LETTER/SUBMISSION from [redacted]

[redacted]

1st June, 2019

Dear Commissioners,

I write (on this occasion) as an individual citizen of Victoria.

My professional work background has been most especially in the alcohol and drug arena over some 49 years and more recently includes membership of the Mental Health Tribunal (current) that has provided me with a perspective of the acute and community based mental health services allowing me to directly observe the way in which these systems interact.

In many of my past and now current professional roles I have had experience of working within, in parallel or in conjunction with mental health services in Victoria. I have also had clients or service users I have shared responsibility for as well as family and friends who have sought assistance in the mental health system; both public and private.

These systems are intimately interwoven; for both high and low prevalence conditions and yet are most often considered separately - at all levels.

As I currently [redacted] for the Medically Supervised Injecting Room, I am not able to comment publicly on some aspects of your Royal Commissions areas of attention. I am offering some brief comments related primarily to my long experience in alcohol and drug services and brief comment on responding to people with complex needs grounded in my 5 years of experience Chairing the Multiple and Complex Needs Initiative here in Victoria.

I am happy to be contacted to elaborate on these points, recognising that I am not offering recommendations or even suggestions at this time; merely observations.

I wish you well with this vital Royal Commission and recognise that you have a very short time in which to develop your ideas and recommendations.

With best wishes,

Your sincerely,

[redacted]

[redacted]

Comments relating especially to:

i. Alcohol and other drug (AOD) problems, responses and treatment
ii. Complex case management and care including mental health (MH)

1. Context

- Identification of problems in both mental health and AOD spheres often come to community attention because of role failure in various domains and/or erratic, chaotic or unpredictable and occasionally risk behaviours. This leads to calls for action or intervention and I agree strongly that a health led response is significantly more appropriate than justice/police led initiative (though there is a place for these services to work together).
- There is reported public concern about certain drugs ("Ice" for example) being conducive of increased risk (to self and others). Whether this is true or not is not the major issue; the need for coordination and response to risky behaviour remains. There are likely to be other pharmaceutical and illicitly produced and marketed drugs that may emerge that will cause or contribute to other aspects of trouble or harm(s) in the future and it is critical that the system is not designed around a specific, currently troubling drug profile but geared to systematically respond to any substance that is causing concern.
- There is clearly a dynamic relationship between mental health and AOD services. Experience of one can precipitate and/or exacerbate the other. They are certainly interrelated.
- Historically however, these problems have been inadequately addressed *together* by policy, programme and service delivery development and implementation efforts.
- Presentation of and service access for people with AOD problems is further complicated by the fact that aspects of their presentation sometimes involves behaviours that are illegal.

2. Alcohol and drug problems.

Responses and treatment; including harm reduction

- The **presentation and expectations** of people in the AOD and MH domains can be 'messy/complex'. Responses in both are also often 'messy or complex' arising, in part, from uncoordinated or 'messy' policy and programmes. There is a lack of clarity and shared expectation of the intentions of policy, programmes and individually targeted responses by the general community, potential service users, carers and clinicians. There is often no apparent agreement on what a realistic/reasonable or successful response to an individual might be. This is especially so for AOD treatment interventions where many expect the outcome to be a 'drug free' individual.
- It is here that a frame of harm minimisation can be useful; particularly when it involves a diagnosed mental health condition at the same time. While many MH practitioners now know this phrase, I think that there has been little attention to its articulation and application in the mental health area.

- Harm reduction and harm minimisation can provide a more useful frame than one focussed on cure or control. This would re-focus on general well-being for the person and those close to them and from that base, attempt to develop necessary interventions to at least hold current gains or to further reduce actual or potential harm. This is likely to need a mix of responses but also requires identification of the sequencing of necessities, such as provision of safe, stable and secure housing as an underpinning element of sustainable, functional change in behaviours for many.
- Harm reduction services in this area seem to be somewhat narrowly conceptualised in both AOD and MH. In AOD it is often only seen as provision of injecting equipment and/or saving lives once an overdose has occurred. This conceptual frame could be much wider and link health and safety services at an earlier point with environmental design/responsiveness and recognition of the impact of other systems such as liquor licencing laws/regulations as well other initiatives such as further development of opportunities to work with families and carers in supporting people who are living with mental illness or drug related troubles. This seems to be an area awaiting systematic development.

Policy Planning / Oversight – A divisional systems where collaboration is needed/desired

- There is a long and vexed history of AOD problems/services being understood/administered within and without mental health services in Victoria (and elsewhere). Opinions and experience vary; as always - it depends on many other aspects of service delivery. There isn't an inherently 'right way'. Conceptually they could both/all be dealt with more successfully in a framework that identifies the multiple and sometimes complex needs and problems that people have: housing, time structuring (work, education and/or other regular pursuits that facilitate meaningful social/emotional connectedness), health (physical and mental), relationships (especially family and carers) and so on. Theoretically the goodness of fit is fine with mental health. However, experience of the AOD sector is that they 'miss out' when incorporated within mental health.
- Origins of service planning in the AOD sector have, after an era of moralising, predominantly come from bio-social context while mental health services have arisen in medicine especially. While each has embraced notions of multiple contextual factors; these origins remain somewhat divisive and carry with them different levels of respect and authority in the eyes of the community and among practitioners.
- AOD often appears ignored in many other sectors – in MH it is often 'listed' or 'noted' but the assessment of the nature and extent of drug related problems/diagnoses is usually scant. The treatment plan or response then moves on, apparently ignoring the AOD element. Understandably this can arise when a sense of uncertainty (at best) prevails or a lack of confidence or it can be a resigned expectation of failure in the service consumer (not worth the effort … again) or in the practitioner/service's knowledge and capacity to deliver responses that might best achieve change.
- While access to mental health services by people with predominantly AOD issues is sometimes patchily available, there is a sense that once a person is accepted in to a MH service, their AOD issues are left to one side as the treating team try to respond to the acute mental health presentation; at least until the person "develops insight"- a concept that the AOD sector has long ago realised is not useful.

- **Funding** - The structures for funding AOD services and MH services seem to be somewhat disjointed and do not appear to be well coordinated between:
    - AOD and MH services,
    - Commonwealth and State funding and with the added complexity of
    - public and private care this is indeed hard for anyone to understand.
    - I also note that philanthropic bodies sometime provide funding in this space (that can be idiosyncratic, often not evidence led but they can gain enormous public support and then expect that public funding will follow).
- There is a need to do as much as possible to map these funding system intersections to better understand what blocks appropriate coordination and avoids duplication and gaps.
- Historically when the COAG Health care agreements were being negotiated there was much debate about where AOD would sit. In the end it was not dealt with clearly and so has remained a shared responsibly of Commonwealth and States/Territories; making it difficult for either level of government to plan. Some sorting out of this might have occurred that I am unaware of but might still be needed. Services within the AOD sector are sometimes reluctant to have this clarified since the dual responsibility and confusion allows for an occasional 'shot in the arm' for them when the Commonwealth government responds to a new or emerging drug crisis and call for applications for funding!
- All efforts to map what is required of an adequate AOD and MH system suggests that both remain significantly underfunded if they are expected to provide adequate responses to current community needs.

- I draw attention to the work of the Drug Policy Modelling Programme of research; a body of work that I initiated and that was developed most especially by Professor Alison Ritter (at Uni NSW) that has engaged in working with governments on service planning using population data. I understand Dr Ritter continues this work with various Australian jurisdictions and has an excellent understanding of the context and complexity of funding formulae, treatment/service types and other arrangements. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf

- Funding of specific service types, at least within the AOD landscape, tends to leave most of the work of integration and responsiveness to the service user; with the clinical service providers and their finance managers to wrangle reporting requirements; a very hard ask in the current funding and service agreement system(s).
- There is a need to avoid merely changing arrangements when integration might be achieved in other ways by supplementing services that can demonstrate a model of care that can work but that has been underfunded.
- Partial implementation of change in the AOD service system over time has been disruptive and dysfunctional. The changes that accompany changes in governments leave a sector reeling and the contracting out of services with these changes tend to disrupt the workforce and continuity of service delivery. It is keenly felt and often transfers to the people requiring services – confusion and a sense that it is not worth trying to get help.
- The AOD and MH systems currently have evolved with some cross over but largely in parallel.
- Starting with client/service user pathways and identifying where people could/do present and how one might best ensure access and follow through to services assessed as needed has long been the goal but it's hard to provide for, especially where acute hospitals are the

fulcrum. Potential to build more capacity in these systems remains a challenge; but a change in pivotal points or significant enhanced service capacity is needed.

- Collaboration and partnerships are the mantra but are harder to achieve in competitive market framed systems and where levels of funding and assumed or regulated authority is externally defined. Co-location and staffing profiles can have an impact on how well these systems work together. Example: AOD clinicians with substantial experience appear to make some difference to area-based Community Mental Health Centres.
- AOD by its very nature in the current legal context where possession (and trade) in certain substances is a criminal offence means that Justice services need to be in the frame of attention re AOD/MH systemic review. Prisons especially are harbingers of drug related problems and exacerbate the likelihood of people using/continuing to use drugs on release with significant risks and ongoing health problems. Trust that the Commission is examining the forensic context as a part of the terms of reference and will not comment further at this time but note that it is a very significant element in the MH and AOD system.

- **Prevention and Earl(ier) identification** and intervention/responses or preventative services are not readily apparent in AOD in Victoria since this funding tends to be dealt with somewhat separately and so has not been mapped as part of the same system in my experience (possibly done more recently and I am not aware). It is hard to trace.
- This is especially so in those services dealing with what is sometimes and sadly recognised as the "next generation" of alcohol and drug troubled people: child protection services and youth justice services having limited funding and capacity to manage significant trauma backgrounds and transitions; with accompanying vulnerabilities to drug use and, when it does appear, limited support. I commend their efforts but think that many are not generally well or strongly linked to AOD (or possibly MH) services.

- **Engagement with consumers and carers** has progressed at different times and pace in the AOD and MH sectors.
- Inclusion of consumers (both drug users and users of AOD services) as well as carers in planning and service provision has been slower in AOD than in the MH area where I note even here it is weak in many services/respects.
- These different systems (MH/AOD) are beset with language differences that constitute barriers to integration. Example: the use and understanding of the word 'recovery'; making for further division that can readily contribute to disdain.

- **Data and evidence** need to underpin planning and implementation of both MH and AOD prevention and direct service responses.
- Available planning models at locality level are needed; yet the sharing of information remains vexed for locality linked planning and service delivery.

- **Capacity -** Levels of training/education and experience re alcohol and drugs remain low among staff of many mental health services who otherwise use a mix of community

sentiment, belief and attitude to drive ground their practices, rather than knowledge of what might best work.

- In addition, this occurs in the context of weak specialist accreditation requirements in NGO AOD's and a lack of clarity about evidence grounded responses. A range of services are thus pursuing treatments or responses grounded in belief, family wish, or *n=1* experience or responding to the most recent media highlighted drug problem with a new magic bullet rather than working within a system that is clearly regulated and evidence driven.
- There has been a lack of continued monitoring or at least upscaling expectations in any systematic manner re **accreditation or licensing of services or individual practitioners** in the AOD sector. While many services do use generic accreditation standards/services (and appropriately increasingly required to meet minimum standards by government), I have long been concerned that there are some across Australia that receive funding in both the private and public domains without any check on the approaches/specific interventions/treatments offered (or prevention). There is minimal or no scrutiny of the required qualifications (or allowance for very low and basic levels) and thus the building blocks of capacity of services to deliver appropriate evidence-grounded and potentially effective responses. Under this guise I have sometimes seen unethical and certainly unsuccessful approaches offered to vulnerable people/families who then pay significant funds to access them[1].[2]
- We have a very low level of medically qualified Addictions Specialists in Victoria compared with, for example, NSW (where many who were trained in Victoria have moved to). This is, in part, due to the failure of Victoria to have appropriately recognised and funded in-patient AOD Units or equivalent that serve to provide a career pathway for these clinicians. Psychiatry has apparently not picked up this gap and since the specialist training sits with the Royal A&NZ College of Physicians, this is perhaps not surprising. This is a system failure that has a profound ripple effect. This continues to be problematic in my view and ensuring that there are pathways for specialisation in this field across key disciplines (not necessarily just medicine but this is the one that currently holds authority) is important in workforce development alongside examination of the minimum qualifications to work in the sector.
- There is a need for a comprehensive workforce development strategy that is coordinated across MH and AOD at least.

[1] My experience has been especially as an Investigator for another State regarding health complaints. I cannot name services either there or in Victoria but make the general point.

[2] I do recall a commitment of DHHS to ensure base level requirement for all staff of funded AOD services and assume this remains; but I think the level is very low and there is possibly a lack of graded supervision in some services.

3. **Complex care**

- The concept of complexity of individual situations and the interface with the complex systems of care is now common. The MH and AOD problems are, for many, merely a component of their difficulties and it can be hard to assess the relative contributions of a range of factors as well as the effort to address and sequence responses to them.
- A critical element necessary for effective and efficient use of resources is care plan coordination; a term developed some years ago (2004) to distinguish it from case management and used to describe a vital and sophisticated role in ensuring that those with complex needs could be managed/responded to in our community. [Written up/about some 5 years later in: Hamilton, M. Elford, K (2009) The Report on the Five Years of the Multiple and Complex Needs Panel August 2009] (https://www.dhhs.vic.gov.au/publications/multiple-and-complex-needs-review-reports).
- Complexity arises in both the person in focus and in the systems necessary in responding. An example: once a person needs acute mental health care and goes or is taken to a hospital based service – very few of these in Victoria have established, adequate, integrated AOD specialist services and those that do are not always well connected to ED, acute MH units or to other community directed services. In this context the person is most likely to have an episode of IP care in a Psych Unit within the hospital, overseen by psychiatrist where time (if not other factors) dictates that the main (and often only) treatment and treatment plan is medication; frequently administered by depot injection. At this point, the assumption is made that it must (usually) be the MH service that must take responsibility for follow up. Currently this is so with regulations and legislation backing up this division of care.

- Some (if not most – I don't know) services in the AOD sector have apparently worked to up-skill their capacity to screen and identify and, for some conditions, manage mental health problems among their clients/service users or to refer on where a more specific MH response is needed.
- It appears that only a few of the community based MH services appear to have adequate AOD knowledge and experience and even here, the consultant psychiatrist is 'in charge' and usually somewhat "'underwhelmed" (as one explained to me) by any offering of AOD responses "until the patient develops insight". When medication is depot driven, this exacerbates the disjunction between these service responses.
- Research tells us that parallel or sequential treatment of MH and AOD problems is less successful in achieving positive gains in each area than an integrated response. Current staffing profiles are generally not appropriate to integrated systemic responses.
- One small step toward addressing this would be to expect that designated Case Managers attend and have a legitimised presence at all meetings/hearings and decision-making forums about an individual's care. This would be more value than having a medical doctor who has sometimes not met the patient or has met them once briefly and then relied on the notes penned by another medical doctor who met them once or twice briefly. Case managers often have substantially longer and deeper knowledge of a person's situation than the clinicians who present and make decisions about treatment plans; but in many services appear to have only limited influence on care plan decisions.
- There is sometimes a distinction between integration and cooperation or collaboration. A difference between systemic togetherness and collaborative wrap around effort and the systematic review of both the MH and AOD services and plans such as workforce have traditionally been done separately (re topics and time). I therefore urge this Royal Commission to attend to both; together.