SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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VAADA would also like to acknowledge the work of Jesse Young, Stuart Kinner and Melissa Willoughby from the Justice Health Unit, Melbourne School of Population and Global Health, University of Melbourne for their input the detailing the additional complexity and costs associated with criminal justice system involvement for people with co-occurring needs. Their report, *Inequalities and inequities experienced by people with mental health and substance use issues involved in the criminal justice system* has been submitted separately.

Notes

Co-occurring needs

In this submission the term **co-occurring needs** means having both an alcohol and other drug, and mental health need together at the same time. This can include people who reach diagnostic threshold for having a *'dual diagnosis'*, and people who may be exhibiting symptoms, harms and impairments because of their alcohol and other drug, and mental health problems but do not have a diagnosis. Another common term used to describe this group is people with '*co-existing needs*'.

Integration

In this submission we refer to integration as having two components; systems integration and operational integration. VAADA does not support the merging of existing mental health, and alcohol and other drug service systems. They should remain separate but integrated at the operational level only. We define them as:

> ***Systems Integration***:
>
> *"The process by which individual systems or collaborating systems organise themselves to implement services integration to clients with co-occurring needs and their families[1]."*
>
> ***Operational (services) integration:***
>
> *"Any process by which mental health, and alcohol and other drug services are appropriately integrated or combined at either the level of direct contact with the individual client with co-occurring needs or between providers or programs serving these individuals. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organised program in which all clinicians or teams provide appropriately integrated services to all clients."*

[1] U.S. Department of Health and Human Services. *Substance Abuse and Mental Health Services Administration 'Services Integration – Overview Paper 6*. DHHS Publication No. (SMA) 07-4294, 2007.

> *Integrated treatment may be provided by a clinician who treats both the client's substance use and mental health problems. Integrated treatment can also occur when clinicians from separate agencies agree on an Individual Treatment Plan addressing both disorders and then provide treatment. This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client*[2]*."*

Good practice examples

Some good practice examples are highlighted throughout this submission. These examples are not intended to be exhaustive and there are likely many good practices occurring which were not shared during consultations.

Acknowledgement of Country

VAADA acknowledges the Wurundjeri people of the Kulin nation as the traditional owners of the land where VAADA's offices are located. We pay our respect to their elders, past, present and emerging.

Citation suggestion

VAADA (2019). *VAADA Submission to the Royal Commission into Victoria's Mental Health System - 2019.*

[2] U.S. Department of Health and Human Services. *Substance Abuse and Mental Health Services Administration 'Services Integration – Overview Paper 6*. DHHS Publication No. (SMA) 07-4294, 2007.

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The Victorian Alcohol and Drug Association (VAADA) is a non-government peak organisation representing publicly funded Victorian alcohol and other drug services. In Victoria there are approximately 100 funded alcohol and other drug services of different sizes located across the state.

VAADA has broad membership that includes alcohol and other drug organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, religious, general youth, local government and others (e.g. schools, counselling services, correctional/diversion services, legal services).

VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug use across the Victorian community.

As a peak organisation, VAADA's purpose is to ensure that the issues for people experiencing harms associated with alcohol and other drug use, and the organisations that support them are well represented in policy and program development, and public discussion.

VAADA seeks to achieve this through:

- Engaging in policy development
- Advocating for systemic change
- Representing issues our members identify
- Providing leadership on priority issues to pursue
- Creating a space for collaboration within the alcohol and other drug sector
- Keeping our members and stakeholders informed about issues relevant to the sector
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drug services.

2 SUMMARY OF RECOMMENDATIONS

VAADA's recommendations in relation to *1) Systems integration*, and *2) Operational integration* are summarised in the two tables below.

Systems Integration Recommendations		
Category	**Recommendation**	**Page number**
Frameworks	***Recommendation 01:*** *Develop an overarching joint Victorian alcohol and other drug and mental health framework that creates a vision for managing co-occurring issues, and offers clarification on the points of overlap, intersection, and the areas of specialisation. Corresponding protocols, practice guidelines and training opportunities should be implemented to translate the framework to clinical practice.*	p. 26
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	Recommendation 12: *Explore the benefits and value of expanding funding to the Victorian Dual Diagnosis Initiative for workforce development activities. Create incentives for participation, especially for the mental health, primary care and emergency medicine workforces*	p.36
	Recommendation 13: *Fund innovative workforce capacity building initiatives between alcohol and other drug, and mental health services*	p.36
Including people with a lived experience in service design	***Recommendation 14:*** *Develop a co-design framework to build organisational and sector capacity for engagement of people with a lived experience of alcohol and other drug, and mental health problems. Test the developed framework in both alcohol and other drug, and mental health services*	p.38

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Category	**Recommendation**	**Page number**
Prevention and early intervention	***Recommendation 15:*** *Adopt the recommendations from the Drug Law Reform 'Inquiry into drug law reform' (2018)*	p.42
	Recommendation 16: *Fund peer outreach workers to support people with co-occurring alcohol and other drug and mental health issues to reduce harm and engage in treatment*	p.42
	Recommendation 17: *Implement stigma and discrimination programs in universal prevention settings and across all health and human services*	p.43
Access to services	***Recommendation 18:*** *Create accessible, user friendly and integrated alcohol and other drug, and mental health intake systems that assess if the presenting person needs support for both conditions*	p.49

	Recommendation 19: *Fund more enduring, relationship based case management which repeatedly and respectfully helps people at risk to navigate pathways through complex service systems*	p.49
	Recommendation 20: *Build the capacity and expertise of mental health and emergency medicine settings to identify and refer people with alcohol and other drug needs by embedding alcohol and other drug staff and resources. Use these specialists to provide ongoing education aimed at improving alcohol and other drug literacy and service navigation*	p.49
	Recommendation 21: *Create accountably measures to ensure all human services operate a no wrong door model, helping clients access the full range of services they need irrespective of where they first access services*	p.50
Support and treatment	***Recommendation 22:*** *Pilot co-location of alcohol and other drug, mental health and other community support services together for people with co-occurring alcohol and other drug, and mental health issues. Provide integrated intake, generalist case management, and peer support services*	p.55
	Recommendation 23: *Provide additional resources in alcohol and other drug settings to assist management of people with mental health symptoms who do not reach threshold for care from mental health services*	p.56
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3 EXECUTIVE SUMMARY

It is well recognised that mental health is impacted by a wide variety of individual, social, and broader socio-economic, cultural and environmental factors. Our mental health can be impacted at any point in our lives, and key transition points as we age are critical to managing our mental health. Difficult experiences people have through their life, including breakdown of family and social connections, unemployment, substance use, trauma, and homelessness are significant contributing factors to mental illness.

VAADA's submission begins with a discussion of the broad conditions for good mental health, while the later sections focus on the specific implications this has for our alcohol and other drug sector, and its intersection with the mental health system.

The submission is underpinned by a population health approach as the most effective way to reduce the down-stream impact of problematic alcohol and other drug, and mental health problems, while also identifying specific challenges and opportunities at the intersection between alcohol and other drug, and mental health services.

This submission was developed based on:

1. A review of best practice population health approaches to better managing mental health
2. A review of recent prevalence data
3. A comprehensive consultation with the Victorian alcohol and other drug sector.

Population Health

VAADA believes that effective management of mental health requires a population health approach which focuses as much attention on the social conditions in which we live as on individual pre-disposing factors. This belief underlines a need to invest more in prevention and health promotion activities to reduce later healthcare costs.

A population health approach recognises that there are significant opportunities to prevent mental illness and promote good mental health in our communities. It recognises the strong contribution that social conditions like housing, employment and positive social relationships have on mental health and acknowledges that problems need to be considered and responded to together. A population health approach acknowledges the importance of community recovery and re-integration support for people leaving settings like prisons, hospitals, and alcohol and other drug residential settings. Without changing the social conditions people return to we are likely to see them re-present back to the services they were discharged from.

Our alcohol and drug sector acknowledge that effective and efficient responses to improve the health of vulnerable populations recognises complexity as common, and must provide holistic, coordinated and ongoing care to address a wide range factors contributing to poor health.

Prevalence Data

It is suggested that more than 20% of the Australian population may have a mental or behavioural condition that impairs their functioning. We are also aware that high rates of co-occurring mental health, and alcohol and other drug problems exist. Dual conditions are recognised as harder to treat compared to people presenting with only one condition. High rates of mental health, and alcohol and other drug problems also exist in criminal justice involved populations and other vulnerable groups (e.g. people experiencing homelessness). For example, data provided to VAADA from the Australian

Community Support Organisation, shows 50% of offenders assessed for alcohol and other drug treatment have a mental health diagnosis. At the same time, the Kessler Psychological Distress Scale, a measure of anxiety and depression, is one of four client outcomes measures administered to clients in the alcohol and other drug sector, recognising the high prevalence of these symptoms among alcohol and other drug clients.

Given the high prevalence of mental health problems in the community, and within specific populations, (and the personal and public health consequences of mental health problems), successive governments have attempted to remedy this with a series of mental health reforms. Unfortunately, these reforms, have struggled to meet their aims, and the mental health and alcohol and other drug service systems remain fractured – giving rise, in part, to the Mental Health Royal Commission.

In recognition of these high rates of both mental health, and alcohol and other drug conditions it is important to consider how we best respond in a way that provides more coordinated and effective services to people presenting with co-occurring needs.

Sector consultation

In developing this submission VAADA undertook a comprehensive consultation with the alcohol and other drug sector. The primary orientating question asked in the consultation was:

> ***How can alcohol and other drug, and mental health services and systems provide more coordinated and effective services to people presenting with co-occurring needs?***

Consultations identified key challenges for the alcohol and other drug sector in meeting the needs of people with co-occurring alcohol and other drug, and mental health needs. These fall under systems and operational themes. A summary of consultation findings is detailed below.

At a systems level our consultations highlighted:

- **Distinct practice philosophies, approaches and language** across the alcohol and other drug, and mental health systems, while valuable, appear to make coordinated and consistent care more difficult
- **Governments continue to fund discrete service types which are unable to address capacity to respond to those with co-occurring needs.** This may reduce effective, person centred and integrated care continuums for people using services
- **Governments have not used research and data** to inform key service design decisions:
    - We know that up to 80% of people presenting to alcohol and other drug services have co-occurring mental health needs, yet it is reported these people find it difficult to access coordinated care
    - Alcohol and other drug services have not been routinely embedded in mental health, and other areas such as emergency departments despite evidence showing high service presentation rates.
- **Strategic and local operational networks that would support more coordinated care are lacking**
- **We have not strategically identified future alcohol and other drug workforce needs**. We need to plan strategically to meet alcohol and other drug and mental health sector workforce needs
- **Health, medical and allied fields need to address stigma and discrimination which reduces access** to vital services
- **People who use services, their families and carers have not been sufficiently included in service design.**

At an operational level our consultations highlighted:

- **Prevention, especially secondary preventions activities must be prioritised in the alcohol and other drug sector in order to reduce later healthcare demand and costs**
- **Access to mental health services is often difficult for people with co-occurring needs**
- **Support and treatment for people with co-occurring needs could be more integrated:**
    - Alcohol and other drug services lack sufficient professional and built-environment capacity to support their clients' mental health needs
    - Acute psychiatric and emergency medicine settings need more specialist alcohol and other drug expertise
    - Healthcare in the criminal justice system could be better supported to include more coordinated services, including alcohol and other drug, and mental health services and care
- **Recovery and community participation support** through community housing and independence skills development is lacking, especially for people leaving prison and those with chronic and cyclical mental health, and alcohol and other drug conditions.

Our consultation with the alcohol and drug sector drew attention to the expressed need for alcohol and other drug, and mental health services to be more closely aligned with a shared purpose in achieving the best outcomes possible for this cohort and their families.

It was clearly stressed though that the development of shared systems has relevance only where the sectors intersect in the management of people with co-occurring issues. The alcohol and other drug sector otherwise offer specialist services not related to the mental health sector, and therefore it should retain a distinct and clear identity.

Given that the message from the alcohol and other drug sector is that it must not be subsumed under the broader umbrella of mental health services, VAADA would also not support any recommendation that the entire sectors be merged.

4 INTRODUCTION

The Royal Commission into Victoria's Mental Health System provides a historic opportunity to fundamentally change how we support people with mental health, alcohol and other drug, and a wide range of associated needs like housing, legal support, family and social support, employment and other social capital. This requires a whole of government response to simultaneously address a wide range of individual and social factors which are contributing to poor mental health.

The most recent Australian Bureau of Statistics National Health Survey (2017-2018) estimated there were 4.8 million Australians (20.1%) with a mental or behavioural condition.[3] An earlier study suggested 14% of young people (4-17 years) experienced a mental health disorder in the previous 12 months.[4] Poor mental health may be associated with suicidality, 3,128 people died in Australia from intentional self-harm in 2017.[5]

According to the Australian Institute of Health and Welfare's Burden of Disease Study, in 2011 the Australian population lost a total of 542,554 years of healthy life as a result of mental and substance use disorders. This accounted for 12.1% of the total burden of disease, making mental health and substance use disorders the third highest burden of disease in Australia.[6]

Given these growing numbers it is unsurprising that our mental health system cannot keep pace with demand for services. Successive governments have attempted to address better care to people with complex mental health and other needs. Recent examples include:

- Because Mental Health Matters (2009)
- Introduction of the National Disability Insurance Scheme (2013)
- Reform of the Victorian community mental health and alcohol and other drug sectors (2014)
- Commonwealth Government mental health reforms like Primary Health Networks (2015)
- Royal Commission into Family Violence in Victoria (2017)
- Community Services Industry Plan developed by the Victorian Council of Social Services and the Victorian Government (2018).

In broad terms, each of these reforms and developments have attempted to:

- Place the person at the centre of the service system
- Create more accessible and coordinated services
- Develop ways to better monitor health outcomes.

While some gains have been made, these changes have also resulted in a range of unhelpful outcomes and social sector fatigue through a continual change process. For example the National Disability Insurance Scheme, while improving more individualised approaches to care, has left gaps where people previously eligible for block funded programs cannot access National Disability Insurance Scheme funding.

Similarly, the reform of alcohol and drug services in Victoria in 2014 initially resulted in a reduction in access to alcohol and other drug services, and created significant disruption to services. The mental

[3] Australian Bureau of Statistics National Health Survey (2017-2018).
[4] Australian Government. The Mental Health of Children and Adolescents (2015).
[5] Parliament of Australia. Mental health in Australia: a quick guide (2019).
[6] Parliament of Australia. Mental health in Australia: a quick guide (2019).

health reforms in Victoria were also considered to create a vacuum of services across the community, with hundreds of staff losing their jobs and significant flow on impacts being felt by people experiencing mental illness. An independent review of the reform supporting these views was subsequently completed by Aspex Consulting on behalf of DHHS in 2015.[7]

Two recent Victorian Auditor-General's Office reports provide further examples of unhelpful outcomes stemming from well-intentioned reform:

- In 2018 the Victorian Auditor-General's Office reviewed the Department of Health and Human Services Community Health Program to assess its contribution to good healthcare outcomes for Victoria's vulnerable populations. The Victorian Auditor-General's Office found the Victorian government had not effectively addressed gaps between mental health service supply and demand, nor invested in improved service access for vulnerable groups and highlighted Victorian per capita recurrent funding for mental health and alcohol and other drug services is among the lowest across Australia.[8]
- In 2019 the Victorian Auditor-General's Office examined how the Department of Health and Human Services designs and administers child and youth mental health services, and facilitates access and service coordination for vulnerable clients. The audit found that the Department of Health and Human Services hasn't provided strategic leadership to plan and fund child and youth mental health services, and this prevents effective identification and service coordination. The report found the mental health system was overstretched and unable to identify and respond to systemic issues.[9]

Most recently, the Commonwealth Government ordered a Productivity Commission Inquiry (2019) aimed at:

> ***"improving mental health to support economic participation and enhancing productivity and economic growth".***[10]

The inquiry is considering how mental health impacts people's ability to participate in the community and workplace, and the associated flow on of economic and productivity costs. An *Issues Paper (2019)* has been released and a draft report is now being prepared.[11] It is likely further Commonwealth Government initiatives will occur as a result of recommendations released by the Productivity Commission Inquiry.

While the principles underpinning commonwealth and state government reforms are sound, the processes used have further reduced service access and coordination, leaving the workforce fatigued by change processes which have not been effectively planned. Any changes implemented as a result of the Mental Health Royal Commission must be effectively planned to ensure both alcohol and other drug, and mental health service providers and users understand how changes will impact them and can effectively prepare for this. It is important that unintended consequences like those discussed through the 2014 reform process are carefully considered and mitigated against.

While reforms continue across mental health and related services, demand for these services continues to grow, resulting in significant health and economic costs to the community. Services state they are

[7] Aspex Consulting. Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services. Final Report. (2015).
[8] Victorian Auditor General's Office (VAGO). Community Health Program - Independent assurance report to Parliament. (2017–18).
[9] Victorian Auditor General's Office (VAGO). Child and Youth Mental Health. (2019).
[10] Australian Government Productivity Commission – Mental Health Terms of Reference (2019).
[11] Australian Productivity Commission. The Social and Economic Benefits of Improving Mental Health - Productivity Commission Issues Paper January (2019).

overwhelmed, people appear to be falling through gaps and we do not have a joined up system capable of responding in a comprehensive, coordinated and holistic way to the wide range of health and other needs people experiencing mental illness have.

Furthermore, there appears to be a failure to recognise how the social conditions in which we live are impacting mental health, and alcohol and other drug use in our communities. People exiting treatment services to social circumstances which include family violence, unemployment and homelessness will not facilitate sustained recovery. There are also increasing numbers of people entering prison, and this growing population do not receive the treatment they need while incarcerated, and are discharged back into the community without additional resources or skills to meaningfully and productively participate.

If we are to improve the mental health of our communities something needs to change.

5 BACKGROUND

5.1 The alcohol and other drug service system

The Victorian Alcohol and Other Drug Sector provides services using well developed frameworks, principles and strategies.

The sector uses a bio-psycho-social model of health to describe how people develop problems related to alcohol and other drug use, and the supports and treatments that can help resolve these problems. This includes considering individual pre-disposing biological and psychological factors, and broader social and environmental considerations that impact on substance use.

High level strategies used include preventing people from using illicit drugs and reducing the harms associated with drug use through provision of education, support and treatment.

The Victorian Alcohol and Other Drug Sector uses 11 principles to orientate practice. These are:

1. Viewing drug use problems as complex but treatable
2. Person-centred care
3. Accessible services
4. Integrated and holistic services
5. Responsive to diversity
6. Evidence-informed
7. Providing continuity of care
8. Involving people who are significant to the client
9. Inclusive of a variety of biopsychosocial approaches, interventions and modalities
10. Inclusive of the lived experience of alcohol and other drug users and their families
11. Delivered by a suitably qualified and experienced workforce.

The alcohol and other drug sector is orientated to minimising alcohol and other drug harm and helping people who have problematic substance use effectively participate in the community. Services assist people to not only resolve alcohol and other problems, but also to connect with other required services and build independence skills.

The range of services provided by the Victorian Alcohol and Other Drug Sector is outlined in *Appendix 1*.

5.2 Social determinants of health

Our health is influenced by the individual choices we make—whether we smoke, drink alcohol, are immunised, have a healthy diet or undertake regular exercise.

Less well recognised is the influence of broader social factors on health. Evidence of the close relationship between living and working conditions and health outcomes has led to an improved understanding of how our health is impacted by our social environment. Factors such as income, education, employment conditions, power and social support are now also recognised as significant factors which impact our health. Because of their potent and underlying effects, these health-determining factors are known as the 'social determinants of health'.[12]

Figure 1 (below) illustrates how broad social health determinants extend inward to affect other factors, including health behaviours like taking drugs, and biomedical factors, that are part of a person's individual lifestyle and genetic make-up.

Using this model to understand health behaviour, we might consider how things like unemployment, a lack of access to health services, housing or positive social relationships might contribute to mental illness and the choice to use alcohol and other drugs. Other intersecting or layered factors such as race, gender and sexuality can also play a large role in intensifying the experience of marginalisation for some individuals.

By understanding the broader factors contributing to poor mental health and substance use problems we can begin to effectively and efficiently target them in order to reduce demand pressures on our acute and broader health treatment systems.

FIGURE 1: DIAGRAM OUTLINING THE SOCIAL DETERMINANTS OF HEALTH

[12]Australian Institute of Health and Welfare. Social Determinants of Health. Australian Government. (2016).

5.3 Good practice using a population health approach

Having recognised that many of the foundations of good mental health exist within our social and environmental conditions we must consider what we can do to influence these.

A population health approach provides a guide to effectively responding to mental health, substance use and associated problems by:

- Recognising that there are significant opportunities to prevent mental illness and promote good mental health by helping people feel included in their communities and providing timely information and education. This reduces demand pressures on acute health and human services
- Recognising the strong contribution that social conditions like housing, employment and positive social relationships have on mental health and problematic substance use, and working to create healthy social environments for people
- Acknowledging that problems need to be considered and responded to together. Addressing someone's drug use, but not mental health, homelessness and lack of employment is unlikely to provide sustained positive outcomes
- Articulating the importance of key life transition points for people as they move from one stage and age to another. For example transitions from school and adolescence, to employment and adulthood can be challenging and often require support to facilitate effective transitions
- Highlighting the importance of community recovery and re-integration support for people leaving settings like prisons, hospitals, and alcohol and other drug rehabilitation centres. Without changing the social conditions people return to we are likely to see them re-present back to the services they were discharged from.

In order to respond in this way we need systems of care which effectively coordinate a wide range of health and human services. This includes prevention and health promoting activities, early intervention services, acute and treatment services, and services supporting recovery and community participation. A whole of government approach is required that includes systems coordination across funding, frameworks and administration functions while also celebrating the diversity and difference distinct sectors bring to different parts of the human services system.

Person centred and coordinated care for people who develop problems is essential to responding effectively using population health approaches. A recent review identified helpful integrated care practices in health service settings. The review suggested agencies were most likely to receive referrals, share information, and engage in joint programming and consultation if health workers perceived the overall quality of the interagency relationship as good. Perceptions of partner agency friendliness and responsiveness to people using services were also found to be linked to whether joint programming and consultation occurred.[13]

[13] Lubman, D., Manning, V., Best, D., Mugavin, J., Lloyd, B., Lam, T., Garfield, J., Buykx, P., Matthews, S., Larner, A., Gao, C., Allsop, S & Room, R, 2014, A study of patient pathways in alcohol and other drug treatment, Turning Point, Fitzroy.

5.4 Supporting people with co-occurring mental health, and alcohol and other drug needs

The Victorian alcohol and other drug sector recognise the majority of people presenting to their services also have co-occurring mental health needs[14]. Prevalence rates vary depending on the treatment setting, population, disorder, and method of assessment; however they consistently fall in the range of 70-90%.[15, 16, 17] The sector has worked hard to build workforce capacity to identify and respond to mental health needs, it has also tried hard to facilitate pathways to mental health care for people with serious and persistent mental health problems.

The sector is now well skilled in the screening and identification of mental health symptoms, screening questions are embedded in the Alcohol and Other Drug Assessment Form and common screening tools (e.g. K10 and Mini Mental State Exam) are regularly used. Data from our sector survey shows the alcohol and other drug workforce also feel competent in supporting many high prevalence mental health conditions simultaneously with their alcohol and other drug care (*see Figure 5*).

However coordinating and integrating care for people with serious mental illness continues to frustrate the alcohol and other drug sector, and may amplify risk in alcohol and other drug settings. Alcohol and other drug services report being required to support people with significant mental health problems who do not reach a threshold for mental health care without resourcing for specialist mental health expertise.

Correspondingly, our consultations suggested that additional alcohol and other drug expertise is required in psychiatric inpatient, and emergency medicine settings in order to improve services to people accessing these settings. People's alcohol and other drug concerns do not appear to be a sufficient focus in these settings.

Best population health practice in supporting people with co-occurring needs requires not only mental health expertise within alcohol and other drug services, and alcohol and other drug expertise within the mental health services, it also requires better bridging services between these and other relevant systems in order to translate language and practice, build cross sector capacity, and work with particularly high risk individuals.

Best Practice Treatment for people with co-occurring needs

Integrated care to people with co-occurring mental health and alcohol and other drug needs is recognised as best practice[18].

Alternative 'sequential' and 'parallel' approaches to providing mental health, and alcohol and other drug treatment have been shown to be produce poorer outcomes and are less cost effective[19]. It is

[14] Chan YF, Dennis ML, Funk RR. Prevalence and comorbidity of major internalizing and externalizing problems among adolescents and adults presenting to substance abuse treatment. Journal of Substance Abuse Treatment. 2008;34(1):14-24.
[15] Dore GM, Mills KL, Murray R, Teesson M, Farrugia P. Post-traumatic stress disorder, depression and suicidality in inpatients with substance use disorders. Drug and Alcohol Review. 2012;31(3):294-302.

[16] Burns L, Teesson M, O'Neill K. The impact of comorbid anxiety and depression on alcohol treatment outcomes. Addiction. 2005;100(6):787-9.

[17] Kaminer Y, Bukstein O. Adolescent Substance Abuse: Psychiatric Comorbidity and High Risk Behaviors. New York: Haworth Press; 2007.

[18] Minkoff, K. Developing standards of care for individuals with cooccurring psychiatric and substance use disorders. Psychiatric Services 52:597–599, 2001.
[19] Drake, R.E.; Muesur, K.T.; Brunette, M.F.; ET AL. A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. Psychiatric Rehabilitation Journal 27:360– 374, 2004.

suggested they are confusing to clients, and reinforce health practitioner perceptions that substance use problems must be managed before mental health conditions can be treated.

Minkoff has suggested integrated mental health, and alcohol and other drug treatment occurs through:[20]

- Outreach services that addresses motivation
- Case management responses provided from a single site or service
- A single clinician cross trained in both mental health, and alcohol and other drug competencies
- Capacity to manage other identified needs in a coordinated fashion.

There are some excellent examples of emerging good practice internationally. These approaches recognise the broad social determinants to health and use population health thinking which considers the range of coordinated responses required. One example comes from New Zealand.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction

The New Zealand Government has recognised that comprehensive and inter-related population health responses are required to support people with complex needs. They have recently completed a Mental Health and Addiction Inquiry[21] and their report *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*[22] was one of several interrelated reviews of health, social welfare, education and other services. The inquiry was important, in the context of this submission, because it focused on both mental health and alcohol and drug problems together.

A comprehensive consultation with people who used and worked in mental health, and alcohol and other drug services was conducted. The most significant finding was a high degree of consensus about the main shortcomings and a call for key structural reforms. Key themes coming from the consultation were problems with access, long wait times, over-reliance on drug treatments, under-resourcing and staff strain, social and economic stress, and difficulty in challenging current practice and holding service providers to account.

The report calls for fundamental change in the way services are designed and delivered. The new direction includes a strong emphasis on well-being, amplification of prevention and early intervention, significant expansion of access to a wider range of treatment and support options, greater service user and community involvement in planning and service delivery, and cross-government action.

Among the 40 recommendations are:

- Expanding access to publicly-funded services
- Establishing a commission on mental health and well-being
- Setting a target to reduce suicide rates by 20% by 2030, and
- Removing criminal sanctions on the possession of drugs for personal use.

The report calls for a whole-of-government approach to tackle social and economic determinants, and promote prevention. Major changes are called for in approaches to alcohol and other drug, and suicide

[20] Minkoff, K. Developing standards of care for individuals with cooccurring psychiatric and substance use disorders. Psychiatric Services 52:597–599, 2001.

[21] New Zealand Government Inquiry into Mental Health and Addiction (2019)

[22] New Zealand Government. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (2019).*

prevention. Recommendations here include strong measures to reduce alcohol-related harm and a substantial increase in detox and treatment services.

The New Zealand Government has accepted all the recommendations in the report. VAADA considers that the NZ example can provide useful guidance to Victoria as we consider how best to respond to co-occurring alcohol and other drug, and mental health needs.

6 METHODOLOGY

A Mental Health Royal Commission Steering Group coordinated development of VAADA's submission. This group comprised mental health and alcohol and other drug subject matter experts with long histories and significant experience in the management and response to co-occurring issues. The focus of this group was on supporting and strengthening the submission by:

- Clarifying the submission scope and consultation questions
- Identifying key experts and informants to interview
- Reviewing the submission prior to lodgement.

Development of the submission occurred through:

- A review of population health frameworks and approaches to improving peoples' mental health (*see above)*
- A review of current prevalence data in key settings (*see above*)
- Commissioning the University of Melbourne School of Population and Global Health to write a report *'Inequalities and inequities experienced by people with mental health and substance use issues involved in the criminal justice system'* This report has been submitted separately
- Consultations with the alcohol and other drug sector to identify key themes and recommendations. There were 321 participant responses to VAADA consultations, including:
    - 254 sector survey participants in an online Alcohol and Other Drug sector survey
    - 54 focus group participants
    - 13 key informant interviews.

6.1 Sector consultation

In total, VAADA completed consultations with a diverse set of 321 alcohol and other drug (and other) stakeholders to support this submission. The purpose of the consultation was to gain an insight from the Victorian alcohol and other drug sector as to specific issues important to them, and identified solutions.

Information under the titles: *What works*; *Challenges*; and *RECOMMENDATIONS* are the result of responses provided by the sector through the consultations, they don't claim to representative of all sector perspectives.

In line with the Royal Commission terms of reference, the key question asked of the alcohol and other drug sector in consultations was:

> ***How can alcohol and other drug and mental health services and systems provide more coordinated and effective services to people presenting with co-occurring needs?***

A supplementary area of enquiry was to review the additional impact of involvement in the criminal justice system for people with co-occurring mental health and alcohol and other drug problems. Evidence addressing this question has been submitted separately. Please see - *Inequalities and inequities experienced by people with mental health and substance use issues involved in the criminal justice system*.

Services providing a range of support and treatment types, offering services in acute and community settings, and in both metropolitan and rural/regional areas were consulted. Services engaging distinct populations were also consulted. Some people from the mental health sector, or who work across both sectors were also included.

A total of 254 people responded to the Alcohol and Other Drug Sector Survey. Nearly all survey participants were direct service staff (97%) and most worked in community based settings (85%). Peer worker responses were over represented compared to their percentage total of the workforce. Most survey participants had considerable experience working in the alcohol and other drug sector.

A total of 54 people participated in focus group discussions. Focus group participants typically came from management and service development roles, and had more than 10 years' experience in the alcohol and other drug sector. Many also had experience working across other community and health sectors and settings. One focus consulted with people who had a lived experience of using both alcohol and other drug, and mental health services.

Thirteen people participated in key informant interviews. These people were chosen based on specialist roles and/or experience related to working across both alcohol and other drug, mental health, or correctional services and systems.

The primary role for key informants interviewed was:

- CEO or executive management roles (8)
- Principle practitioner or psychiatrist roles (5).

Key informants also held supplementary roles in research, service development and advocacy, and worked across a wide range of geographic settings, service types and specific populations.

The findings of these consultations are outlined in the sections below which cover both *Systems Integration* and *Operational Integration* considerations.

7 FINDINGS: SYSTEMS INTEGRATION

7.1 Summary

VAADA believes that population health strategies which recognise the close intersection between mental health problems and the broader social, economic and environmental conditions in which people live is fundamental to creating systems which support people with mental health (and other) problems.

Our consultations suggested there are barriers within our Victorian alcohol and other drug, and mental health systems which reduce the capacity to provide these population health responses. Participants also suggested this reduces capacity to work in an integrated and coordinated manner, build workforce capacity, and provide accessible and understandable services to the people that use them.

A range of funding challenges emerged; however it was acknowledged that the mental health, and alcohol and other drug systems have a strong structural base and improvements to funding could be achieved by extending, enhancing and re-redeploying resources, and through a continued focus on flexible, person centred funding. A greater focus on funding outcomes was also supported.

Consultation participants believed that we should use research and data to inform more of our service design planning, that data wasn't consistently shared, and that a continued focus on more outcomes based data collection was required.

It was suggested that better resourced local networks which included the full array of health and human services would help plan and better coordinate services to people with complex needs. They would underline important population health principles which recognise the close intersection between individual health and conditions in which people live.

The need to strategically prepare for future needs was highlighted. The alcohol and other drug sector suggested a workforce development strategy was necessary, and this must be considered in tandem with broader whole of community services workforce development considerations.

Finally, it was considered important to find ways to better include people with a lived experience of mental health and substance use problems in decision making about how our systems are designed.

Good practice example – Strategic inter sector partnerships

One regional service has developed strategic planning and partnership activities to support more coordinated and comprehensive service responses to people using alcohol and other drug services, including people with co-occurring mental health, and alcohol and other drug needs.

As lead agency for a consortia comprising district health services, a youth and family service, and the local primary health network they created a partnership aimed at improved catchment based planning and improved pathways navigation and service delivery.

To support more integrated systems and services they have co-located alcohol and other drug, mental health, medical, psychiatric and peer support staff together in one location. They have also invested in 'no wrong door' partnering arrangements with a broad suite of other community and health services including housing, Aboriginal, youth, community health, and family violence services.

Benefits of these strategic partnerships have included building shared practice frameworks, more effective planning, better cross sector service coordination, and joint education opportunities.

7.2 Frameworks

7.2.1 Key Findings

Consultations suggested that the alcohol and other drug, and mental health sectors retain distinct values and frameworks. This can result in different conceptual and practice models, language, and hoped for outcomes. However, participants also said that both sectors bring important and needed qualities to the care of vulnerable people and consolidating sectors would result in the loss of important qualities and practices, this is strongly discouraged.

The alcohol and other drug system is grounded in relationship based practice that prioritises reducing harm and the subjective experience of service users framed by social health models. This includes recognising that drug use is not necessarily related to psychological problems. For example it may be associated with normal developmental trajectories where young people seek to experiment with new identities and experiences.

The mental health system has evolved from medical models, and while increasingly focused on population health approaches and the important prism person centred practice brings, continue to prioritise diagnostic categorisations to make treatment decisions.

> *"Services needs to be OK with the fact I will continue to cycle through my problems, it's not about recovery for me. I don't need to be cured, I need people to accept me the way I am, and help me when I need it"*[23]

7.2.2 What works

- **The different values and approaches used across the two sectors** bring unique and important qualities to the care and support of people. The relational approaches espoused by alcohol and other drug services facilitate access and the development of trust and rapport. Mental health services have skills in the categorisation of specific problems in order to provide targeted care
- **Agreements about common principles and approaches,** for example social inclusion, service continuity, person centred practice and trauma informed care.

7.2.3 Challenges

- Each sector can have different outcome goals. For example '*cure*' is typically prioritised in mental health services and '*harm minimisation'* in alcohol and other drug settings.

7.2.4 RECOMMENDATIONS

There are a range of touchpoints and areas of overlap between the alcohol and other drug and mental health sectors, specifically where models of integrated practice can be agreed upon, and implemented to facilitate better person-centred care and a consistent approach to service provision. VAADA suggests developing an overarching joint Victorian alcohol and other drug and mental health services framework to guide the respective sectors in relation to how this can be achieved, and also to obtain a joint approach in relation to other issues identified such as language and breaking down stigma.

[23] Focus group participant (2019).

Developing accompanying protocols and practice guidelines are also important to ensure that the principles of the framework are translated into practice, together with the provision of training opportunities and protocols.

Recommendation 01:

Develop an overarching joint Victorian alcohol and other drug and mental health framework that creates a vision for managing co-occurring issues, and offers clarification on the points of overlap, intersection, and the areas of specialisation. Corresponding protocols, practice guidelines and training opportunities should be implemented to translate the framework to clinical practice.

7.3 Funding

7.3.1 Summary

VAADA consultations identified structural funding considerations which may impact on the capacity of alcohol and other drug, and mental health systems to work effectively together. These included a lack of mental health, and alcohol and other drug funding coordination, the weighting of funding to different points of the service continuum, recent changes to a more individualised funding approaches, and funding focused on outputs, not outcomes.

Previous alcohol and other drug reform activities were seen as a lost opportunity to better align and resource the mental health and alcohol and other drug sectors, and ensure they also had strong connections to broader social and community services like housing and other social services. The need to move more funding upstream to prevention and early intervention activities was also supported.

Furthermore, participants were concerned that significant funding to law enforcement and correctional services failed to provide positive health or economic benefits, with suggestions some of this money should be reinvested in therapeutic treatment.

It was suggested the move to more person centred funding in some areas (e.g. National Disability Insurance Scheme, primary health networks) while supported in principle had also left gaps for people who were previously able to access block funded programs due to inflexible eligibility criteria (e.g. that they must be suffering a permanent disability). Funding to further progress outcomes models was also recognised as a priority.

Nonetheless the alcohol and other drug sector broadly felt that a strong structural funding base was in place and much could be achieved by extensions to funding, rather than making significant changes. Examples included funding specialist mental health expertise in alcohol and other drug settings to support people who did not meet symptom threshold for mental health services, and building the capacity of psychiatric inpatient and emergency medicine services to better manage substance use problems by employing alcohol and other drug workers in these settings.

7.3.2 What works

- **Primary Health Networks have created some more flexible, location specific and person centred funding** to meet a wider range of immediate and specific needs. For example funding a social worker to work in an emergency department so that people presenting with substance use problems are effectively referred to alcohol and other drug services.

7.3.3 Challenges

- **Funding is often narrowly focused** in one area and lacks flexibility to provide the holistic responses we require using a population health approach
- **Alcohol and other drug, and mental health services re-commissioning occurred separately and did not consider more coordinated funding.** It was suggested the historic opportunity to better align these two systems was an opportunity lost. A function of this was failing to address the funding shortfalls and system design issues inherent across both sectors, as well connections to other key required services like housing and the criminal justice system
- **Funding is not weighted equally across the service continuum.** It is clear that significantly more funding is provided to acute, rather than prevention and early intervention streams and respondents would like to see this re-balanced.

- **Areas which show no return on investment continue to be funded.** There was frustration with the continued investment in prisons which costs the community money, and does not reduce crime or rehabilitate prisoners
- **The move to individualised funding** through the National Disability Insurance Scheme has resulted in some vulnerable people missing out on services. Participants noted that some people previously accessing block funded services are unable to access National Disability Insurance Scheme services, leaving a gap
- **We are still funding services based on outputs, not outcomes**
- **Alcohol and other drug services are not sufficiently funded to support people with obvious mental health symptoms** although this group are regularly unable to access mental health services**.**

7.3.4 RECOMMENDATIONS

More flexible funding could be used to create better integrated and coordinated responses which focus attention around the service user, not the service system. Currently alcohol and other drug providers are funded solely by prescribed treatment types (e.g. counselling) utilising drug treatment activity units, and these do not necessarily meet client needs. For example, a person with a co-occurring alcohol and other drug and mental health issues might also have an acquired brain injury which makes it difficult to travel to appointments. This person would benefit from outreach, but this is not a funded activity. Current funding systems do not promote outcomes and practices that clients need. More flexible funding would allow for flexible support provision to effectively meet unique presenting needs.

Recommendation 02:

Provide more flexible funding to meet individual needs

We have strong foundations and systems on which to build. Providing strategic enhancements and extensions to services which better meet the needs of people with co-occurring needs is a cost effective way to improve services. Examples might include funding mental health specialists in alcohol and other drug settings, especially residential settings to support people who do not reach symptom threshold for mental health services.

Furthermore, it was suggested that locating more alcohol and other drug specialists in psychiatric inpatient and emergency department settings may assist in providing more integrated care given the high presentation rates of people with substance use issues in these settings. The Emergency Department Clinical Liaison Addition Network model, while well intentioned is under-resourced. For example, within the hospital environment, a range of issues exists with the integration of mental health and alcohol and other drug services for clients entering emergency departments. This relates to both nursing and medical intervention as well as acute step-up capacity, and the subsequent step-down into community capacity to ensure that clients do not simply re-appear shortly after exit.

Recommendation 03:

Provide strategic enhancements and extensions to existing systems to better meet the co-occurring needs of people accessing them

Population health approaches focus on community responses which prevent problems before they occur, or intervene early to stop their progression. However our mental health system often excludes all but the most acute and serious cases of mental illness. Funding is also heavily weighted to treatment services. Re-deploying funding upstream to prevention and earlier intervention activities is likely to reduce later acute healthcare costs.

Similarly there are significant costs to keeping someone in prison, yet prisons have a poor record of improving health or reducing recidivism, this results in significant health and economic costs to the community. Re-directing funding from prisons to more therapeutic residential environments may improve individual health and reduce community costs.

Recommendation 04:

Explore reinvestment opportunities that focus on evidence-based prevention and earlier interventions

The development of frameworks and funding models which reward strong outcomes for service users would incentivize service providers to focus more on this, and possibly to better coordinate care given the well-recognised need to address multiple problems together in order to achieve sustained and successful change. Importantly, outcomes frameworks need to reflect the needs and expectations of services users, first and foremost.

Developing outcomes frameworks will help us establish systems and services which improve mental health, reduce substance use, and provide value for money. Frameworks developed should be cross sectorial in recognition that factors influencing health are multi-factorial. Close attention should be paid to the burden of disease created through the criminal justice system and the economic costs of this.

Recommendation 05:

Design and develop outcomes based frameworks, measurement and funding models

The 2014 reform for the alcohol and other drug, and mental health sectors in Victoria caused a disruption to services and a reduction in people accessing alcohol and other drug services following implementation. Service providers implementing recommendations flowing from the Royal Commission into Family Violence have also reported a lack of strategic coordination. Any recommendations which give rise to significant structural changes must be carefully considered and appropriately funded to reduce impact on workforces and the people using these services. Where system changes are of significant breadth and depth, careful consideration needs to be given strategically planned and well-resourced implementation.

Recommendation 06:

Provide sufficient resources for service systems to manage implementation of Royal Commission recommendations

7.4 Research and data

7.4.1 Summary

VAADA consultations with the Victorian alcohol and other drug sector suggest government funding, system architecture and service provision decisions are not based on effective use of research or data.

While pockets of effective use and data sharing were reported in some local areas, these are typically self-resourced. There have also been attempts to better consolidate available data and create data collection and retrieval systems that can be used across services.

Participants suggested that while alcohol and other drug service providers are expected to collect and report on a range of output measures, this data is not routinely shared or used to help inform planning decisions, and some sectors appear to retain a culture of data secrecy.

Alcohol and other drug services remain unclear on the value of data collection while it is not routinely shared, raising scepticism that data systems are developed more for the purposes of performance management than the development of more evidence based services.

Some participants are concerned that outcome measures and frameworks for many activities are still lacking.

7.4.2 What works

- **Local partnerships which self-resource coordinated local area planning** activities using their own data and catchment based information provided by primary health networks
- **AODstats[24] provides information on the harms related to alcohol, illicit and pharmaceutical drug use in Victoria.** This information provides a convenient statistical and epidemiological resource for policy planners, drug service providers, health professionals and other key stakeholders
- **The Victorian Drug Court has created a shared database** used by police, alcohol and other drug, mental health, legal aid, family violence and other services to provide coordinated care to people using these services.

7.4.3 Challenges

- **Sectors and services often have a reluctance to share their data** and some areas retain a culture of data secrecy
- **Government departments rarely share consolidated data**, alcohol and other drug (and other sector) service providers report frustration at being unable to access data sets they contribute to
- **The health and community workforce remain unclear about why they need to collect data** when it is not routinely shared or used to inform future planning decisions
- **Outcomes remain unclear for many services and programs**; clear monitoring and evaluation frameworks are not in place.

[24] Turning Point. AODstats

7.4.4 RECOMMENDATIONS

Data collection systems are required which collect a range of relevant data including service user outcomes and which can be shared across sectors given the need for a population health response to people with complex needs. This must include the criminal justice system given the clear intersection between mental health, alcohol and drugs, and engagement with correctional services. We need to use data better to plan services, which are effective, efficient and good value for money.

Recommendation 07:

Design, fund and implement suitable data collection systems in the alcohol and other drug, and mental health sectors. Ensure that other relevant data collections can be accessed, and are regularly assessed for the purpose of program and service design

Recommendation 08:

Use research and data to inform service design decisions

7.5 Networks

7.5.1 Summary

VAADA consultations suggest there has not been sufficient focus on either strategic or operational networks as a way to provide more coordinated care. While platitudes related to '*working together*' are well documented, leadership modelling and resources have not demonstrated this in practice.

The *Victorian Dual Diagnosis Initiative* and some catchment based networks were acknowledged as helpful in building more consistent cross sector understandings and practice, with individual examples of well-coordinated strategic and operational networks operating, and with tools and processes available to support this.

However, broadly speaking alcohol and other drug, and mental health services do not appear to have well developed coordination processes in place to share data, strategically plan for services or workforce needs, or evaluate the effectiveness of their joint service provision.

7.5.2 What works

- **The *Victorian Dual Diagnosis Initiative*** has supported the development of more collaborative alcohol and other drug, and mental health service relationships. This has occurred through more integrated treatment practices and cross sector capacity building activities. These services operate in four metropolitan and six rural/regional areas across the state
- **One regional alcohol and other drug service leads a consortia that has developed strategic planning and partnership activities** to support more integrated and comprehensive service responses to people using alcohol and other drug services, including people with co-occurring mental health needs
- **One metropolitan alliance oversees the development of an integrated multi sector service coordination framework** for people with mental health and co-occurring problems, and their families and carers:
    - Twenty-five services have signed a Memorandum of Understanding in order to provide more seamless and integrated responses across alcohol and other drug, mental health, psychiatric disability, housing, family violence, youth, Aboriginal, culturally and linguistically diverse and other specialist services who need to work together to meet the needs of people using their services
    - Services have developed multiple collaborative: strategic – '*direct and authorise*', integration – '*align and allocate resources*' and operational – '*connect with service users*' networks to better coordinate local activities[25,26]
    - Navigation tools have been developed to assist services in cross sector referrals. It is hoped that shared assessment and care planning tools improve practice consistency, making it easier for people receiving services to navigate through the system and understand the care being provided to them
- **The *Using Collaborations as a Capacity Building Tool*[27] is a resource to enhance coordination and collaboration** (and build workforce capacity) to better manage co-occurring mental health and alcohol and other drug needs without the need for significant financial investment. It outlines

[25] Eastern PHN Drug Treatment (updated) Activity Workplan 2016-2019.
[26] Eastern Mental Health Service Coordination Alliance.
[27] VAADA. Using Collaborations as a Capacity Building Tool (2018).

strategies to help alcohol and other drug, and mental health services build capacity by developing enhanced networks and collaboration opportunities

- **The *Dual Diagnosis Consumer Advisory Council*** was created to provide input into strategic leadership groups across the Eastern region, providing insights into how mental health, and alcohol and other drug services can better meet the needs of people experiencing both problems. Initiation of the Dual Diagnosis Consumer Advisory Council was supported by position descriptions for council members, guidelines to support consumers and carers, orientation processes, and a formal job interview process. Terms of Reference[28] have been developed which cover both Dual Diagnosis Consumer Advisory Council and the Dual Diagnosis Working Group. More recently (2018) the Victorian Dual Diagnosis Leadership Group have attended the Dual Diagnosis Consumer Advisory Council meetings to encourage greater consumer and carer participation at the state wide level.

7.5.3 Challenges

- **Resources are lacking** to facilitate shared cross sector working together strategies
- **Data is not readily available** to assist local network planning activities
- **It is difficult to coordinate the wide range of government departments, sectors and specialists required** to participate in both strategic and operational networks.

7.5.4 RECOMMENDATIONS

A population health approach requires a joined up human services system that is coordinating a wide array of services across the prevention to rehabilitation continuum, and using local area data to provide specific responses to unique local needs. This requires strong communication between all parts of the service system and must be adequately resourced in order to be effective.

The broadest possible range of stakeholders should participate in these networks and the *Victorian Dual Diagnosis Initiative* should be a central participant to provide advice and direction in relation to people with co-occurring mental health, and alcohol and other drug needs.

These networks should be directed to share data, complete joint planning activities, develop enforceable protocols for working together, and build 'no wrong door' practices.

Recommendation 09:

Resource networking and coordination activities between all human services in local areas

[28] Turning Point. (2014). Dual Diagnosis Working Group and Dual Diagnosis Consumer Advisory Council Terms of Reference.

7.6 Workforce development

7.6.1 Summary

VAADA consultation findings and broader human services workforce data[29] suggest the educational and experience backgrounds of the alcohol and other drug, and mental health workforces are distinct.

Most of the mental health workforce have completed university education in a given speciality, providing a high level theoretical orientation to their practice prior to initiating their direct work experience.

While significant sections of the alcohol and other drug workforce are also university educated this is more often complemented by vocationally based training and direct on the ground experience. Different minimum qualifications result in significantly lower remuneration for people working in the alcohol and other drug sector.

Workforce development considerations emerging through our consultations included providing incentives to complete the *Certificate IV in alcohol and other drug and mental health* as a minimum level qualification. There is also a desire to incorporate more mental health content in the *Certificate IV in alcohol and other drug,* and include more alcohol and other drug content in mental health education programs. Consultations highlighted concerns about alcohol and other drug literacy and referral pathways in the mental health, primary care, emergency medicine and criminal justice workforces.

Overall our consultations suggest there has been a void in relation to workforce strategic planning, education and training for the alcohol and other drug sector. There has been limited consideration or discussion of issues such as workforce registration, accreditation or a committed investment in alcohol and other drug workforce development other than recent activity in the forensics area and some investment in nurse training. We believe strategic consideration should be given to educational qualifications, attainment and the staffing profiles within both alcohol and other drug, and mental health services.

7.6.2 What works

- **Resources for supporting both alcohol and other drug, and mental health workforces** to build their capacity to work with people who have co-occurring needs:
    - **New Zealand has developed a website and set of resources** supporting organisations to develop their workforce.[30] A range of workforce development tools acknowledging that alcohol and other drug, and mental health problems come together have been developed
    - **Ziapartners.com[31] provides resources to support workforce development** for more coordinated services to people who have complex health needs, including co-occurring mental health and alcohol and other drug needs
- **Integrated mental health, and alcohol and other drug practice development through the Victorian Dual Diagnosis Initiative** was highlighted as helpful during consultations. Participants suggested that opportunities to undertake joint training activities assisted understanding the perspective of mental health services.

[29] State Government Victoria (2018). Victoria's Alcohol and Other Drugs Workforce Strategy 2018-2022.
[30] Te Pou o te Whakarro Nui – Supporting organisations to develop their workforce
[31] Ziapartners.com

> *"There are a wide range of opportunities for the two systems to coordinate care including…. Shared case planning and reviews, combined supervision, registrar programs with addiction medicine and psychiatry. Increased working together with consultation and liaison."*[32]

7.6.3 Challenges

- **The growth in all community services leading to workforce shortages** and challenges. There is a need to consider the workforce needs of all alcohol and other drug and human services sectors that require an uplift in mental health capacity to respond to presenting needs
- **The 2018 Alcohol and Other Drug Workforce Strategy** does not go far enough to supporting and building the alcohol and other drug workforce of the future
- **There is insufficient alcohol and other drug workforce development funding,** this needs to be increased significantly in line with that currently spent on the mental health sector
- **There is poor alcohol and other drug literacy in the mental health, emergency medicine, primary care and criminal justice system workforces.** These workforces do not effectively screen for alcohol and other drug problems and continue refusing services to people are still using drugs despite clear evidence that both problems are best treated together. Mental health, emergency medicine, and criminal justice services are not clear on available referral pathways or the services available in the alcohol and other drug sector:

  > *"Better training for mental health clinicians in assessing and treating alcohol and other drug issues - often the drug problem could be treated by mental health rather than having two separate services involved. Dual diagnosis training seems to be almost exclusively completed by alcohol and other drug clinicians."* [33]

  > *"Staff training in both alcohol and other drug, and mental health. There appears to be significant lack of understanding of alcohol and other drug issues amongst mental health clinicians and case managers."* [34]

- **A lack of shared training** between alcohol and other drug and mental health services reduces capacity of the two systems to work effectively together, this has in part been re-dressed by the *Victorian Dual Diagnosis Initiative*
- **There is insufficient training on stigma and discrimination,** and the impact this has on access to healthcare services. A very strong finding from our consultations was that people using services report feeling judged and discriminated against for their alcohol and other drug use (and other choices and identities) by mental health, emergency medicine and primary care services.

7.6.4 RECOMMENDATIONS

There is a need to develop comprehensive workforce development and retention strategies across all health and human services. Demand for these services is increasing as our population ages and becomes more disabled. This should include consideration of both the generalist and specialist capacities required in each sub-sector.

Recommendation 10:

Create workforce development strategies to effectively attract, educate and retain a high quality AOD, health and human services workforce for the future

[32] Alcohol and Other Drug Sector Survey participant (June, 2019).
[33] Alcohol and Other Drug Sector Survey participant (June, 2019).
[34] Alcohol and Other Drug Sector Survey participant (June, 2019).

The existing alcohol and other drug workforce strategy does not meet the needs of the alcohol and other drug sector, in particular to manage complex and co-occurring issues such as alcohol and other drug and mental health. The alcohol and other drug sector needs a focused workforce development strategy to ensure it has a workforce ready for future needs. This should include specific capacities related to supporting people with co-occurring needs and providing integrated care.

We need to resource and research alcohol and other drug workforce competencies and capacity in order to map and plan future needs, including workforce composition and qualifications, and retention strategies

Recommendation 11:

Review and revise the 2018 Alcohol and other Drugs Workforce Strategy

Creating opportunities for joint training and relationship building across sectors is important to improve the coordination of services to people accessing multiple health services. Training activities which can bring different sectors together to build shared understandings and agreements about the best way to integrate care and communicate effectively are important. The Victorian Dual Diagnosis Initiative has experience in this area and may be one resource that could facilitate this further.

Recommendation 12:

Explore the benefits and value of expanding funding to the *Victorian Dual Diagnosis Initiative* for workforce development activities. Create incentives for participation, especially for the mental health, primary care and emergency medicine workforces

Additional alcohol and other drug, and mental health workforce opportunities to build relationships and shared understandings of good dual diagnosis practice are important in facilitating better care. This could occur through initiatives such as cross sector secondments and supervision activities, and joint reflective practice using online technologies. Resources such as the *Using Collaboration as a Capacity Building Tool*[35] may also assist in building cross sector workforce capacity to meet the needs of people with co-occurring needs. Events which highlight good coordinated alcohol and other drug, and mental health activities are also indicated as a way to build relationships and consistent understanding of effective practices.

Recommendation 13:

Fund innovative workforce capacity building initiatives between alcohol and other drug, and mental health services

[35] VAADA. Using Collaborations as a Capacity Building Tool (2018)

7.7 Including people with lived experience in service design

7.7.1 Summary

Our consultations indicated we have not included people with a lived experience of alcohol and other drug problems, (or their supports) sufficiently in designing services. While involving people with a lived experience of mental health problems in service design has a longer history, it was recognised that much more needed to be done in order to create truly person centred service delivery.

Effective co-design strategies are still emerging, a range of ideas and approaches are currently being tested. The Victorian alcohol and other drug, and mental health systems can draw on international, interstate and local approaches in considering how to better include people with a lived experience of alcohol and other drug, and mental health problems in service design activities.

It should be highlighted this section only discusses participation and engagement of people with a lived experience in service design activities. Engaging people for the purpose of their own care planning is discussed throughout the *Operational Integration* section of this submission.

7.7.2 What works

- **The Dual Diagnosis Consumer Advisory Council** was created to provide input into strategic leadership groups across the Eastern region, providing insights into how mental health and alcohol and other drug services can better meet the needs of people experiencing both problems. Initiation of the Dual Diagnosis Consumer Advisory Council was supported by position descriptions, guidelines to support consumers and carers, orientation processes, and a formal job interview process to identify members and remuneration for attendance.
- **The Association of Participating Service Users** has been created to allow people who use alcohol and other drug services to contribute to policy, research, and service and workforce development
- **The Western Australian Government developed -** *Working Together: Mental Health and Alcohol and Other Drug Engagement Framework (2018-2025)*[36]. This co-designed framework outlines guiding principles and strategies to encourage best practice in engagement, with the goal of working together to achieve better outcomes for people whose lives are affected by mental health issues and/or alcohol and other drug use
- **The Queensland Mental Health Commission** is currently trialling the *Stretch2Engage Framework*[37] in seven alcohol and other drug, and mental health sites across Brisbane and Toowoomba, it places the onus on organisations to engage with people and provides seven value domains to help guide developments
- **Aboriginal Community Controlled Organisations** have been initiated, and are controlled by Aboriginal people, and acknowledge their right to self-determination. Aboriginal Community Controlled Organisations are experienced in participatory approaches to needs identification, planning and implementation of activities in close collaboration with the communities they serve
- **IAP2 - The International Association for Public Participation.**[38] IAP2 seeks to promote and improve the practice of public participation, and community and stakeholder engagement. They

[36]Western Australian Government. Working Together: Mental Health and Alcohol and Other Drug Engagement Framework (2018-2025)

[37] Queensland Mental Health Commission. Stretch2Engage Framework (2018)

[38] The International Association for Public Participation

have a framework which describes a continuum of participation that includes informing; consulting; involving; collaborating; and empowering.

7.7.3 Challenges

- **The culture change required to hand over more power and control in service design decisions** to people with a lived experience
- **Including people who are yet to use services** or have negative experiences and don't return in service design. We need to identify creative ways of connecting with and receiving feedback from people who do not or cannot currently access and use services as well as people who do successfully use services.

7.7.4 RECOMMENDATIONS

Engagement frameworks that include both mental health, and alcohol and other drug services are currently being tested in Western Australia and Queensland. There is a need to build similar capacity in Victoria. Creating principles, and trialling processes and practices to improve engagement of people with a lived experience in service design activities is fundamental to creating more person centred service delivery. We need to build an understanding that the onus for service engagement sits with organisations, not the people who use services. The cornerstone is to ensure that people with a lived experience are engaged in an ongoing and meaningful way to ensure services better meet the client's needs.

Recommendation 14:

Develop a co-design framework to build organisational and sector capacity for engagement of people with a lived experience of alcohol and other drug, and mental health problems. Test the developed framework in both alcohol and other drug, and mental health services

8 FINDINGS: OPERATIONAL COORDINATION

8.1 Summary

Our consultations with the alcohol and other drug sector identified strong support for drug policy reform in Victoria. Commentary from sector representatives clearly supported alternatives to criminal prosecution, with the criminalisation of drug use and possession seen to be compounding harms to people who are fundamentally dealing with a health issue. Generally speaking, the comments from the sector are reflected and supported by those made in the report by the Victorian Law Reform, Road and Community Safety Committee *'Inquiry into drug law reform'* (2018):

> *"A reorientation to a health-based framework does not suggest going soft on crime but rather emphasises that responses to illicit drug use should focus on trafficking and punishment of criminal behaviour arising from use, while people apprehended solely for use and personal possession be directed to a range of treatment and support options, where necessary."*[39]

Service gaps for people experiencing co-occurring alcohol and other drug, and mental health problems were acknowledged. Alcohol and other drug services believe this contributes to additional healthcare costs because service users find service access and navigation difficult, meaning they often fail to receive the right services at the right time.

Participants said alcohol and other drug system reform to intake and assessment has created frustrations for service users and service providers, and high thresholds for access to mental health services meant people with clear mental health needs cannot get the support they need.

While the alcohol and other drug sector understands the demand pressures on mental health services, they are frustrated that they cannot access mental health services for their clients, and are often required to carry significant risk in their services without appropriate specialist mental health resources.

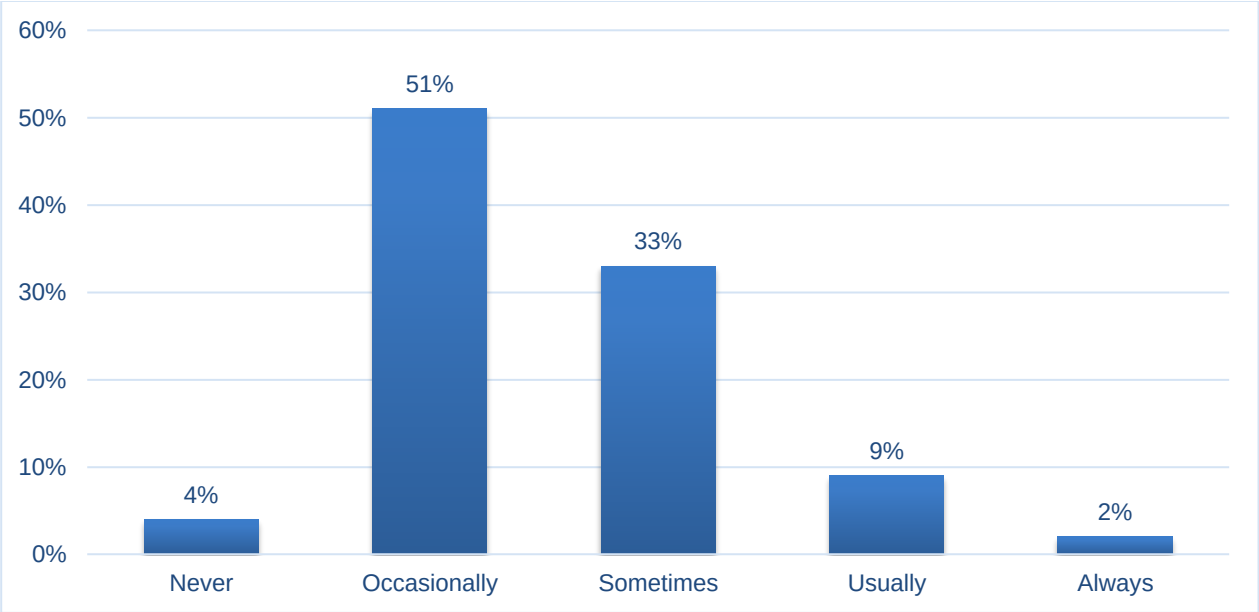
Participants were also concerned that about the lack of coordination between alcohol and other drug, mental health (and other community services), and corrections services which participants believed was contributing to poor health outcomes and increased recidivism. They highlighted the importance of support to facilitate recovery as people return to the community from residential, hospital and prison settings.

More specifically in relation to the alcohol and other drug and mental health systems figure 2 (below) shows service provider beliefs about how coordinated they think care is to people presenting with co-occurring alcohol and other drug, and mental health needs.

[39] Victorian Law Reform, Road and Community Safety Committee *'Inquiry into drug law reform'* (2018)

FIGURE 2 –ALCOHOL AND OTHER DRUG SECTOR SURVEY

I BELIEVE THE ALCOHOL AND OTHER DRUG, AND MENTAL HEALTH SYSTEMS WORK WELL TOGETHER (N=181)



While 84% of alcohol and other drug service providers believe mental health, and alcohol and other drug services '*occasionally*' or '*sometimes*' work well together, only 14% of alcohol and other drug service providers believe they '*usually*' or '*always*' work well together.

8.2 Prevention and early intervention

8.2.1 Summary

Evidence demonstrates that up to 75% of all mental health conditions emerge prior to the age of 25[40], a focus on prevention and early intervention may reduce the length and severity of mental health problems. Secondary prevention and early intervention activities are vital to reducing harm related to alcohol and other drug use, and mental health problems. Our alcohol and other drug sector consultations suggested that secondary prevention activities may decrease healthcare costs by supporting positive mental and physical health, and reducing drug use, overdose and virus transmission. Peer workers were seen to be valuable in providing education services as messages were thought to be taken up more readily when shared by someone with a lived experience. Providing education and information in settings preferred by people using drugs (e.g. festivals, nightclubs) was also recognised as valuable.

Consultation participants highlighted the additional harms being caused by engagement with correctional services and the growth in prisons. They felt this compounded existing mental health and alcohol and other drug problems, rather than working to resolve them. Participants suggested activities which prevented progression to criminal justice involvement would provide significant health and economic benefits. Diversion activities which were more trauma informed were considered likely to produce better individual and community outcomes, as was re-deploying punitive funding toward more therapeutic approaches.

8.2.2 What works

- **Re-orienting the focus of drug laws away from criminal behaviour and penalties toward a health focused approach**
- **Diverting people and resources away from the criminal justice system** and resourcing therapeutic care to manage underlying needs
- **Peer educators working with specific sub groups** (e.g. young people; LGBTI people; people using drugs) in settings these groups feel comfortable. This is thought to improve uptake of education messages compared to provision of messages in clinical health settings:
    - *DanceWize* is a program that utilises a peer education model to reduce drug and alcohol related harm at Victorian dance parties, festivals, nightclubs and events
    - *The DOPE project* educates approximately 250 current drug users every year through peer education workshops. These workshops are held in settings people who inject drugs frequent
- **Youth early intervention programs** which engage young people with identified mental health and alcohol and other drug risks.

8.2.3 Challenges

- **The growth of prisons** and the increasing number of people with mental health and/or alcohol and other drug problems who are caught in the criminal justice system. Engagement with the criminal justice system is seen to increase rather than reduces harms and costs

[40] Kessler, RD et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62: p. 593-602.

- **Stigmatising and discriminatory behaviour by health professionals which reduces access to services.** This is particularly the case for young people, people using drugs, people with alternative sexual and gender orientations, and people from culturally diverse backgrounds. Our consultations suggested that discriminatory responses are most often reported in primary care and emergency medicine settings
- **Young people with problem behaviours are excluded** from schools and other education settings, it was suggested that exclusion from important social connections and institutions typically exacerbates problems and increases later health costs.

8.2.4 RECOMMENDATIONS

VAADA supports the recommendations that were outlined in the Victorian Law Reform, Road and Community Safety Committee *'Inquiry into drug law reform'* (2018), in particular Recommendations 13:

'The Victorian Government, while maintaining all current drug offences in law, treat the offences of personal use and possession for all illicit substances as a health issue rather than a criminal justice issue. This approach will ensure appropriate pathways are in place for the referral of people to health and treatment services in a timely manner where required. Mechanisms to achieve this should include:

- *exploring alternative models for the treatment of these offences, such as the Portuguese model of reform*
- *removing the discretion involved with current Victoria Police drug diversion processes by codifying them Inquiry into drug law reform xxv Executive summary*
- *reviewing all threshold amounts for drug quantities in order to appropriately distinguish between drug traffickers and people who possess illicit substances for personal use only*
- *conducting education and awareness programs to communicate with the public about the need to treat drug use as a health issue.'*

VAADA maintains that by treating drug use as a health issue and by setting up appropriate referral systems and pathways more people will access alcohol and other drug and mental health services.

Recommendation 15:

Adopt the recommendations from the Drug Law Reform *'Inquiry into drug law reform'* (2018)

Programs providing information and advice to people using drugs in settings they frequent and feel comfortable were reported to increase uptake of information and improve links to health and support services. This can reduce harms related to substance use, especially injecting behaviour, as well as related sexual and other risk behaviours.

Recommendation 16:

Fund peer outreach workers to support people with co-occurring alcohol and other drug and mental health issues to reduce harm and engage in treatment

A strong finding through our alcohol and other drug sector consultations was the role stigma and discrimination continues to play in reducing access to health services. Our findings suggest that people who use drugs are often judged and criticised when seeking help. This was especially true in primary and emergency medicine settings. We recommend continued provision of stigma and discrimination training across settings like schools, community and sporting clubs, and the entire health and human services system.

Recommendation 17:

Implement stigma and discrimination programs in universal prevention settings and across all health and human services

> *"I have worked in private and public mental health, dual diagnosis and now drug and alcohol. I have never seen such stigma, marginalization and lack of support until I started working in alcohol and other drugs. I believe one of the biggest issues is mental health services refusing to support clients who use alcohol and other drugs. They often tell us " they need to stop their use" "it's all alcohol and other drugs " "they are just junkies". I have personally heard these words when calling psych triage for suicidal clients or trying to bring clients into hospital for help. I have seen our clients get discharged the same day without any support due to their alcohol and other drug use. They are refused hospital admission as hospitals "do not support withdrawal". Mental health services in the community refuse care to clients due to their alcohol and other drug use and alcohol and other drug workers are left holding and extraordinary complexity without anyone to turn to for help. There is no respect by mental health sector for dual diagnosis. Mental health DOES NOT practice within the "open door" model. Discharge summaries are not passed on, care planning is not engaged in. The sectors are completely disconnected and it's the clients who suffer.[41]"*

[41] Alcohol and Other Drug Sector Survey participant (2019).

8.3 Access to services

8.3.1 Summary

Our consultation with the sector suggested that alcohol and other drug services have an excellent reputation for engaging high risk groups and facilitating access to a wide range of health and support services in a non-judgemental manner. They are recognised as welcoming and non-judgemental environments. Case management services, especially outreach case management was viewed as an excellent way to facilitate service access for particularly vulnerable groups, technology was also suggested as an economical channel to improve access to services. Day programs and 'no wrong door' models were also noted to improve service access.

Nonetheless the recent alcohol and other drug reforms have created some difficulties for people using alcohol and other drug services through the newly centralised intake and assessment system which can create time lags for people between their help seeking and first appointment. Time lags for people seeking residential detoxification and rehabilitation services have also been reported.

Our consultations suggested alcohol and other drug workers felt confident screening for mental health symptoms, however they find it difficult to navigate the mental health system for people who require these services, especially in times of crisis.

FIGURE 2 - ALCOHOL AND OTHER DRUG SECTOR SURVEY

I FEEL CONFIDENT SCREENING FOR AND SUPPORTING PEOPLE WHO HAVE HIGH PREVALANCE MENTAL HEALTH SYMPTOMS (N=174)

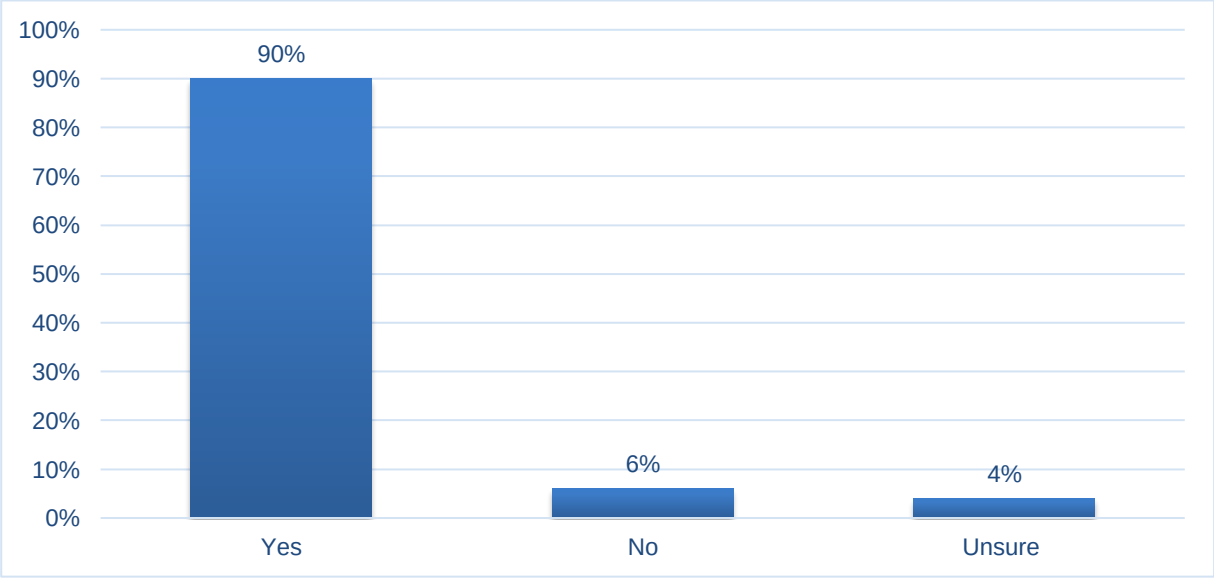


Figure 5 (above) shows the alcohol and other drug sector workforce is confident in their capacity to screen for high prevalence mental health symptoms. Ninety percent (90%) of respondents believe they have the skills to screen for (and support) people with these conditions.

FIGURE 3 - ALCOHOL AND OTHER DRUG SECTOR SURVEY

I HAVE CLEAR REFERRAL PATHWAYS FOR MY CLIENTS HOW HAVE MENTAL HEALTH NEEDS? (N=174)

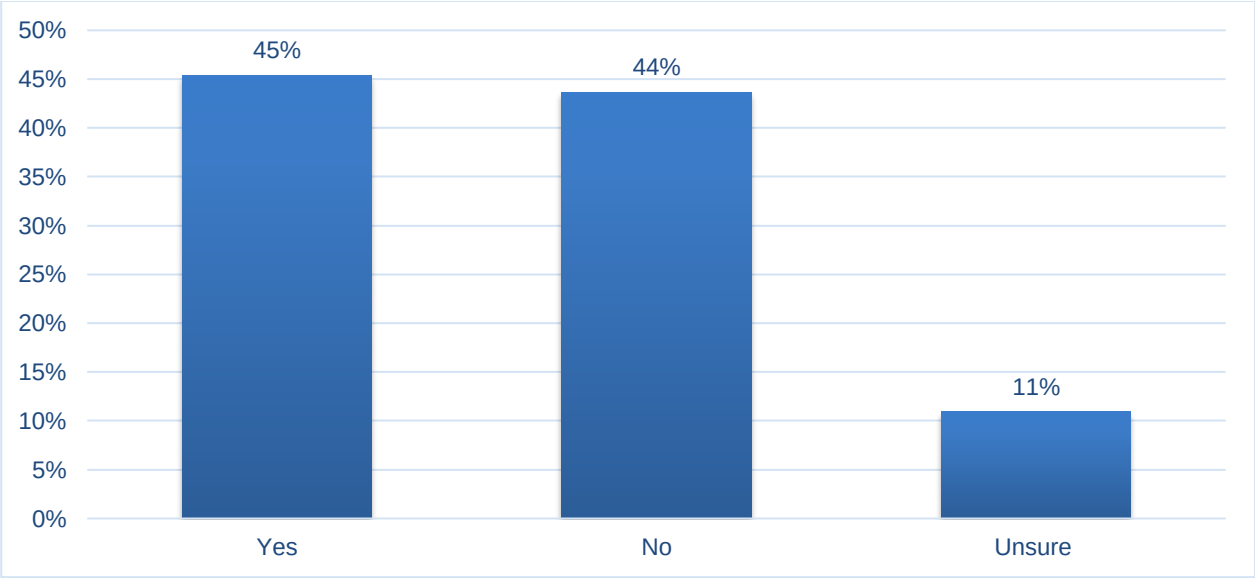
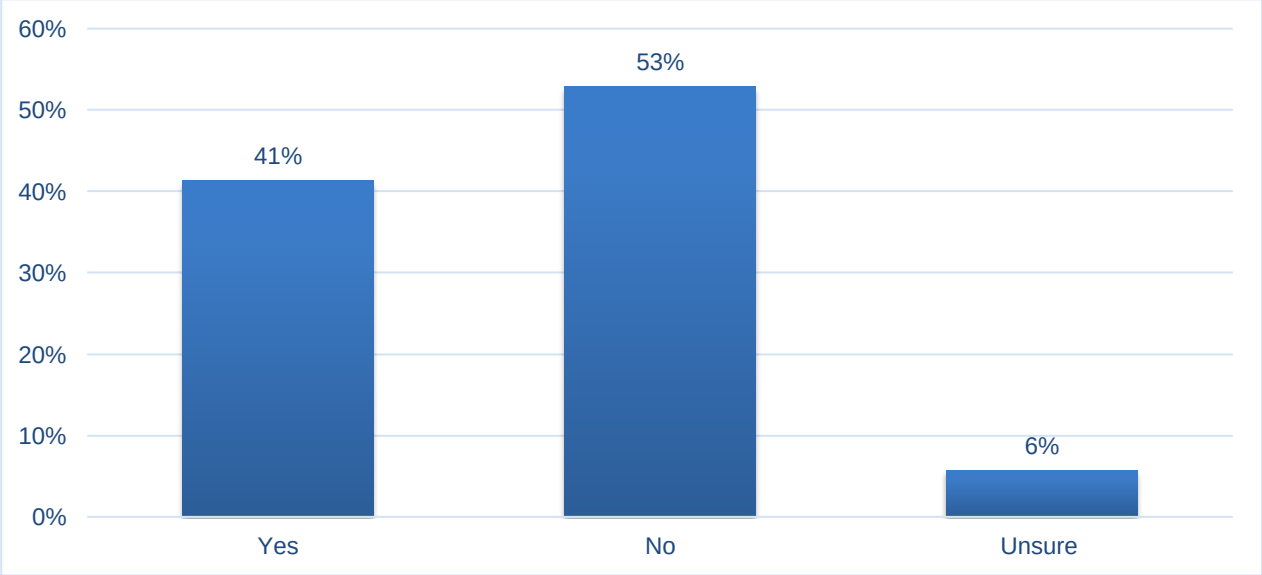


Figure 7 (above) suggests that the alcohol and other drug sector is sometimes unclear about the best referral pathways for their clients. Qualitative responses suggested this relates more to difficulties having referrals accepted than a lack of knowledge about which mental health services to refer to. Participants noted that it was rare for them to make a successful referral to the Crisis Assessment and Treatment Team.

FIGURE 4 – ALCOHOL AND OTHER DRUG SECTOR SURVEY

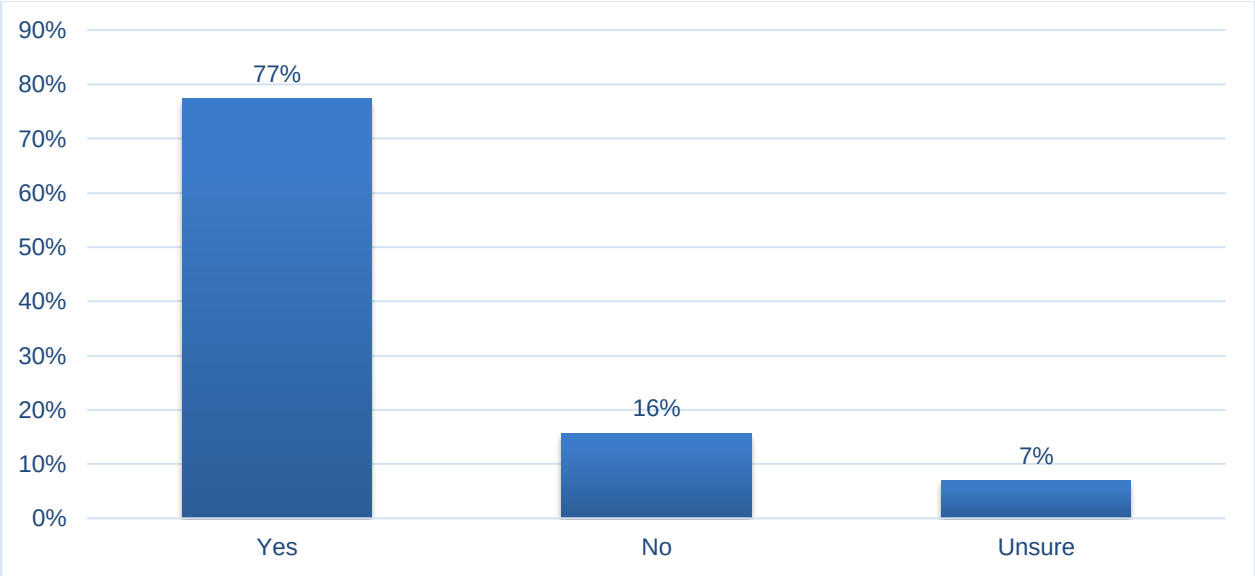
I HAVE A MENTAL HEALTH SPECIALIST I CAN EASILY TALK TO WHEN I NEED INFORMATION OR ADVICE (N=174)



Alcohol and other drug workers were also divided on whether they had a mental health specialist they could call for advice and information (Figure 7). Having access to a trusted person in the mental health sector may assist in navigating alcohol and other drug service users to the right mental health service. More than 50% of respondents did not have a key person they could easily contact for advice and information.

FIGURE 5 - ALCOHOL AND OTHER DRUG SECTOR SURVEY

MY REFERRALS TO MENTAL HEALTH SERVICES ARE SOMETIMES UNSUCCESSFUL (N=172)



Consistent with the previous graph, figure 8 (above) highlights the difficulties alcohol and other drug workers have in referring client to mental health services. More than three quarters of participants agreed that their referrals were sometimes unsuccessful. Considered in tandem with their belief that they are competent in screening for mental health symptoms, this raises concerns that some people who need mental health services are not receiving them.

Alcohol and other drug workers said they were frustrated that people using their services were unable to access mental health services despite obvious needs. Alcohol and other drug workers are disappointed that mental health services often inform them they were not using correct terminology when attempting to refer their clients in crisis. People using alcohol and other drug services stated barriers to accessing mental health services compound feelings of stigma and discrimination.

Sector consultations identified some mental health, primary care and emergency medicine services lack the skills to identify and refer people with alcohol and other drug problems, and that when they are referred this often occurs without consultation or coordination. Stigma and discrimination in these settings was identified as reducing access to important health services for people using drugs. Some mental health services are also reported to be excluding people because they continue to use drugs in direct opposition to current policy.

Specific sub groups like people with a psychiatric disability, personality disorder, acquired brain injury or from culturally diverse backgrounds are reported to experience additional difficulties accessing appropriate services.

8.3.2 Working well

- **Services that include an integrated mental health, and alcohol and other drug intake system** and encourage cross program referrals. In one example:
    - A dual diagnosis clinic sits in between their alcohol and other drug and mental health services

  - An on-site general practitioner, psychiatric nurse, and a nurse practitioner accept and provide referrals
  - A primary health network funded social worker is located at the local hospital emergency department to improve access to alcohol and other drug services
  - All services are in close geographic proximity and are bulk billed to facilitate engagement and access
- **Alcohol and other drug services have developed capacity to screen** for:
  - Emerging mental health problems using well recognised tools (e.g. K10; Mini Mental State Exam). The *Victorian Alcohol and Other Drug Comprehensive Assessment Form* includes mental health screening questions
  - Key health and behavioural risk, including for blood borne viruses, sexually transmitted infections, self-harm and suicidality
- **Enduring, non-judgemental, relationship based case management improves access to services**. Clients at particular risk of exclusion and falling through gaps respond well to the development of a trusting relationship with one continuous person
- **'Soft entry' points for young people** to receive a range of health, service referral and other information in a relaxed and non-stigmatising environment is important to information uptake. Some youth alcohol and other drug services provide a location based template for good practice through *Day Programs*, and undertake successful outreach activities to share information and build service links in settings preferred by people who use drugs
- **No wrong door models** which commit to warm referral of clients across services irrespective of where they first seek help were reported to be helpful. See *No Wrong Door*[42] as an example.
- **Technology solutions are cost effective and well utilised approaches to improving access**
  - **YoDDA** (Youth Drug and Alcohol Advice) is an online service that identifies and links young people to a wide range of services in their local area, including mental health, family, housing, family violence, education, government departments and youth services. Young people are repeatedly followed up until YoDDA is confident they have made the connections they need
  - **DirectLine** provides a 24-hour telephone counselling, information and referral service for anyone in Victoria wishing to discuss an alcohol or drug related issue

8.3.3 Challenges

- **Triage and intake services for mental health, and alcohol and other drug issues remain separate** despite evidence demonstrating most people attempting to access services come with both needs
- **Mental health services have high symptom thresholds for admission to services**, this leaves a significant group with obvious and harmful mental health symptoms unable to access help

  "Mental health teams should stop handballing clients with dual diagnosis issues back to alcohol and other drug services without proper assessment"[43]
- **Alcohol and other drug workers report being told they are not using correct language** when attempting to refer people to mental health services. They find this patronising and unhelpful, especially when trying to support someone in crisis

[42] No Wrong Door – online youth service directory

[43] Alcohol and Other Drug Sector Survey participant (2019)

> *"I've been working with drug users for 20 years and I know when someone needs mental health services. It drives me crazy that they tell me I'm not using the correct terminology to describe someone's problems."*[44]

- **Alcohol and other drug clients continue to be excluded from mental health services due to current drug use**, this is contrary to alcohol and other drug services understanding that clients presenting with co-occurring alcohol and other drug and mental health issues should be treated in an integrated manner
- **Stigmatising attitudes by health professionals reduces access to mental health services.** There were reports that mental health services continue to blame service users for their substance use problems.

> *"The stigma that clients with alcohol and other drug issues experience is unacceptable. When I ask for assessments from mental health [*services*] they still say they have 'done it to themselves' and therefore are not as deserving of care as those with traditional mental health issues."*[45]

- **Emergency psychiatric and medicine services are very hard to access and communicate poorly**

> *"*[there are] *long wait times when mental health triage is contacted, and CATT* [Crisis Assessment and Treatment Teams] *will only attend if really high risk and the referral is made in correct mental health medical terminology. Some rural areas don't even have availability of CATT. Clients taken to a public hospital emergency department will often be discharged 6 hours later without any treatment or discharge plan."*[46]

- **Clients with acquired brain injury, and alcohol and other drug and mental health needs require specialist neuropsychological assessment**s that are not readily available. Without neuropsychological assessments clinicians encounter challenges understanding the clients' level of disability, and with tailoring referral, case planning and treatment
- **Personality disorders are not recognised** yet the trauma related symptoms hypothesised to cause these disorders are common in alcohol and other drug populations
- **Access to services for culturally and linguistically diverse people with alcohol and other drug, and mental health problems is compounded by language and cultural differences**. Many people have limited English speaking skills but no access to interpreters for either initial assessments or ongoing support and treatment. Distinct cultural differences exist in relation to experiences of things like social and gender roles, and trauma.

> *"[We need] far greater access for interpreter services, they are a key part of each step of entry into alcohol and other drug / mental health - understanding the specific culturally and linguistically diverse trauma, culture and role of gender / norms and response is respectful of this* [is important]."[47]

> *"Our service does not do this well at all. There is no signage in other languages in the community health building."*[48]

[44] Alcohol and Other Drug Sector Survey participant (2019).
[45] Alcohol and Other Drug Sector Survey participant (2019).
[46] Key Informant Interview (June, 2019).
[47] Alcohol and Other Drug Sector Survey participant (June, 2019).
[48] Alcohol and Other Drug Sector Survey participant (June, 2019).

8.3.4 RECOMMENDATION

The high prevalence of people with co-occurring alcohol and other drug, mental health (and other) needs is well evidenced. It makes sense to ensure intake and assessment process are carefully considering if people have multiple needs requiring support together. This reduces the need for people to tell their story again and creates an expectation about support and treatment coordination for both service providers and users.

Recommendation 18:

Create accessible, user friendly and integrated alcohol and other drug, and mental health intake systems that assess if the presenting person needs support for both conditions

Outreach case management services which build enduring relationships with high risk individuals irrespective of their current situation have been consistently identified by the sector as improving access to services and health outcomes. We are aware that some mental health, and alcohol and other drug conditions are chronic and cyclical, they require repeated, compassionate and respectful responses in order to help people recover. Trusting relationships with one continuous person is an excellent way to provide services which do not re-traumatise people through repeated story telling.

Recommendation 19:

Fund more enduring, relationship based case management which repeatedly and respectfully helps people at risk to navigate pathways through complex service systems

There is a high prevalence of alcohol and other drug presentations in emergency department and acute mental health settings. Our consultations identified that these settings do not always effectively screen for, or refer people with substance use issues.

Providing more alcohol and other drug specialists in acute mental health and emergency medicine settings would facilitate the flow of referrals to alcohol and other drug services in a more structured and coordinated manner. It is also likely to improve the literacy of workers in these settings to identify alcohol and other drug problems, and to know where and how to refer people into alcohol and other drug services. While the Emergency Department Clinical Liaison Addiction Network has played a role here, it requires more investment and support.

Recommendation 20:

Build the capacity and expertise of mental health and emergency medicine settings to identify and refer people with alcohol and other drug needs by embedding alcohol and other drug staff and resources. Use these specialists to provide ongoing education aimed at improving alcohol and other drug literacy and service navigation

No wrong door approaches[49] are well supported by the alcohol and other drug sector as a way to help people find the services they need. Our consultations suggested approaches like this build cross service and sector relationships and facilitate more joint planning activities. These approaches have been shown to increase the integration and coordination of services[50]. Accountability measures and incentives may further reduce unhelpful practices such as refusing mental health treatment until substance use has ceased.

Recommendation 21:

Create accountably measures to ensure all human services operate a no wrong door model, helping clients access the full range of services they need irrespective of where they first access services

[49] No Wrong Door – online youth service directory

[50] Lubman, D., Manning, V., Best, D., Mugavin, J., Lloyd, B., Lam, T., Garfield, J., Buykx, P., Matthews, S., Larner, A., Gao, C., Allsop, S & Room, R, 2014, A study of patient pathways in alcohol and other drug treatment, Turning Point, Fitzroy.

8.4 Support and treatment

8.4.1 Summary

Coordinated care for people experiencing both alcohol and other drug, and mental health problems remains less common despite being acknowledged best practice[51]. Many of the reasons for this are outlined in the foregoing section titled *Systems Integration* (see p. 24).

FIGURE 6 - ALCOHOL AND OTHER DRUG SECTOR SURVEY

I REGULARLY WORK WITH MENTAL HEALTH CLINICIANS TO PROVIDE COORDINATED CARE FOR MY DUAL DIAGNOSIS CLIENTS (N=168)

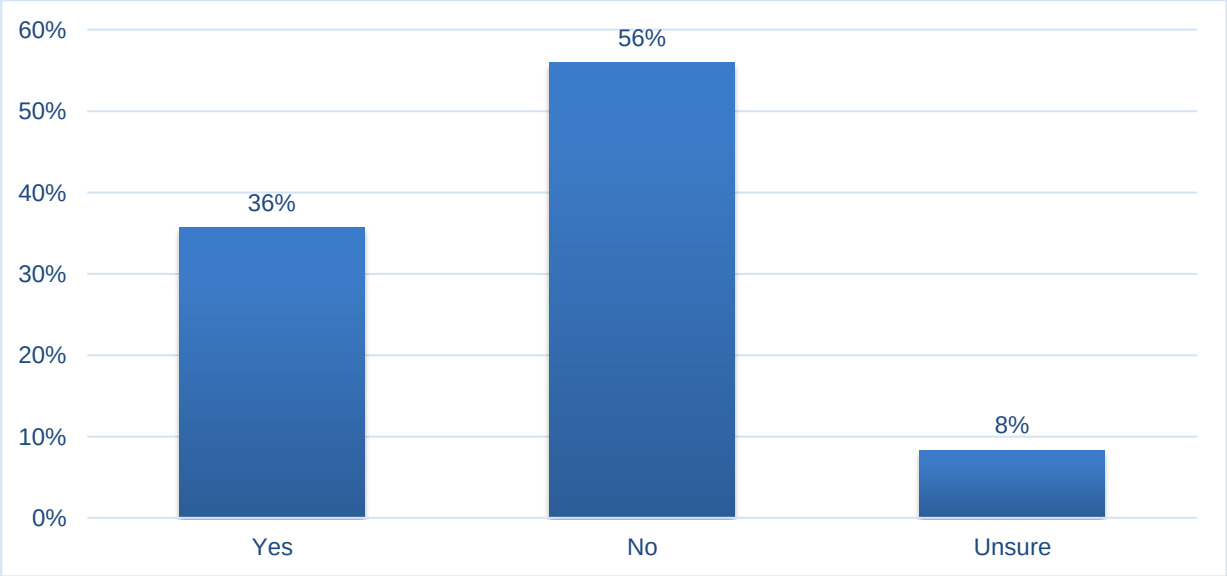


Figure 9 shows that 56% of participants responding to the Alcohol and Other Drug Sector Survey did not regularly work with mental health clinicians to coordinate care for people presenting with co-occurring needs. Although it is pleasing that a minority group do feel services are regularly coordinated. It is unsurprising that this is the case given the earlier findings outlining how hard it is for alcohol and other drug workers to refer their clients to mental health services.

[51] Minkoff, K. Developing standards of care for individuals with cooccurring psychiatric and substance use disorders. Psychiatric Services 52:597–599, 2001.

FIGURE 7 - ALCOHOL AND OTHER DRUG SECTOR SURVEY

WE ARE SOMETIMES UNABLE TO ACCEPT PEOPLE WITH MENTAL HEALTH PROBLEMS INTO OUR SERVICE

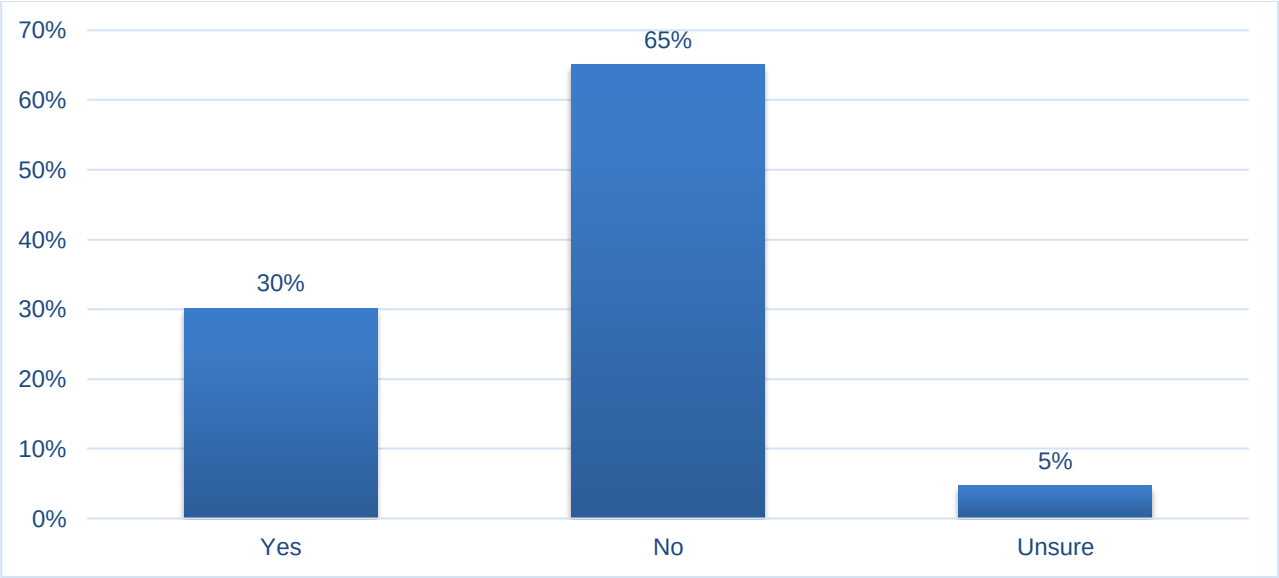


Figure 10 suggests that alcohol and other drug services are prepared to work with people who have both mental health, and alcohol and other drug needs. This appears to be in contrast to the mental health sector, who are reported to frequently refuse access to people with alcohol and other drug problems.

Alcohol and other drug services have the skills to screen and support people with high prevalence mental health symptoms (figure 5), and are already supporting high numbers of people with mental health needs in their services who are unable to access mental health support. Given this it seems alcohol and other drug services would benefit from additional specialist mental health resources.

Our consultations also identified co-located service hubs which included the full range of health and human services in one place as one way to improve coordinated care. It was suggested co-located hubs which better coordinated care were likely to reduce service duplication, improve the consistency of interventions and build better cross sector understanding of how to support people with complex needs.

Attaching generalist outreach case managers to these hubs who build trusting and continuous relationships with high risk individuals to help them navigate the service system, repeatedly support people back into required services, and to coordinate care across multiple services was also strongly supported. Peer workers were increasingly viewed as another important component of care to people with complex needs with some participants suggesting that trust is more easily built with people who have had a lived experience and they have a unique and valuable perspective to bring on the way care should be provided. It was felt this may also reduce feelings of stigma and discrimination in people accessing services.

Our consultations highlighted the need for alcohol and other drug expertise in other settings such as Aboriginal services, housing services and family violence services.

The failure of the criminal justice system to provide effective care which improved the lives individuals, and reduced harms to the community was often highlighted. Participants suggested prisons, and the broader corrections system was producing more work for them. They noted people leaving prison had

not had important physical and psychological health needs considered while incarcerated, nor had they had discharges planned so support was available to them to address these needs on release. Alcohol and other drug service providers noted they did not have strong relationships with correctional services and did not routinely provide services into prisons or have opportunities to effectively plan prison exits in order to create supports around people leaving prison.

Complex needs panels (e.g. *Multiple and Complex Needs Initiative*), while expensive were seen as an important way to build and scale high quality coordinated care. Some people suggested that more economical intra-agency panels could be established which would provide a similar function.

Some participants suggested we needed more pharmacotherapy providers, and better alcohol and other drug literacy in people prescribing and supporting pharmacotherapy services.

Good practice example – Coordinating care

Across the Grampians region services have come together to provide earlier and more integrated responses to people presenting with co-occurring alcohol and other drug, and mental health problems.

An alcohol and other drug, and mental health capable team work closely together. This includes specialist alcohol and other drug and mental health workers, dual diagnosis workers, an early intervention (sub-acute) worker, psychiatric nurses, a social worker located at the local hospital emergency department, and peer support workers who have a lived experience.

The program runs a dedicated *Dual Diagnosis Clinic* and the team expect to cross refer and share care in order to reduce the severity and length of illness, and make services more accessible, understandable and consistent.

8.4.2 Working well

- **Co-located mental health and alcohol and other drug services which prioritise integrated assessment and care** for people with co-occurring alcohol and other drug, and mental health (and other) needs. This makes care more accessible, consistent and understandable, and builds cross sector capacity to manage both problems together *(see good practice examples)*.

  > *"*[I want] *collaborative treatment planning to assist with engagement and remaining engaged, developing positive and trusting relationships with services"*[52]

- **Ongoing, relationship based, trauma informed outreach case management services** which persist irrespective of current circumstances, service use or other issues, and where there is a capacity to increase or reduce the level of support depending on current needs

  > *"We must recognise that people need to be treated as a whole, and recognition that its more valuable for one clinician to build rapport and manage all symptoms and treatment in one plan."*

[52] Focus group participant – person with lived experience (June, 2019).

- **The emerging practice of employing peer workers** builds trust and credibility in services
- **Multiple and Complex Needs Initiative Panels** which review and support complex cases by:
    - Coordinating diverse local area health practitioners
    - Developing rigorous case formulations and plans
    - Setting accountability and outcome measures.

Good practice example – Coordinating care

One regional area alcohol and other drug service has developed a comprehensive range of integrated alcohol and other drug, mental health and broader community health and support responses.

They have developed operational partnerships with the local alcohol and other drug intake service; a primary health consortia and broader medical services; mental health services; local youth and family services; housing and homelessness services; and an aboriginal cooperative. They also employ a federally funded Dual Diagnosis Worker to provide both clinical and capacity building services.

alcohol and other drug, mental health, dual diagnosis, primary care and peer support staff all operate from the same building and provide coordinated and consistent care. Co located services allow workers to undertake reflective practice opportunities that build more integrated service responses that are person centred, especially through the important prism peer support staff with a lived experience are able to share.

8.4.3 Challenges

- **Demand pressures experienced by mental health services,** reducing their capacity to support many people presenting with real and obvious mental health impairments, and the common refusal of mental health services to support and treat people for mental health needs while they continue to use alcohol and other drugs
- **Insufficient resources in alcohol and other drug settings to respond to people experiencing mental health symptoms**, but who cannot access mental health services because they don't reach symptom thresholds

> *"There are huge service gaps, leading people to fall through the cracks- e.g., residential alcohol and other drug services can't accept* [high risk] *clients with acute mental health….and mental health services won't accept clients that are substance using. This means that clinicians are left trying to support the clients despite being an inappropriate service and* [having] *insufficient resources to do so."*[53]

- **A lack of alcohol and other drug services and expertise in acute psychiatric, emergency medicine and community based services** (e.g. Aboriginal, housing, family violence), or clear enough pathways between these services

[53] Alcohol and Other Drug Sector Survey participant (June, 2019).

> *"There is limited funding for Aboriginal Community Controlled Organisation's to deliver alcohol and other drug and mental health support. They have problems attracting staff and retaining staff with appropriate qualifications. Mainstream alcohol and other drug and mental health services are becoming better at support aboriginal people, but more work needs to be done in this space."*

- **The management of clients from the criminal justice system**. There is a need for additional funding and resources for post-release planning and the availability of skilled forensic and dual diagnosis clinicians and services in criminal justice settings

> *"Corrections need to step up and take some responsibility and get funding for specialists or brokerage out to private psychiatrists and psychologists - they refer to our service for counselling and we cannot cope with the numbers."*[54]

> *"More Aboriginal liaison officers. Encourage pathways for Aboriginal and Torres Strait Islander staff in both alcohol and other drug and mental health. Still need to improve the welcome environment for this group."*[55]

- **Providing care to clients presenting with acquired brain injury in alcohol and other drug settings**, especially where neurological assessments are unable to be accessed

8.4.4 RECOMMENDATIONS

Given the strongly identified need to improve access to services for vulnerable groups it makes sense to locate a broad range of health and community services together, including community mental health, alcohol and other drug, housing, family violence, employment support and other services. This will facilitate cross referral and build more consistent and understandable frameworks for practice.

Integrated intake and assessment systems reinforce that complexity is common and that high risk individuals need coordinated, comprehensive, continuous, wrap around support in order to achieve a successful recovery. Attaching outreach case management and peer support services would help reduce the chances of people falling through the gaps. These case management and peer support services should have the capacity to increase or decrease support depending on current circumstances and need. This will build dual diagnosis competency across mental health and alcohol and other drug sectors.

Recommendation 22:

Pilot co-location of alcohol and other drug, mental health and other community support services together for people with co-occurring alcohol and other drug, and mental health issues. Provide integrated intake, generalist case management, and peer support services

[54] Alcohol and Other Drug Key Informant Interview (June, 2019).
[55] Alcohol and Other Drug Sector Survey participant (June, 2019).

There is a significant cohort of people with co-occurring mental health, and alcohol and other drug needs who are unable to access mental health services because they are not considered sufficiently unwell. Nonetheless this group do need support for their mental health needs and are regularly present in alcohol and other drug services.

We suggest providing additional resources into alcohol and other drug services to meet the needs of this group and reduce demand pressure on the acute mental health system. Key settings for additional support and resources would include care and recovery, residential detoxification and residential rehabilitation services. Providing additional resources in these settings would address problems earlier, facilitate more coordinated care, and reduce risks associated with mental health symptoms in alcohol and other drug settings.

Additionally, we suggest providing dedicated '*dual diagnosis'* beds in residential detoxification and rehabilitation settings. This would be facilitated by the additional mental health expertise and resources discussed immediately above.

Recommendation 23:

Provide additional resources in alcohol and other drug settings to assist management of people with mental health symptoms who do not reach threshold for care from mental health services

8.5 Community Connection

8.5.1 Summary

A key finding from our consultations with the alcohol and other drug sector was the lack of suitable housing for people who are recovering from alcohol and other drug, and mental health issues, especially people leaving rehabilitation centres and prisons. This was viewed as a significant reason why people find recovery and community reintegration difficult, especially if they are required to accept accommodation away from key family and other supports.

Providing supported accommodation services with attached case management and peer support that can be increased or decreased depending on current needs was viewed as a useful way to help people re-integrate with their communities. Case management and peer support services recognise that many people need support to develop independence skills and recovery is not linear, meaning people will need more or less support at different times. Alcohol and other drug, and mental health problems are often chronic and cyclical conditions and we need services which can be flexibly increased and decreased in intensity as people require them. This reduces crisis presentations in emergency medicine settings by acting early when relapse occurs.

Discharge planning from prisons was highlighted as deficient throughout our consultations with the alcohol and other drug sector. This is supported in the literature which suggests not enough has been done to create seamless care continuums for people leaving prison[56,57]. This system failure is likely to increase chances of recidivism and later healthcare costs, placing a significant economic burden on our community.

VAADA consultations suggested that co-ordinated links from mental health, and alcohol and other drug services to a broad range of community resources and participation opportunities was important to reduce the chances of people becoming unwell again. This includes collaborative relationships with families, carers and supporters, education and employment providers, government support agencies, community, cultural, religious and sporting groups, and other community assets designed to help people feel they are valued and contributing community members.

Previously discussed local area networks comprising of a wide range of community health and support services was viewed as an important way to coordinate recovery and reintegration services as were 'support groups' to assist people to connect with others who have a lived experience.

Police record checks and stigma and discrimination associated with previous substance use were noted as barriers to people gaining employment opportunities, a significant and important factor in people's recovery journey.

8.5.2 Working well

- **Networks which include not only alcohol and other drug, mental health and primary care services but the full array of required community support and development services**.

[56] Abbott P, Magin P, Lujic S, Hu W. Supporting continuity of care between prison and the community for women in prison: a medical record review. *Australian Health Review* 2017; **41**(3): 268-76.
[57] Johnson J, Schonbrun Y, Peabody M, et al. Provider Experiences with Prison Care and Aftercare for Women with Co-occurring Mental Health and Substance Use Disorders: Treatment, Resource, and Systems Integration Challenges. *J Behav Health Serv Res* 2015; **42**(4): 417-36.

- **Meaningful community participation opportunities** which build practical independence and relationship skills. For example *Men's Sheds*, and local sporting, environmental and religious groups, choirs, theatre groups and other community activities
- **Peer support and mentor roles from people who have a lived experience** of alcohol and other drug and/or mental health problems, including 'support groups'.

8.5.3 Challenges

- **There is a lack of safe, affordable housing.** This includes emergency housing, social housing, supported accommodation and purpose built dual diagnosis accommodation.

> *"Poor mental health has shown to contribute to re-occurring homelessness which in turn contributes to escalating poor mental health and problematic and expensive emergency department presentations. Treatment in most alcohol and other drug and mental health, and housing services is episodic...demand exceeds supply and men will not ever be housed in other than unsafe and substandard boarding houses."*[58]

- **The criminal justice system doesn't adequately plan discharges** resulting in difficulty for people re-integrating into their communities
- **Police records checks can exclude people from employment opportunities**
- **The different outcomes sought by the criminal justice system (abstinence) and alcohol and other drug system (harm reduction; social health)** can negatively impact recovery journeys.

8.5.4 RECOMMENDATIONS

We need a much wider range of housing options for people with complex needs, including people leaving rehabilitation services, hospitals and prisons. Supported housing must be connected to case management and peer support services focused on building skills, resources and links. Flexible funding which can meet immediate and unique needs should be provided to assist with this process. Funding could be used to gain memberships to social groups, fund employability or training activities and foster existing skills and talents to build self-worth and self-efficacy.

Recommendation 24:

Provide more community housing which includes case management and peer support to help develop key skills and resources for people re-entering the community

[58] Alcohol and Other Drug Sector Survey participant (June, 2019).

We recommend stronger links between the criminal justice system, especially prisons and the broad suite of health and support services people leaving prison need. This includes access to immediate accommodation and other basic needs, and clear plans in relation to health needs, employment or training, social connections and positive community participation opportunities. This should occur in the same settings that other people recovering from complex health needs receive services from to reduce stigma and discrimination.

Recommendation 25:

Review discharge planning services for people with alcohol and other drug and mental health conditions who are exiting prison. Provide effective planned reintegration into the community which keeps people housed, safe, employed and engaged

Employment provides a strong financial, social and psychological foundation for people who are reintegrating into their communities. It allows them to fund accommodation and other basic needs, make connections and feel valued. We recommend offering incentives to employ people who are leaving prison and/or recovering from substance use and mental health problems. We also suggest the reducing the need for criminal records checks, or the threshold for employer notifications. This will improve employability prospects. We also believe additional person centred funding that can be directed to specific needs (e.g. literacy, getting a licence) would facilitate improved employability for people recovering and re-entering communities.

Also in reference to this recommendation, VAADA would also like to highlight the findings of the Melbourne School of Population and Global Health who were commissioned to report on the experience of people with co-occurring needs in the criminal justice systems. Please see: *'Inequalities and inequities experienced by people with mental health and substance use issues involved in the criminal justice system.'* which has been submitted separately.

> "*Given the high prevalence of complex health conditions, such as co-occurring mental health and substance use issues among people in contact with the criminal justice system, it is not surprising that they access health services for these conditions at a rate that far exceeds the general population. However, even though service use is higher than in the general population, not all justice-involved people who need health services access them, and disengagement from these services is far too common. Engaging people released from prison with primary healthcare is an important part of ensuring continuity of care however is sadly lacking in terms of service availability.*
>
> *The health needs of people with co-occurring mental health and substance use issues are not being met in the community. Addressing avoidable barriers to accessing mental health* and alcohol and other drug *treatment, which have the potential to prevent or reduce contact with the criminal justice system, should be a matter of priority."*

Recommendation 26:

Provide resources and incentives to help employ people who are leaving prison and recovering from alcohol and other drug, and/or mental health problems

9 APPENDICES

Appendix 1: The alcohol and drug service system

Treatment principles

The Victorian alcohol and other drug programme is guided by 11 treatment principles. Based on these principles, all alcohol and other drug programs and services are expected to be:

1. Reflective of the complex but treatable nature of alcohol and other drug problems
2. Person-centred
3. Accessible
4. Integrated and holistic
5. Responsive to diversity
6. Evidence-informed
7. Provide continuity of care
8. Involve people who are significant to the client
9. Inclusive of a variety of biopsychosocial approaches, interventions and modalities oriented towards people's recovery
10. Inclusive of the lived experience of alcohol and other drug users and their families at all levels
11. Delivered by a suitably qualified and experienced workforce.

Alcohol and other drug services

The Victorian alcohol and other drug system is made up of the following service types.

Intake

Catchment-based intake services are the primary point of entry into the Victorian alcohol and other drug treatment system inclusive of youth, adult, residential and non-residential, Aboriginal, state and Commonwealth-funded services. Catchment-based intake providers work closely with the statewide screening and referral services, DirectLine, and other treatment providers to facilitate client intake and referral to treatment.

Counselling

Counselling services incorporate face-to-face, online and telephone services for individuals and, in some instances, their families, as well as group counselling and day programs. Counselling can range from a brief intervention or single session to extended periods of one-to-one engagement or group work.

Non-residential withdrawal

Non-residential withdrawal services support people to safely withdraw from alcohol and other drug dependence in community settings, in coordination with medical services such as hospitals and general practitioners.

Residential withdrawal

Residential withdrawal services support clients to safely withdraw from alcohol and other drug dependence in a supervised residential or hospital facility. These services support people with complex

needs or those whose family and accommodation circumstances are less stable and unsuited to non-residential withdrawal.

Therapeutic day rehabilitation

Therapeutic day rehabilitation is a non-residential treatment option that offers an intensive structured program over a period of weeks, which includes both counselling and a range of other elements designed to build life skills and promote general wellbeing, such as financial management and nutrition.

Residential rehabilitation

Residential rehabilitation provides a safe and supportive environment for people who are not able to reduce or overcome their drug use issues through other programs. Residential rehabilitation works to address underlying issues leading to their drug use, providing a range of interventions, such as individual and group counselling with an emphasis on mutual self-help and peer community, and supported reintegration into the community.

Care and recovery coordination

For people with complex needs, care and recovery coordination is available to support people to navigate treatment and access appropriate services. It also supports a person to plan for exit from treatment and to access other services that can assist with health and wellbeing needs such as housing, training, education and employment, or other support that can help prevent relapse.

Pharmacotherapy

Pharmacotherapy is the use of medication to assist in the treatment of opioid addiction. The Victorian pharmacotherapy system consists of community-based pharmacotherapy providers and specialist pharmacotherapy services. Specialist pharmacotherapy services provide secondary consultation for complex clients.

Youth specific services

The alcohol and other drug system includes services designed for the developmental and other needs of young people. These services help vulnerable young people up to the age of 25. This is achieved through a family-based approach, where appropriate, that is integrated with other services including mental health, education, health, housing, and child protection and family services. Services include:

- **Youth intake** - via catchment based services, self-referrals, direct referrals from a wide range of youth support services, child protection and out of home care, the police and youth justice providers. Telephone and web based referrals may also be made through *DirectLine* or *YoDDA* (the Youth drug and alcohol advice service).
- **Youth day programs –** accessible, youth friendly spaces where young people can engage in positive social relationships, meet basic needs, get information and advice about available services, and receive primary health services.
- **Youth outreach and support** - assessment, support and ongoing case coordination for young people in their own environment.
- **Youth residential withdrawal** - provided through a community residential drug withdrawal service or through hospital-based treatment.
- **Youth home-based withdrawal** - for young people for whom the withdrawal is of mild to moderate severity and the person can be supported by a family member or friend at home.
- **Youth residential rehabilitation** - a 15-bed statewide facility to provide 24-hour staffed residential programs that provide a range of interventions for young people whose established use of drugs has caused them significant harm.
- **Youth-supported accommodation** - a supportive residential environment to help young people achieve lasting change and assist in their reintroduction into the community.