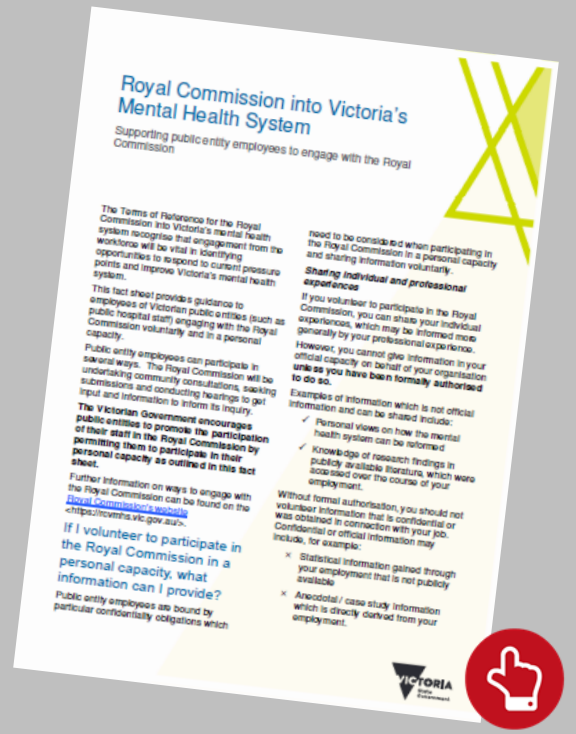
Developing submission:

- Rigorous process to represent sector's views
- Greg Denham oversight
- Nich Rogers chief writer

- **Focus Group Discussions**
  - 1. Fri June 7th 9.30-11.30
  - 2. Fri June 7th 1:00-3:00
  - Rural sessions

- **Survey of Sector**
- **Key Informants**
- **Your feedback today**

Your submission

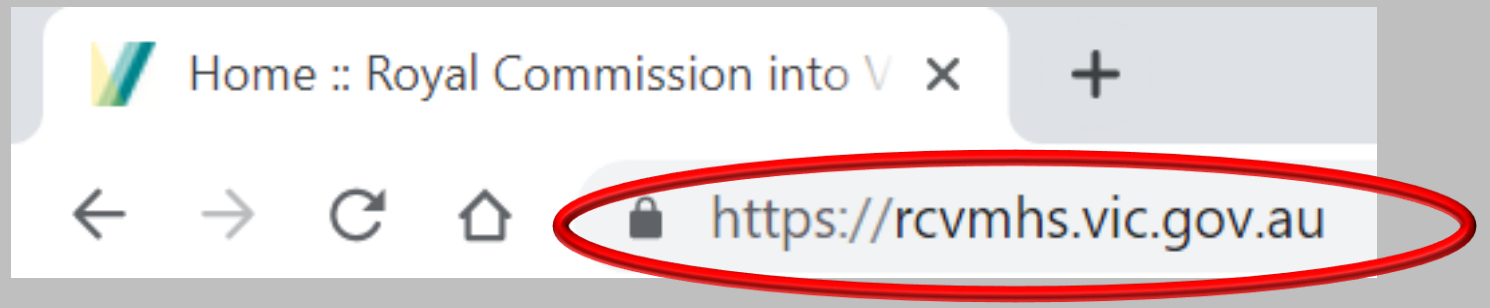

Royal Commission into Victoria's Mental Health System

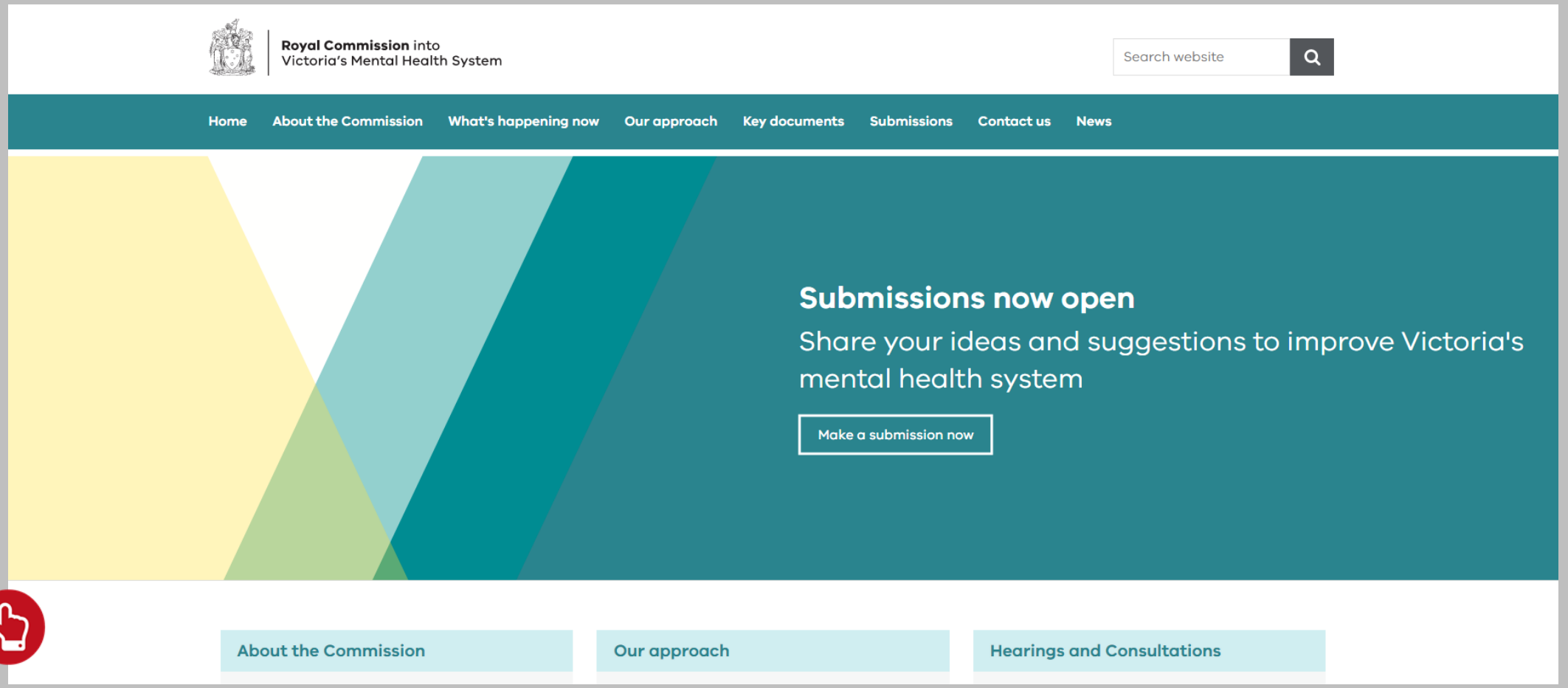
Supporting public entity employees to engage with the Royal Commission

DHHS Fact Sheet:

[Supporting public entity employees to engage with the Royal Commission]

Your submission:





Today:

- ***What is the main thing you would like to say to the Royal Commission?***
- ***What would you like the RC to consider?***
- ***What would you like the RC to recommend?***

gary.crotonATawh.org.au

www.dualdiagnosis.org.au

@Dual_Dx_ANZ