Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF SAM BIONDO

I, Sam Biondo, Executive Officer of the Victorian Alcohol and Drug Association (**VAADA**), 211 Victoria Parade, Collingwood, Victoria, say as follows:

PROFESSIONAL BACKGROUND

1 I am the Executive Officer of VAADA. I have had this role since February 2007. As Executive Officer, I am responsible for day to day management of VAADA which is the peak Victorian alcohol and other drug (**AOD**) organisation. I manage nine staff and have overall responsibility for financial and organisational matters at VAADA and I report to the VAADA Board. I have oversight of numerous projects and program funding and deal with an array of membership needs related to Victoria's AOD sector. I work with the Board and VAADA staff in delivering on our strategic objectives.

2 Prior to taking the role as Executive Officer of VAADA, I was the Community Development Officer at Fitzroy Legal Service from 1989 to 2007. I hold a Bachelor of Arts, a Bachelor of Social Work, a Diploma of Education and a Masters in Criminology.

3 My curriculum vitae is attached as SB-1 to this statement.

4 I give this evidence on behalf of the VAADA and am authorised by the VAADA Chairperson to give this evidence on its behalf.

VICTORIAN ALCOHOL AND DRUG ASSOCIATION

VAADA's purpose and key activities

5 VAADA is a non-governmental peak organisation representing publicly funded AOD services and is an incorporated association. There are about 100 publicly funded AOD services of different sizes located across Victoria.

6 VAADA was established for the purpose of creating a forum for agencies working in the fields of AOD dependence. In doing so, VAADA provides mutual support to its organisational members, facilitates planning, development and evaluation in the fields of AOD dependence, and fosters education and the exchange of information.

7 In undertaking its work, VAADA aims to support and promote strategies that prevent and reduce the harms associated with AOD use across the Victorian community. Further, VAADA seeks to ensure that the issues for people experiencing harms associated with AOD 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 for our members, providing leadership on priority issues, creating a space for collaboration within the AOD sector, keeping our members and stakeholders informed about issues relevant to the sector and supporting evidence-based practice that maintains the dignity of those who use AOD services.

VAADA's role in the education and training of the AOD workforce

8 VAADA is not a training provider and does not deliver training. However, it coordinates and commissions training and other learning and development opportunities through a number of workforce capacity building projects that are largely federally funded. These projects may include conferences, seminars, webinars, professional development opportunities, and targeted training in response to an identified need. VAADA also coordinates a number of network meetings providing peer to peer learning opportunities and promotes education and training opportunities through its e-news service.

9 VAADA is a member on Department of Health and Human Services (**DHHS**) run committee's including the 'Joint Mental Health and other Drug Expert Advisory Committee'. From time to time, VAADA also provides input into various other workforce focussed committees, inquiries, surveys and other like activities.

UNDERSTANDING THE AOD SYSTEM

A summary of Victoria's AOD services and providers

10 The AOD treatment sector comprises a wide range of public organisations including non-government organisations, hospitals, community health services and primary health networks. Some of these agencies may be quite small single site services, others have multiple sites. More recently, there has also been a substantial increase in forensic patients referred to the AOD system.

11 Beyond the public sector there are a number of 'private AOD providers' in Victoria. These private providers range in quality and capabilities and operate with little regulatory control. VAADA does not represent the interests of private AOD providers.

12 AOD treatment is delivered through a number of treatment streams across Victoria. These treatment streams include intake, counselling, withdrawal and rehabilitation and pharmacotherapy.

13 The Victorian system consists of a broad spectrum of community-based and residential treatment options which are available to people experiencing harms related to AOD use. The system includes:

(a) statewide screening and referrals;

(b) catchment-based intake;

(c) assessment;

(d) counselling;

(e) care and recovery coordination;

(f) non-residential withdrawal;

(g) residential withdrawal;

(h) therapeutic day rehabilitation;

(i) residential rehabilitation;

(j) specialist dual diagnosis residential rehabilitation;

(k) subacute withdrawal and intensive stabilisation; and

(l) pharmacotherapy.[1]

14 The activities noted above are supported by a separate planning function, led by a funded service provider in each catchment where AOD service providers work in partnership to identify critical service gaps, pressures and strategies to improve the service system. The planning function is led by a funded service provider in each catchment. Each catchment-wide plan provides a basis for improved cross-service coordination at the catchment level to achieve a more consistent, joined-up approach to meet the needs of individual clients.

15 In order to treat problematic AOD use, a complex and extensive suite of treatment types is required. People are complex, and the solutions in respect of problematic AOD use are also necessarily complex. Further, the current AOD system is under strain. This means that the AOD system needs to interact with a range of other systems. As such, AOD agencies are proficient in developing partnerships which create pathways and activities through the use of partnership arrangements, guidelines and memorandums of understanding.

The services provided by Victoria's publicly funded specialist AOD treatment services

16 The services provided by Victoria's publicly funded specialist AOD treatment services are as follows:

(a) *Counselling:* Counselling services incorporate face-to-face, online and telephone services for individuals and, in some instances, their families, as

[1] Alcohol and other drugs program guidelines Part 2 - program and service specifications. https://www2.health.vic.gov.au/Api/downloadmedia/%7BD9F0F87E-AF08-4580-8A75-4911FBD8DA95%7D.

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.

(b) *Non-residential withdrawal:* Non-residential withdrawal services support people to safely withdraw from AOD dependence in community settings, in coordination with medical services such as hospitals and general practitioners.

(c) *Residential withdrawal:* Residential withdrawal services support clients to safely withdraw from AOD 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.

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

(e) *Residential rehabilitation:* Residential rehabilitation provides a safe and supportive environment for people who are not able to reduce or overcome their AOD use issues through other programs. Residential rehabilitation works to address underlying issues leading to a person's AOD use, provide a range of interventions (such as individual and group counselling with an emphasis on mutual self-help and peer community), and support reintegration into the community.

(f) *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 a person holistically such as housing, training, education and employment, or other supports that can help prevent relapse.

(g) *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.

(h) *Outreach & Community Development:* Unfortunately, since the 2014 AOD reform (which I discuss at paragraph 26 below) outreach is no longer a funded activity type for mainstream AOD services. Outreach services only remain in

relation to Needle and Syringe Programs and in relation to youth AOD treatment.

17 Victoria's publicly funded specialist AOD treatment services also treat the following population specific services:

(a) *Youth services:* Youth services offer treatment and support to vulnerable young people who are aged 12 to 25 years to help address their AOD use issues. Support is also provided to a young person's friends and family. The approach integrates a range of other services including mental health, education, health, housing, and child protection and family services.

(b) *Aboriginal services:* Aboriginal services offer holistic, culturally-appropriate care, support and treatment to Aboriginal clients, families and communities to help reduce the harms associated with AOD use.

(c) *Forensic services:* Forensic-specific programs and services are for people who access AOD treatment as a result of their contact with the criminal justice system. Treatment for forensic clients is aimed at reducing the harms associated with AOD drug misuse, including the related offending behaviour.

(d) *Harm Reduction Services:* The Victorian AOD sector also includes harm reduction services such as Needle and Syringe Programs, the Medically Supervised Injecting Room, and harm reduction focussed outreach services. It is of note that the outreach services are only available as a harm reduction service, not as a treatment service involving counselling.

The workforce profile of Victoria's publicly funded specialist AOD treatment services

18 In 2019, a DHHS and the National Centre for Education Training and Alcohol and Drugs (**NCETA**) conducted a workforce survey for the purpose of putting together a national overview document regarding the AOD workforce. From this survey, it is understood that Victoria's AOD workforce comprises around 1500 staff working across approximately 100 services.[2] The following is statistically known about the workforce from a sample of approximately 700 staff:

(a) approximately two thirds of the AOD workforce are women;

(b) around half of the workforce are in the mid-age range (36 to 54 years);

(c) around two thirds of workers (64%) reported have lived experience in relation to AOD;

[2] This data arises from NCETA's, Victorian AOD Workforce survey 2019/20. NCETA is based at Flinders University.

(d) the majority of workers had worked in another sector prior to joining the AOD sector. Health and mental health were the most common sectors of prior employment;

(e) the AOD workforce primarily comprises either very experienced workers with 10+ years in the AOD sector (38%) or relatively new workers with three or fewer years in the sector (33%); and

(f) a substantial proportion of workers (42%) were employed in their first role in the AOD sector; an increase in less experienced workers compared to 2016 (33% in first role). Workers in regional areas were more likely to be in their first AOD role.

19 The AOD workforce includes a diverse range of occupations in various work roles. The largest cohort comprised drug and alcohol counsellors in direct client service roles. Around three quarters of workers indicated their main work role was direct client service provision, and one quarter of workers were in a management role. The table below depicts the breakdown of occupations in the AOD sector:

Table 1: AOD Workforce Profile[3]

Occupation	%
Drug and alcohol counsellor	30
Service manager	9
Drug and alcohol nurse	8
Social worker	7
Community worker	5
Counsellor	5
Youth worker	4
Clerical and office support worker	3
Contract/program/project administrator	3
Education professional	3
Research & development manager/professional	3
Aboriginal AOD worker	2
Chief Executive or Managing Director	2
Policy and planning manager/professional	2
Welfare worker	2
Clinical psychologist	1
Enrolled nurse	1

[3] Skinner, N., McEntee, A. & Roche, A. (2019). Victorian Alcohol and Other Drug Worker Survey 2019. Adelaide, South Australia: NCETA.

General registered nurse	1
Health promotion officer	1
Medical practitioner	1
Nurse practitioner	1
Nursing professional	1
Office/practice manager	1
Psychotherapist	1
Social professional	1
Volunteer (unpaid)	1
Welfare support worker	1
Family support worker	0.4
Public relations professional	0.4
Nurse educator	0.3
Personal assistant / secretary	0.3
Pharmacist	0.1
Psychiatrist	0.1
Total	100

The extent that Victoria's publicly funded specialist AOD treatment services are meeting demand for services

20 In 2018, over 31,000 people received government-funded AOD services.[4] Over recent years there has been a huge increase in forensic client referrals into Victoria's AOD system. Further, these increased numbers track increased prison numbers and general increases in community drug consumption, as outlined in paragraphs 22 and 23 below.

21 AOD treatment capacity is insufficient for the many people who need it. Some estimates suggest that treatment places would need to more than double to provide treatment for every person who has clinical need. According to work done by leading academics in this space[5], only 26.8% to 56.4 % of those with clinical need for AOD treatment are able to access services each year. It is estimated that annually between 180,000 and 553,000 Australians in clinical need do not access AOD treatment.[6]

[4] (Victorian Government, 2018) https://www2.health.vic.gov.au/about/publications/policiesandguidelines/aod-performance-management-framework.

[5] Ritter, A, Chalmers, J and Gomez, M: Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model, *Journal of Studies on Alcohol and Drugs*, 2019, No. 18, p. 47.

[6] Ritter, A, Chalmers, J and Gomez, M: Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model, *Journal of Studies on Alcohol and Drugs*, 2019, No. 18, pp 41-50.

22 As a result, a portion of these people are likely to be funnelled into the justice system, with a 2072% increase in minor drug offences involving methamphetamine being heard in the Magistrates' Court of Victoria from 2007/08 to 2016/17.[7] As a result of capacity issues in both the AOD and mental health sectors, many individuals enter the justice system embarking upon a steep curve of disadvantage. This is evident with the prison population growing over three times faster than Victoria's population growth.

23 In our view, prison does not manage or treat AOD or mental health issues effectively. This is evidenced by the statistics that indicate that between 55% to 76% of prisoners experience substance dependence, and 43% to 80% experience mental health issues. The co-occurrence of mental health and AOD issues occurs in 18% to 55% of the prison population.[8]

24 A feature of the Victorian system is the increased volume of clients referred into the AOD sector from the forensic system. According to figures available in 2018-2019, from the Victorian-based Australian Community Support Organisation (**ACSO**), 17,760 referrals were received from the forensic system (encompassing Corrections Victoria, youth justice, Victoria Police, Victorian courts and through diversion programs). Of the 11,811 referrals from Corrections Victoria in respect of adult prisons, ACSO undertook 8,405 forensic assessments which were then referred to Victoria's AOD treatment agencies.[9] These numbers are large and have an impact on voluntary clients being able to access treatment. Further, forensic clients often come with a greater amount of client complexity, particularly around co-occurring mental health issues.

25 Forensic client growth raises a number of questions about the viability of Victoria's AOD system in the long-term. While research in this area is scarce there is a perception that for voluntary clients their treatment can be postponed or delayed because of issues with system capacity. This places such clients at a particular disadvantage, because there is an expectation that they can wait. In relation to increased client complexity associated with the AOD forensic population who are prioritised entry into our system, it is also recognised that there is a much greater justice client churn associated with increasing complexity and recidivism. In reality both voluntary and forensic populations are in need of assistance.

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[7] VAADA, *Inequalities and inequities experienced by people with mental health and substance use issues involved in the criminal justice system – VAADA commissioned Report to the Royal Commission into Victoria's Mental Health System,* 2019, https://www.vaada.org.au/wp-content/uploads/2019/07/Melbourne-Uni-JusticeHealth_VAADA_RoyalCommission_FINAL-003.pdf.

[8] Ibid.

[9] ACSO Community Offenders Advice and Treatment Service, Aggregate Report for DHHS Quarter 4, 2018-2019, produced by Data Integrity, Reporting and Client Services Officer, p 7.

26 There are limited AOD intervention opportunities arising from Victoria's current sentencing legislation. In effect, the prison system is being seen as a form of 'waiting room' for a large number of individuals that cannot have their health and welfare issues addressed in the community. While the legal and justice approaches driving people towards correction solutions is problematic, there is an obvious need for these individuals to be better supported, particularly around their integration needs both within prison and when they enter back into the community (including in relation to their housing, education and training options). Having an increasingly complex and exponentially bigger prison population feeding into the AOD, mental health and other key sectors makes no sense. It is unnecessarily expensive, wrong and must be addressed. Places like Norway have reduced their recidivism rates from around 50% to around 20%[10]. Other regions like Singapore, Holland, Portugal, and some US jurisdictions have made the switch from investing in prisons to investing back into health and community services. This has resulted in a range of societal and individual benefits.

The impact of the 2014 recommissioning reforms on AOD services

27 The 2014 review occurred after a period of about ten years of reviews that were not actioned. There was a need for reform based on the AOD system and community's dissatisfaction with the sector. At the time, VAADA was quite vocal in encouraging government to review and fix the system. As such, in 2014, the Victorian Auditor-General's Office looked at the AOD system and made various recommendations about reforming the system.

28 One of the key features of the 2014 reform was the establishment of catchment-based intake and assessment services. Each catchment established an intake and assessment service accountable for screening and assessment. The separation of assessment from treatment services was intended to provide a degree of independence and greater objectivity of assessment. However, this change unfortunately increased the number of steps that people needed to get to treatment, especially for complex clients and clients in rural areas. Sector staff reported that the system was more difficult to access and the referral pathway from catchment-based intake and assessment to treatment was problematic when multiple agencies were involved. The structure also limited services' capacity to provide an immediate and meaningful response to those seeking treatment[11] and undermined the previous Mental Health Dual Diagnosis 'no wrong door' principle.

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[10] Fazel S, Wolf A. A Systematic Review of Criminal Recidivism Rates Worldwide: Current Difficulties and Recommendations for Best Practice. *PLoS One* 2015; 10(6): e0130390.

[11] VAADA, Centre for Health and Social Research and the Australian Catholic University, *Regional voices: The impact of alcohol and other drug sector reform in Victoria, Final Report,* February 2016, https://www.vaada.org.au/wp-content/uploads/2018/06/VAADA-Regional-Voices-Final-Report.pdf.

29 In 2015, AOD services experienced a downturn in client engagement of approximately 20%. This was attributed in large part to service dislocation and confusion regarding entry points and processes.

30 In 2017, intake and assessments were de-coupled. An initial intake process was undertaken separately then clients were referred for assessment and treatment. While this has helped resolve some issues, multiple barriers to entry into treatment remain. For example, it is not uncommon for a client to be screened by one service, assessed by another, and sent back to the screening service for treatment.

31 The 2014 reforms have meant that our stakeholders in primary health, the courts and a range of other allied services continue to have difficulty in assisting people in need to access the AOD system.

32 The Victorian AOD funding model remains problematic as there are a number of perceived shortfalls. The AOD sector gets funded according to the 'Drug Treatment Activity Unit' (**DTAU**). It sets a standard price (and fractions of this price) as the basis for funding various AOD service activities. From its beginnings, the DTAU has been problematic as the price is misaligned to the service models delivered. The DTAU is poorly priced, and the relativities between the different funded services types were misaligned with each other. In addition DTAU's make it difficult to manage budgets and staff resources. Further, as it introduced output-based funding it also made it difficult to plan service improvement. The ASPEX review undertaken in 2015 for DHHS noted potential under-pricing when considering the value between different treatment types, including issues with the operationalisation and limitations in flexibility[12].

33 VAADA's 2020/21 budget submission to the Victorian government states that care and recovery coordination is significantly under resourced. This treatment type is important in assisting complex clients, VAADA estimates that it is under-resourced with capacity for an additional 10,000 treatment episodes required.[13]

The key similarities and differences in treatment approaches of the AOD and mental health sectors

34 In the context of treatment approaches, and broadly speaking both the AOD sector and mental health sector:

(a) operate from a client centred approach that places clients at the centre of decision making;

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[12] Aspex Consulting. *Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services.* Final Report. (2015).
[13] VAADA (2020) *VAADA State Budget Submission 2020-2021,* https://www.vaada.org.au/wp-content/uploads/2018/06/SUB_state-budget-submission_19122016.pdf.

(b) recognise the importance of holistic treatment and engaging with significant others in the process;

(c) utilise a range of psycho-therapeutic treatment modalities to suit needs and operate in varied settings (for example care and recovery co-ordination and inpatient and outpatient services);

(d) have a focus on their workforce having a high level of lived experience; and

(e) deal with large numbers of clients with a dual diagnosis (although the mental health system tends to deal more with low prevalence issues and the AOD system with high prevalence issues).

35 The key differences between the AOD sector and mental health sector are as follows:

(a) While both sectors are underfunded, the AOD system lacks a range of directly accessible resources. By virtue of the fact that the AOD system predominantly sitting in the community sector and is not clearly articulated within a "medical model", services utilise a range of psychosocial therapies and motivational engagement. The location of AOD services outside the formal health system has a range of benefits such as being welcoming, adaptive and responsive to changing circumstances. However, there are a range of financial, workforce and client related negotiations which are more difficult. In my view, while it may be recognised that mental health is the 'poor cousin' of the health system, AOD is clearly the poor cousin of the mental health system.

(b) It is perceived that the mental health sector has more developed consumer consultation processes and consumer-led service design processes.

(c) It is common to hear that mental health services may refuse to treat AOD clients who may still be using drugs, or who have not withdrawn from drugs.

(d) Both sectors could be doing better in handling referrals from each other. Mental health services could expand their remit to work more effectively with drug users. In this regard the mental health system has a number of similarities with the general healthcare system which retains considerable thresholds for the entry of AOD clients into these systems.

Reconciling the AOD sector's philosophy of voluntary engagement and self-help with the mental health system (including compulsory treatment)

36 The AOD sector centres around motivation and supporting people who have problematic AOD use until a point they are ready to stop using substances, whilst also keeping them safe. That may mean that a person goes through periods where they use substances and periods where they do not.

37 While both sectors have voluntary engagement and both have capacity for compulsory treatment, application of the AOD sector's compulsory treatment is very limited and used rarely. Whatever the presentation (AOD, mental health or both) the treatment response should be proportionate, helpful and effective for the individual's needs at the time.

38 Compulsory treatment across both sectors operates from a similar premise: that the individual needs immediate treatment to prevent a serious deterioration in their health or to prevent serious harm to self or to another person. It may be that the mental health sector uses compulsory treatment (specifically involuntary treatment under the *Mental Health Act 2014*) more than the AOD sector uses compulsory treatment (under the *Severe Substance Dependence Treatment Act 2010*), but one position is not more desirable than the other, nor necessarily transferrable.

39 It should be noted that the AOD sector has considerable experience in treating offenders who are mandated to attend many types of AOD treatment (for example by court orders). Since the inception of the Community Offenders Advice and Treatment Service (COATS) in 1997, AOD clinicians have developed some exceptional skills in engaging, and promoting behavioural change with regard to substance use in clients who present to services with limited motivation. Therapies such as motivational interviewing and cognitive behavioural therapy are routinely used with all presenting clients, both mandatory and voluntary alike. Therefore, despite some potential differences in philosophy, this does not translate to an issue in actual service delivery at the grassroots level with forensic clients. However, there is a significant and notable exception to this approach which relates to mandated treatment referrals from the criminal justice system. These referral numbers are large and occupying increasing system capacity each year.

What Victoria's AOD and mental health service systems can learn from one another

40 There is much to be learnt and shared between the AOD and mental health sectors. Clearly there are many common clients that journey between sectors. This necessarily requires that staff have some common knowledge about each other's sectors as well as having specialist mental health and/or AOD knowledge within each system. This is essential for the movement of clients between systems and the adaptation of each system to a client's needs. This will depend on the complexity of a client's needs and where they enter their care pathway.

41 As discussed earlier, in 2019 NCETA undertook a Victorian AOD workforce survey which identified that the most commonly identified workforce learning priority (after responding to clients with experience of family violence or trauma) was skills in addressing mental health issues including clients' risk to self and others. Such a

response clearly indicates a desire by the AOD sector for increased knowledge around mental health diagnosis, working with trauma and addressing and managing vulnerable individuals with psychological distress.

42 The AOD sector could also learn from the mental health sector's engagement with consumers and its consumer-driven approach to program design. While some work has occurred within the AOD sector, it remains localised and largely organisational dependent.

43 From an AOD perspective there is a view that the mental health sector could work better and be more welcoming of AOD clients and become more AOD capable.[14] This would require there to be knowledge transfer between the sectors. For the mental health sector, this should include a better understanding of the AOD sector's approach to harm reduction and harm minimisation as opposed to abstinence. Further, AOD clients would benefit if eligibility criteria for access to mental health services changed so that they did not have to be abstinent from drugs in order to receive treatment for their mental health. In my view, it is completely unrealistic and inappropriate to expect a person to cease their substance use just to be able to receive mental health treatment.

44 VAADA consultation findings and broader human services workforce data[15] suggest the educational and experience backgrounds of the AOD, and mental health workforces are distinct. Most of the mental health workforce have completed university education in a given speciality and have been provided a high-level theoretical orientation to their practice prior to initiating their direct work experience. The majority of the AOD workforce are also university educated but 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 AOD sector which disadvantages the AOD sector.

Major gains in AOD service reform outside Victoria

45 Most Australian jurisdictions have experienced reform, commissioning or strategic activity over the past decade. I perceive that these reforms have not made any 'major gains' in relation to the AOD space. The changes appear more typically incremental in nature – and are not necessarily progressive. I am therefore unable to inform the Royal Commission of any major gains in AOD service reform outside Victoria.

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[14] General sentiment and perception in the AOD field it is that the AOD sector is often asked to become capable in, and accommodate other capacities such as mental health, forensic treatment, family violence etc, whereas other sectors are rarely required to become AOD competent and capable.

[15] State Government Victoria, 2018, *Victoria's Alcohol and Other Drugs Workforce Strategy 2018-2022*, https://www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022.

CO-OCCURRING MENTAL ILLNESS AND PROBLEMATIC AOD USE

The challenges for people with co-occurring mental illness and problematic AOD use

46 People presenting to services with both AOD and mental health problems often have other co-occurring issues (homelessness, trauma, family violence etc) and these issues are complex. This complexity is reflected in their 'choice' to use substances, often to self-medicate or 'escape' from increasingly unpleasant mental health symptoms. The challenges these people encounter often include:

(a) access to treatment systems;

(b) people presenting with co-occurring issues require an intake, assessment, care planning and treatment process that meets both of their AOD and mental health needs simultaneously. The current siloed systems mean that many people in the AOD sector do not get their mental health needs met and vice-versa;

(c) since the AOD sector reform in 2014, people are having to tell their story multiple times to different clinicians in their intake, assessment, treatment and then referral to other services. People get lost navigating the system or simply do not want to have to engage with so many people. This can be a considerable hurdle and disincentive for clients in need;

(d) trauma is a significant factor underlying many people's substance use. The initial trauma is often masked by substance use and mental health symptoms. It requires a suitably trained dual diagnosis clinician to establish a therapeutic working relationship with the person (in particular trust) to expose, and address the trauma in the longer term;

(e) anecdotally, AOD staff indicate that the standard four sessions of AOD counselling are not long enough, or suitable enough for people with complex mental health/AOD presentations.[16] Although, some people qualify for complex counselling (12 -15 sessions) and 15 hours of care and recovery coordination, many people presenting with underlying trauma do not meet the stringent eligibility criteria. AOD agencies are severely constrained by funding limitations on the number of these treatment episodes they can offer. Mental health plans do not offer enough sessions, and most people in the AOD sector cannot afford to access them anyway even with a Medicare rebate;

(f) people with AOD problems and high prevalence mental health disorders (anxiety, depression and personality disorders) are refused mental health

[16] VAADA 2019 sector survey. This survey is an internal VAADA document conducted to obtain feedback from the Victorian AOD sector to inform VAADA's original submission to the Royal Commission.

services because they do not meet their criteria for being acutely ill, and do not have a low prevalence disorder (schizophrenia and bi-polar disorder);

(g) people in rural and regional areas are not able to access AOD, mental health and other services with limited transport. While telehealth has been rolled out to some areas (prior to COVID-19) the focus was on a medical model and GPs, not AOD and community services. Many people presenting to AOD services do not have access to digital devices and/or the technological expertise to operate them;

(h) many people with co-occurring disorders have other co-morbidities including homelessness and family violence that impact on their capacity to engage with services. Other than a limited amount of care and recovery coordination in AOD services they cannot readily access outreach services;

(i) many people get 'bounced' between AOD and mental health services. For example, mental health services send people with co-occurring disorders to AOD services saying "it's a drug problem";

(j) in relation to stigma, both AOD and mental health issues are individually stigmatised, and this is compounded when the two co-exist;

(k) significant others, such as families/carers experience, often do not know how and where to access reliable information or supports;

(l) people with forensic histories are exceptionally vulnerable to overdose upon release.[17] Appropriate prison discharge and efforts at reintegration that can improve the chances of stability are required if we are to make a difference to the level of post release of suicide, homelessness and recidivism; and

(m) the intersectionality of AOD, mental health and criminality compounds the level of risk/need for the forensic cohort.

The challenges for mental health services in supporting people with different types of problematic AOD use

47 One challenge is around workforce issues and system issues. Generally, within the mental health system there is a need to improve knowledge and capacity around dual diagnosis. While I am unaware as to the extent of this, it is often said anecdotally, that many dual diagnosis clients are referred away from mental health until their substance use issue is resolved. Whatever the extent of this, it is important to address this problem

[17] Coroners Court 2019. Initiatives to reduce drug related harms among former prisoners. Correspondence, 30th August 2019. Preliminary data from the Coroners Court of Victoria indicates a strong association between prior incarceration in prison and lifetime risk of overdose.

and any underlying cultural issue of the mental health sector not having the capacity to work with AOD issues.

48 At a workforce level, it would appear that many mental health clinicians lack training, knowledge and expertise in AOD and vice-versa. To address the dual diagnosis competency issue within the mental health arena, it will require education and training as well as improvements around screening, assessment, care planning and enhancement to referral pathways within, and external to, the mental health system.

49 At a systems level, it will also require physical capacity to work with clients either through in-house beds, residential support, step up/down facilities, halfway houses, residential solutions, and adequately funded and supported aftercare.

50 The mental health system must be better prepared and have the capacity to address the AOD needs of those seeking assistance. Some referral of dual diagnosis clients with low prevalence issues to other systems (such as the AOD system) may be appropriate, subject to those service systems having physical capacity and requisite skills to deal with such referrals. Seamlessness of referral and case management continuity is important.

51 It is critical to have senior expert practitioners such as addiction psychiatrists, addiction medicine specialists, and dual diagnosis capable nursing and other staff located/linked or accessible. This is not just in mental health facilities but also within AOD and other relevant service systems.

52 Referral pathways, protocols shared care planning, clinical liaison, secondary consultation, adequate clinical supervision and support are vital.

53 Notwithstanding workforce and infrastructure needs that may exist in both AOD and mental health systems there needs to be:

(a) Significant improvements and resolution to rigid and centralised intake services between systems with the need to be able to make "warm" referrals.

(b) Additional investment to address limited resources.[18]

(c) A need to address systemic priorities that differ from AOD, resource allocation and funding models that do not align with the AOD sector.

[18] Victorian Auditor General, State of Victoria, 2019, *Access to Mental Health Services Independent assurance report to Parliament 2018-19,* https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf

54 There is a need to address misaligned eligibility criteria. As noted above, the mental health sector prioritises people with low prevalence disorders whereas most people in AOD services have high prevalence disorders.

The challenges for AOD services in supporting people with different types of mental health problems or issues

55 The AOD sector is a relatively small and specialised sector. The level of integration with other allied services, other than possibly those existing for forensic clients, rests more on informal relations, ad hoc protocols and agreements. The AOD sector has no specific regulatory or legislative base other than possibly that for 'poisons regulation'.[19]

56 The AOD sector has been subjected to numerous reforms over the years including the late 1990s under Professor Pennington (the 'Turning the Tide' report) and in 2014. Further, the sector has been subject to numerous internal DHHS reviews where it was aligned with mental health and then separated from mental health. Funding which relates to the community demand for AOD treatment has always been an issue. Other than some funding increases in recent years, community AOD support needs have not been adequately addressed.

57 As a small and 'boutique' sector, Victoria's AOD staff are required to engage and work across an enormous range of fields. Under existing DHHS AOD program guidelines and contractual obligations many staff and organisations in the sector are required to work with and across a number of areas and groups including young people, homeless, Indigenous, CALD clients, victims and perpetrators of family violence, those with trauma, those with a mental illness and/or referred from the prison system as forensic clients.[20]

58 For many years, the sector has not had an effective data management system to help inform its work and planning to the degree that it should.

59 As for the challenges AOD services face in supporting people with mental health issues, there are many. Some of the most notable are mirrored from the mental health system but also include additional matters. This "jack of all trades" approach might mean that

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[19] There is no overarching Act that governs AOD treatment delivery like say the Corrections Act for the prisons (which details everything from the administration of seclusion to hours a prisoner should work each day.) Instead we have a set of guidelines which outline the Victorian Government's principles and objectives, key service delivery requirements and minimum performance and reporting standards for Victorian Government-funded AOD programs and services. However, all services must also meet quality and safety standards and comply with relevant legislation such as *Drugs, Poisons and Controlled Substances Act 1981*, *Victorian Charter of Human Rights and Responsibilities Act 2006*, *Health Complaints Act 2016*, *Health Records Act 2001*, *Occupational Health and Safety Act 2004*, *Privacy and Data Protection Act 2014* and *Equal Opportunity Act 2010*.

[20] DHHS, (September 2018), *Alcohol and Other Drug program Guidelines, Part 2 – Program and Service specifications*
https://www2.health.vic.gov.au/Api/downloadmedia/%7BD9F0F87E-AF08-4580-8A75-4911FBD8DA95%7D

AOD clinicians can identify some mental health symptoms in their clients, but they often lack the expertise to treat these clients on their own. They require access to secondary consultations, appropriate referral pathways and shared-care plans with mental health treatment providers to address their clients' risk and needs.

60 The challenges for AOD workers include:

(a) A lack of access to internal infrastructure capacity as well as senior expert practitioners such as addiction psychiatrists, dual disability capable nurses and other staff located or linked, not just in mental health facilities, but also within AOD and other relevant service systems.

(b) A lack of appropriate referral pathways, protocols, shared care planning, clinical liaison, secondary consultation, and adequate clinical supervision (clinical supervision is most often provided to staff externally, or by a suitably qualified staff member within the organisation. It is distinct from line management supervision).

(c) Not being able to access mental health services readily, particularly in times of crises. Crisis Assessment and Treatment Teams (CATT) are not resourced enough to respond to AOD clients who are often suicidal. AOD clinicians are forced to call ambulances/emergency services and the person is generally taken to hospital, then discharged hours later without follow-up. Drug induced behaviour often leads to the attendance of police, which in turn could escalate both individual behaviours and likelihood of entry into the justice system.

61 People with AOD and mental health issues, often have other problems such as homelessness and criminality that intersect with and compound the AOD and mental health issues.

62 Anecdotally, VAADA understands that accessing mental health treatment is also difficult in rural and regional areas with limited access to mental health outreach services.[21]

Challenges for service organisations, clinicians and support workers who support people with co-occurring mental illness and problematic AOD use

63 There have been numerous policy frameworks released across both AOD and mental health at the state and federal levels. All of them use the language of “integrated”, “co-ordinated” and “collaborative”. Interestingly, there is no shared definition of what these terms mean, nor how these should be translated into practice.

[21] VAADA 2019 sector survey. This survey is an internal VAADA document conducted to obtain feedback from the Victorian AOD sector to inform VAADA’s original submission to the Royal Commission.

64 The lack of a shared vision between the state and federal government in relation to the AOD and mental health sectors has been a major frustration for organisations and workers. Good initiatives get discarded, while other initiatives get established that do not create the necessary reforms or changes. This 'churn' impacts sustainability, stability, morale, and client outcomes. Some issues include:

(a) Staff not being adequately trained in dual diagnosis across both the AOD and mental health sectors.

(b) Instability of funding and common purposes across AOD and mental health is common. We have siloed sectors with differing intake and assessment systems, and a resulting lack of care co-ordination and shared care-plans between services.

(c) Funding structures, for example, the Drug Treatment Activity Units fund specific treatment types in the AOD sector (such as intake, assessment and standard counselling). These funded treatment types do not include any room for flexibility in developing holistic client-centred approaches to treatment. In my view, these sort of endeavours usually sit under opportunistic funding as it may arise.

(d) Both sectors are underfunded and under-resourced, therefore different client cohorts are prioritised (for example, a psychotic person suffering from schizophrenia will be prioritised).

(e) Funding is based on units of treatment only, and there are no funds available with which agencies (in both sectors) can capacity build. This would include developing partnerships and collaborations with agencies from other sectors to promote better shared care.

65 Problems and challenges faced by organisations and workers in addressing the needs of dual disability clients is not new. The establishment of the Victorian Dual Diagnosis Initiative 'Key Directions' in 2002 (**Key Directions**)[22] was in response to an identified need for the development of better services and pathways for this client cohort. The Key Directions policy outlined by the then Victorian Department of Human Services, listed a number of key outcomes and key performance criteria for both AOD and mental health organisations to meet, and report against. The key outcomes included:

(a) Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as 'core business' in both mental health and AOD services;

[22] DHS (2007). *Dual Diagnosis: key directions and priorities for service development.,* Victorian Department of Human Services, Melbourne, State of Victoria https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions

(b) Staff in mental health and AOD services are dual diagnosis capable, that is, they have the knowledge and skills necessary to identify and respond appropriately to dual diagnosis clients and advanced practitioners provide integrated assessment, treatment and recovery;

(c) Specialist mental health and AOD services establish effective partnerships and agreed mechanisms that support integrated assessment, treatment and recovery and ensure 'no wrong door' to treatment and care;

(d) Outcomes and service responsiveness for dual diagnosis clients are monitored and regularly reviewed; and

(e) Consumers and carers are involved in the planning and evaluation of service responses.[23]

66 The incentive for agencies to make the necessary changes to their service provision was evident in the number of performance indicators in each outcome, against which agencies were required to report.

67 Similarly, in 2008, the then federal Department of Health and Aging launched the Improved Services Initiative (**ISI**) project, aimed at capacity building across the AOD landscape nationally. Under this project 122 non-government not-for-profit AOD agencies were funded throughout Australia to build the capacity of AOD treatment services to better identify and treat clients presenting with co-occurring mental health and AOD issues. The project had four main objectives:

(a) Building sustainable linkages and strategic partnerships;

(b) Assisting AOD non-government organisation treatment services to undertake service improvements;

(c) Identifying and facilitating training opportunities, and

(d) Providing targeted and relevant information and resources.[24]

68 The initiative was part of the *National action plan on mental health (2006-2011)*. It began as the ISI between 2008 – 2012, and was then funded as the Substance Misuse Service Grants Fund between 2012 – 2016, at which time the funds were redirected from capacity building into direct service delivery. Funded agencies were required to demonstrate their progress against the objectives of the program that included the completion of a self-audit tool agency wide. Most agencies used the Dual Diagnosis Capability in Addictions

[23] Ibid. pp 31-35

[24] National Improved Services Initiative Forum (2010). Outcomes from the National Improved Services Initiative Forum: A Tale of Two Systems. A Report Prepared by the Australian State and Territory Peak Alcohol and Other Drugs (AOD) Non-Government Organisations. Adelaide 2011 pp8http://www.atoda.org.au/wp-content/uploads/National-ISI-Forum-Report-2010.pdf

Treatment (**DDCAT**) tool. [25] The initial audit was used as a baseline, and it was then undertaken every twelve months to chart the agencies progress.

69 Throughout this period the AOD peak bodies in each state and territory were also funded to provide support to the ISI grant (and later the Substance Misuse Service Delivery Grants Fund (**SMSDGF**)) recipients to coordinate and work closely with the grant recipients. There was a focus on building partnerships and identifying training needs.

70 All of the state AOD peaks including VAADA have continued to receive funding by the Australian Department of Health to support the AOD sector in capacity building, though it is no longer exclusively dual diagnosis focused. This funding is current until June 2022.

71 Both initiatives sought to measure their dual diagnosis capability and implement strategies to improve their response. Both of these initiatives resulted in some improved care for the client cohort, including the development of shared intake and assessment processes, and shared treatment plans between AOD and mental health agencies in some areas. However, the outcomes from Key Directions were not sustained on an ongoing basis, and the ISI project was not offered to mental health agencies and largely focussed on AOD services. Therefore, many AOD agencies struggled to build relationships with their local mental health providers. Despite the gains into this area, the ISI program later morphed into a more generic focussed funding source and lost its key focus on dual diagnosis capacity building across the AOD sector. In combination and with some modification the continuance of both the Victorian 'Key Directions' focus an expanded ISI program, could have had a much more significant impact on dual diagnosis in Victoria and made the gains made by each state and federal initiative (ISI and Key Directions) more sustainable in the longer term.

72 In addition, I believe there was also a National Comorbidity Collaboration consisting of representatives from state and federal governments across AOD and mental health which was established in 2008 to improve relationships between all parties, develop best practice guidelines and increase professional education and training. I understand that in 2011 it was disbanded and there is now no public record of its activities.[26]

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[25] SAMSHA., *Dual Diagnosis Capability in Addictions Treatment (DDCAT) Toolkit* ,Substance Abuse and Mental Health Services Administration, 2011, Version 4.0, Publication Nol SMA-XX-XXXX, Rockville, MD

[26] Croton G. (2011), *Potential: Australia's evolving responses to co-occurring mental health and substance use disorders. Submission to Senate Community Affairs Committee - Commonwealth Funding and Administration of Mental Health Services Inquiry.* http://www.dualdiagnosis.org.au/home/images/documents/Senate_Submisssions/Dual_diagnosis_submission_Senate_MH_Inquiry_2011_CROTON.pdf

COVID-19

Observations around emerging changes to service delivery resulting from COVID-19

73 There have been some emerging patterns about client engagement and clinical practice as a result of COVID-19. Although there have been some differences of service delivery depending on the client cohort (age) and the types of services offered, at this stage, other than comments below VAADA is not able to present any formal data about the impact of COVID-19.

74 Through VAADA's AOD Manager's network meetings across five out of six Primary Health Networks (**PHNs**) regions across Victoria, the following anecdotal information has been raised:

(a) There has been an increase in clients reporting heightened levels of anxiety (it is not clear if this is due specifically to COVID-19 or other factors).

(b) Most clinicians have been required to quickly adapt to the use of all forms of digital health including counselling via telephone and video conferencing. However, this has presented numerous challenges including ensuring the privacy of both client and the clinician (who might be working from home).

(c) There have also been reported incidents whereby the client has experienced a sense of shame arising from the clinician seeing inside their home on video calls.

(d) Younger clients appear to have engaged better through telephone texting.

(e) There appears to have been a higher attendance for telephone appointments by forensic clients. It is unclear why this is the case however a possible explanation is that there is no travel involved.

(f) Telephone counselling requires more attention and focus by both the client and clinician due to the absence of visual cues in interviews. Some agencies have reported that clients are engaging more often over the phone, but for less periods at a time. This increases the clinicians' workload.

(g) Clinicians are being offered more online training options.

(h) Working from home can be exhausting for clinicians and reduce the 'boundary' between work and home life.

(i) Managers have had to provide more regular supervision to clinicians who do not have the ability to debrief with colleagues in between interviews, and to ensure that the clinicians are managing with their increased workload.

(j) There are cost savings in running some events. For example, VAADA conducted its Service Providers' Conference (convened on behalf of DHHS)

via four separate webinars rather than in person, thus saving on venue and catering costs.

Longer term opportunities for new approaches to service delivery for the benefit of consumers and carers following COVID-19

75 Due to COVID-19, I consider there will be changes in respect of service delivery. This could mean the AOD sector can offer longer term opportunities in service delivery. However, formal research and evaluation should be undertaken to assess the validity of this.

76 It is also extremely important that the consumer voice is sought in understanding the consumer experience and engagement with various treatment options. Some caution will also need to be exercised with regards to interpreting the data given that clients have been 'forced' in many instances to use technologies because of COVID-19 in circumstances where it would not be their preference to do so.

77 Further work needs to be undertaken to identify and implement digital platforms that are suited to the AOD cohort. Whilst many clients have engaged relatively well in one-to-one counselling, the provision of group therapies has been far more challenging. It is likely that HealthDirect (the federal government service that offers health advice online and over the phone) will be made available for use in the AOD and mental health sectors. However, the platform for HealthDirect does not have capacity beyond one facilitator and three clients. Some agencies have experimented with other platforms such as Zoom and Microsoft Teams, however the security of these modalities is questionable.

78 The more rapid adoption of online group therapy in the future telehealth and digital environments could conceivably bring great efficiency and benefits to all concerned. In rural/regional areas particularly, telehealth presents an exciting opportunity to save time and costs in travel for clinicians, clients and carers. It is important however, that the needs of each individual client is carefully assessed and that flexibility in service provision is maintained so that clients can have the option of face-to-face treatment where needed.

79 Yet adoption and adaptation of the medium will continue to take shape over time. I suspect that successful adoption of telehealth will depend on the development of a platform that is more fit-for-purpose for the AOD sector, however this is without reference to research or evaluation.

80 All individual clients present with different risk and needs, and capabilities with technology. Just as there could be great benefits to some under certain circumstance there could be some inherent limitations for some. There are groups of AOD clients for

whom telehealth options might not be suitable. These include those with acquired brain injuries and intellectual disabilities, and those who do not have regular access to a phone with credit and data. Clients experiencing family violence may be placed at further risk if they are overheard by the perpetrators, and clinicians cannot necessarily ensure their clients' safety in these situations.

81 The use of online platforms provides an opportunity for significant cost-savings with the availability of more online training, and the hosting of some events like forums, training, support and counselling virtually on an occasional basis. While there may be a role for expanded telehealth service delivery this should not be at the expense of face-to-face human contact.

POTENTIAL REFORMS

Examples of jurisdictions or services providing successful models of treatment for people with co-occurring mental illness and problematic AOD use

82 A few good examples of programs providing successful models of treatment might include:

(a) The Hume region's "No Wrong Door" Model is an example of a project that provided a shared intake/assessment model. Funded under the Federal 'ISI', the project involved the development of an Integrated Dual Diagnosis Protocol 2010[27] in the Hume region of Victoria, between AOD and mental health services in that area. The Protocol outlined procedures for the management of joint/shared clients, from initial contact, screening and assessment, treatment planning, referral and interventions. In addition, a suite of common intake and assessment tools were developed for use by both AOD and mental health clinicians alike.

(b) The Eastern Mental Health and Services Coordination Alliance (**EMHSCA**)[28]: This is an alliance of cross-sector (mental health, homelessness and AOD) treatment services that serve clients in all parts of the inner and outer east and is now well known across the Eastern Metropolitan Region as EMHSCA.[29] Part of EMHSCA's work involved the development of a regional shared care protocol in 2008 which includes AOD, mental health, family and homelessness services involved in shared care. The protocol describes expectations,

[27] Williams, R., *No Wrong Door 2 – Integrated Dual Diagnosis Procotocol, 2010.* An initiative of Ovens & King Community Health Service in collaboration with regional partners. Published by Ovens & King Community Health Service, Wangaratta, Victoria.
[28] See https://www.easternhealth.org.au/site/item/124-eastern-mental-health-service-coordination-alliance.
[29] The need for dual diagnosis linkages was identified in late 2007 and continue today with over 100 members from a wide range of health & community services across the region. The range of sectors includes AOD, Homelessness & Housing, Family services, Family violence, Aboriginal services, Primary and Community health, Consumer advocacy and legal services and is supported by DHHS.

requirements and processes for shared care by EMHSCA member agencies/programs, with the objective of improving outcomes for consumers, their carers, impacted families and children. The protocol includes guidelines on the collaborative practices for service providers when working together and sharing consumers. It also includes guidelines about the development of shared care plans and around appropriate and effective information sharing between parties. EMHSCA also includes workforce development, a peer alliance and a shared care audit conducted on an annual basis to ensure quality improvement.

(c) The LIFT Program: The LIFT Program funded by the Eastern Metropolitan PHN and is a stepped care model that provides wrap-around services for clients with co-occurring AOD and mental health problems. It is the result of partnership collaborations between Banyule Community Health, Nexus Primary Health and Health Ability. Other participating agencies include the GP Superclinic and DPV Health. The Stepped Care Model for Mental Health is a national rollout of community mental health services via PHNs which commenced in 2016 after the expert advisory panel advised the federal government that the current system was highly fragmented, not person centred, and had an undue emphasis on diagnosis and disability, rather than on impact and strengths. Along with increased flexibility to make the system work for clients (rather than the reverse). Additionally, through this program Banyule Community Health has been able to employ dedicated peer support workers in all areas of mental health and addiction, and an increase in care coordination on a fulltime basis.[30].

The ideal response to people in crisis who have mental health problems and problematic AOD use

83 An ideal response for a person who is in crisis and has comorbid mental health and problematic AOD use, is to first meet the person warmly when welcoming them into a service. The person should have both their AOD and mental health problems considered as primary issues to be addressed simultaneously because co-occurring disorders would be considered the "expectation not the exception"[31]. The assessing and treating clinicians should be fully trained and have specialist knowledge in either AOD and/or mental health. They should have the skills and expertise to immediately respond to the other issue (this would include assessment, obtaining secondary consultation from a specialist service or referral at a later date). Where more than one clinician

[30] This information was confirmed with Lara Jackson, General Manager Wellbeing and Support, Banyule Community Health Service via email on the 11th May 2020.
[31] Minkoff, K., Cline, C.,(2004), Changing the World: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders, *Psychiatry Clinical North America*, December 27(4), pp 727-43.

and/or agency is working with a person, an integrated shared care plan should be utilised.

84 The treatment that is offered should also be an integrated "one stop-shop" that is truly client centred. This means that the client would not be 'bounced' between agencies. The client would go through intake and assessment at one agency (either an AOD or mental health agency) and their clinical worker at the agency would retain responsibility for the client. Any secondary consultations or referrals required would be co-ordinated by the responsible clinician who would develop a shared care-plan with the client.

85 It is important to note that an ideal response does not necessarily require the establishment of dedicated co-occurring mental health and AOD treatment services. What is required is the establishment of seamless and efficient pathways, protocols, including human resources and infrastructure capacity at a number of levels including AOD, mental health, hospital, housing, aftercare and the community care environment.

Strategies to address discrimination and 'double stigma' for people with co-occurring mental illness and problematic AOD use

86 Stigma is a very complex issue and requires involvement at many levels including through services, government, and the community. From VAADA's perspective an individual's human rights are inalienable irrespective of their circumstances - be they related to health, age, gender, economic or social status. Over recent years much has changed in relation to the perception of those with a mental health issue through work done by the mental health community, individuals, families, mental health organisations and government. However, the AOD sector has much to learn about changing perspectives about those with substance abuse issues. It appears to us that there is some fundamental belief that people with substance use issues are 'in charge of their destiny' and are to blame for their substance use when in fact, problematic AOD use must be seen every bit as much a health issue as mental health issues. This necessarily requires a reconceptualisation of the messaging around AOD use and the role and approach of governments. We need to move towards more enlightened policies and health focussed strategies that seek to de-stigmatise and deal with root causes rather than superficial stereotypical analysis. Some practical suggestions might include:

(a) The development of a framework with a shared vision, goals and objectives and guiding principles applicable to all services across the mental and AOD sectors who work with people with co-occurring problems. The framework could outline joint approaches to the identification and management of clients who present to services with both AOD and mental health problems, in addition to affirming to both AOD and mental health clinicians that they are

working with the same clients. This would assist in breaking down any potential barriers relating to perceived client stigma between workers.

(b) Raising the voice of consumers in the AOD and/or mental health space, through the establishment of formal consumer participation processes, and the provision of meaningful feedback to agencies regarding their experience of a service.

(c) The facilitation of consumer involvement in co-design, in order to enhance quality improvement. At present this process is not separately funded (at least in the AOD sector), therefore agencies already stretched for resources will unfortunately not always prioritise these tasks to the extent required.

(d) The provision of specific training and education for all staff (including managers) across all community services – not just AOD and mental health, about problematic AOD use and mental health issues. This could be integrated into existing training opportunities in each sector and should be directed at changing culture.

(e) I would refer the Commission to the Queensland Mental Health Commission paper 'Changing attitudes, changing lives'[32] and the recommendations in this paper. The paper outlines six key domains including human rights, social inclusion, engaging people and their families with a lived experience, access to services (health care and social services), the justice system and economic participation. I would propose that the Royal Commission considers these domains for inclusion in its Final Report and recommendations.

EXPLORING INTEGRATION

Integrated care for people with co-occurring mental illness and problematic AOD use

87 In summary, 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 a shared treatment plan for an individual that addresses both disorders and then provides 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.

88 It is also important to note that the language surrounding the term "integration" has been used differently under different circumstances. In some circumstances, it has been conflated with concepts such as administrative-driven merging of whole systems and

[32] See: https://www.qmhc.qld.gov.au/sites/default/files/downloads/changing_attitudes_changing_lives_options_to_reduce_stigma_and_discrimination_for_people_experiencing_problematic_alcohol_and_other_drug_use.pdf

departments. Merging departments is a concept that is not supported by VAADA. It is therefore very important that all stakeholders are working together with the same and clear definitions of integration.

89 Based on the influential work of Ken Minkoff and Chris Cline, both psychiatrists in the USA, who suggest that,

> An implication of the prevalence of people with co-occurring disorders is the: 'need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already'.[33]

90 According to this approach there are four terms to describe "integrated care" as follows:

(a) Integrated treatment: The 2007 Key Directions document is clear and instructive in relation to integrated treatment which states:

> 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 cooperation between agencies in reassessing and treating the client.[34]

(b) Integrated Programs: These are "implemented within an entire provider agency or institution to enable clinicians to provide integrated treatment'[35]. An example of an integrated program is a senior AOD clinician with mental health training and experience who provides consultation and support to AOD colleagues in working with their clients.

(c) Services or Operational Integration: This is defined as:

> 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

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[33] Minkoff, K., Cline, C.,(2004), Changing the World: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders, *Psychiatry Clinical North America*, December 27(4), pp 727-43.
[34] DHHS. (2007) *Dual Diagnosis: key directions and priorities for service development,* https://www2.health.vic.gov.au/Api/downloadmedia/%7BCA006246-2A26-4CD3-A3EB-3D2244CE3686%7D
[35] CSAT. (2007) *Definitions and Terms Relating to Co-Occurring Disorders*. COCE Overview Paper 1. DHHS Publication No. (SMA) 07-4163 Rockville, MD: Center for Substance Abuse Treatment. Substance Abuse and Mental Health Services Administration, https://atforum.com/documents/OP1-DefinitionsandTerms-8-13-07.pdf

services to the client, or an organised program in which all clinicians or teams provide appropriately integrated services to all clients.[36]

In this context "services" refer to all organisations within the relevant sectors. This involves the organisations (both within each sector and cross-sector) working with one-another with a common vision to provide integrated treatment for the client utilising a common approach and set of procedures. Service integration can be achieved and supported via the development of protocols and partnership agreements across agencies. Operational integration can also occur within an organisation, where separate programs are organised and clinicians work together (with a common set of policy and procedures). An example of this would be the AOD and mental health programs located in the same organisation working together to offer joint co-occurring intake, assessment and treatment services.

(d) Systems Integration: This is defined as "[t]he process by which individual systems or collaborating systems organise themselves to implement services integration to clients with co-occurring needs and their families."[37] In this instance the senior management of each sector is directed to work together to implement common policies throughout each sector to ultimately result in the provision of integrated treatment at the grass-roots level.

91 Integrated care can be achieved by designing and implementing a system of client-centred care for dual-diagnosis clients. An example of best practice is "The Comprehensive, Continuous, Integrated System of Care (**CCISC**). This is an evidence-based model developed by Minkoff and Cline. The CCISC model has been used in numerous countries and jurisdictions including Victoria and focuses on the redesign, but not the merging of administration between the AOD and mental health sectors. As such, this model can be very cost effective.

92 The CCISC system is underpinned by eight principles and can be achieved by implementing 12 steps.[38]

93 A recent Victorian example of the implementation of the CCISC model is EACH Social and Community Health. This organisation underwent the process of developing a set of service principles for the entire service in 2016. The resulting principles included:

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[36] Minkoff, K., Covell, N. (2019) *Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: 'What's Known, What's New, and What's Now?* National Association of State Mental Health Program Directors, https://www.nasmhpd.org/sites/default/files/TAC_Paper_8_508C.pdf

[37] 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

[38] For descriptions of both the principles and steps see: Minkoff K & Cline C, Developing welcoming systems for individuals with co-occurring disorders: the role of the Comprehensive Continuous Integrated System of Care model. J Dual Diagnosis 2005, 1:63-89, pages 70-75

(a) We welcome you with empathy and hope.

(b) We make services safe and easy to access.

(c) We are trained to respond to all of your needs.

(d) We respect diversity and learn about your culture.

(e) We recognise and respond to the impact of trauma.

(f) We include the people important to you.

(g) We believe making change is possible.

(h) We respect your lived experience and work with your strengths.

(i) We work with you and others to respond to your needs.

(j) We advocate with you and for you and your community.

(k) We are committed to getting better at all that we do.[39]

94 A service "Innovation Lab" was formed to develop and test the service principles at EACH Social and Community Health. It used the CCISC model in combination with a co-design model with consumers and with input from an advisory group consisting of a range of EACH staff, carers and consumers. A series of over 40 workshops and activities were held to orient all EACH staff (from all programs) with the new principles, after which a comprehensive evaluation was undertaken. The evaluation indicated that the principles had an overwhelmingly positive affect on staff and made recommendations to resource teams to integrate the methods into service development, and ensure that all programs allocate budget to co-design. In addition, the evaluation recommended that capability frameworks and baseline measures be developed for all individuals and programs, and that the service principles be integrated into recruitment processes and position descriptions amongst others.[40]

Specific components, structures or processes required to enable integrated care for consumers with co-occurring mental illness and problematic AOD use

95 In VAADA's view, there should be well understood/developed pathways across a care continuum from community-based services to tertiary services, and vice versa. Ideally the pathway would not be hindered by either eligibility criteria, location, gender, ethnicity or physical and specialist staffing capacity issues.

96 From a community based AOD service perspective, our system should be able to comfortably manage 'high prevalence' dual disability type issues for clients across an

[39] EACH, (2016) *EACH Service Principles,* EACH Social and Community Health, Melbourne, Victoria (internal document). Permission was formally obtained from Mr. Peter Ruzyla, CEO, EACH Social and Community Health to quote this internal document.
[40] Ibid.

enhanced AOD system. Pathways and protocols and availability of physical infrastructure for escalating clients into more specialised AOD services and residential systems should be available as should pathways and protocols for transferring clients into other systems such as a tertiary acute settings where greater AOD or mental health complexity would be dealt with.

97 This approach should work in reverse as well with the orderly transfer of clients back into community settings from tertiary or specialist facilities. These step-up step-down arrangements occurring between key yet disparate parts of the health and community-based systems must be addressed for clients not to continue falling through the net. A key component of this is the availability of specialist staff in both mental health and AOD in different parts of the system. Such staff would include addiction psychiatry specialists, addiction medicine specialists and dual diagnosis nurses all incorporated into the different levels of stepped care. There should be step up capacity within acute settings as well as step down to better prepare complex clients for return to community settings and services. Outreach and aftercare need to be performed diligently with clear and measurable assessment of client outcomes. Enhanced care co-ordination/case management can be located at different points of the continuum depending on where the clients commences their journey. Formal processes should be developed if care co-ordination is to be transferred to another agency or institution.

Future system changes required to deliver more integrated care for people with co-occurring mental illness and problematic AOD use

98 There should be a joint vision across all agencies in all relevant sectors for the treatment of people with co-occurring mental health and AOD problems. This joint vision should be supported by policy, protocols, and planning outlining agreed upon guidelines and procedures to inform clinical practice for this client cohort within all services. All sector leaders should be directed and assisted with various resources to implement these.

99 The vision and supporting guidelines and procedures should be used to inform the development of collaborative partnerships between agencies from different sectors and across the care continuum to support service accessibility. The development of strong collaborative partnerships is key to the role of clinicians in providing integrated treatment at the coalface. The agreed upon vision and procedures should also include an agreed upon set of client outcomes, with corresponding data collection processes, and performance indicators. These should include mechanisms for consumer-oriented continuous quality improvement processes.

100 Past projects were instrumental in raising the capacity of AOD agencies to manage people with mental health presentations. The objectives of the projects involved building

collaborative relationships between agencies through the development of agreements such as memorandums of understanding and protocols that clearly outlined the roles and responsibilities of all agencies (both AOD and mental health) for the engagement and treatment of clients with co-occurring disorders, and enhanced referral pathways. For example, the federal government had the ISI project between 2007-2012, and then the SMSDGF from 2012-2016. However, the projects had limited sustainability because the mental health sector was not given the same directive to work collaboratively with the AOD sector. Therefore, while many AOD agencies were funded and keen to develop working relationships with mental health agencies (with performance indicators to meet in their funding agreements) this keenness was not reciprocated by mental health agencies in some regions as they had no financial, reporting or incentive to do so. Projects like the ISI should be considered for future system changes, but the funding needs to be made available to both sectors simultaneously with common deliverables to work with one another.

101 Barriers to intake and assessment (such as eligibility criteria) in each sector should be removed so that shared care pathways and care plans can be developed and implemented. The current centralised AOD intake system does not support a model of integrated care, but rather the opposite through funnelling people into one isolated sector only. This is because clients coming into the AOD sector must undergo intake (usually over the phone) and assessments and care-planning through an AOD process only. The client is screened for mental health issues, but these issues are not always managed effectively in the AOD agency because many clinicians are not dual diagnosis trained. The client is referred to a mental health service where they will undergo another complete assessment (telling their story yet again) and if accepted by the mental health service another separate care-plan will be developed, potentially at cross-purposes with the AOD plan.

102 AOD and mental health services cannot develop any shared intake, assessment and treatment for clients because of the current funding constraints and the mandatory use of the one AOD assessment tool. Prior to AOD sector reform in 2014, in some regions they developed collaborative and shared intake and assessment processes (for example, in the Hume Region – the “No Wrong Door Project”) and they were even using shared intake and assessment tools that meant the client was not assessed twice. Also prior to this reform, clients could walk into AOD agencies to undergo intake and assessment. If mental health issues were identified clinicians could literally walk them down the hall to make a warm referral to the mental health service (if they were co-located). A range of structural impediments based around centralised intake now exist.

103 Funding should be reflective of the work actually undertaken with the person, rather than in rigid treatment types that do not match with the services required/provided.

Streaming clients due to the severity and complexity of their support needs

104 All people with co-occurring issues present to services with differing problems of different severity, different needs and aspects that are individual to their particular circumstances. This cohort is not homogenous and their presenting issues cannot be classified into "boxes". A person attending an AOD service in a state of psychosis will need to be managed very differently than a person who presents with substance use and medicating for an anxiety disorder.

105 A flexible and responsive system is one that can respond effectively to these differences based on thorough assessment and case formulation practices, and then the availability of pathways and entrance points to other required services. To use the examples above, the AOD dual-diagnosis capable clinician completing the assessment will be skilled in identifying the psychosis on the person with florid symptoms, but is unlikely to be able instigate any treatment without immediately referring the person to a mental health service. The mental health service should be able to respond (in a timely manner) based on the original assessment (which would be shared) and by obtaining additional information (not making the person tell their story again). In accordance with the collaborative agreements between the AOD and mental health agencies a shared care-plan would be developed. The same scenario would also apply vice-versa, if a person in AOD withdrawal was assessed at a mental health agency.

106 In relation to broad "streaming" there are models that can be considered such as the three-level scheme for responding to dual diagnosis illustrated in the 2007 Victorian Key Directions policy document.[41] The dual-diagnosis response is described as follows:

(a) Tier 1: Services for people experiencing severe mental health problems and disorders and problematic AOD use. This involves dual diagnosis capable staff in specialist mental health services should provide integrated treatment to the majority of clients with severe mental illness and substance use disorders; collaborate with AOD services in service provision for those whose needs are best met in this way; and provide secondary consultation to other sectors regarding the treatment of mental health disorders.

(b) Tier 2: Services for people experiencing severe substance use disorders with lower severity mental health problems and disorders. This involves dual diagnosis capable staff in AOD services should provide integrated treatment to clients who experience severe substance use problems and lower severity mental health problems; collaborate with mental health services in service

[41] DHS., (2007) Dual Diagnosis: *Key directions and priorities for service development,* https://www2.health.vic.gov.au/Api/downloadmedia/%7BCA006246-2A26-4CD3-A3EB-3D2244CE3686%7D

provision; and provide secondary consultation regarding the treatment of problematic drug and alcohol use to other sectors.

(c) Tier 3: Service for people experiencing lower severity mental health problems and lower severity drug and alcohol problems. This involves 'dual diagnosis' capable primary care services staff, including general practitioners, counsellors and community health services, should provide integrated responses to people experiencing low level mental health and drug and alcohol problems; collaborate with mental health and alcohol and other drug services in joint service provision (for example shared care arrangements) and refer those in need of more intensive services.

107 An additional model that describes the same concept of streaming is the Co-occurring Disorder Four quadrant model which is described as follows:

(a) Quadrant 1 – Less severe substance use disorder and less severe mental health disorder.

(b) Quadrant 2 – More severe mental health disorder and less severe substance use disorder.

(c) Quadrant 3 – More severe substance use disorder and less severe mental health disorder.

(d) Quadrant 4 - More severe mental health disorder and more severe substance use disorder.[42]

108 Whilst VAADA acknowledges that some broad streaming is required to enable the locus of responsibility to be delineated for some clients (i.e. which agency and/or staff should engage and work with the client), we would urge caution around considering streaming clients into strict eligibility categories. Assessments are fluid and client circumstances can change very rapidly, i.e. they can be stable one week and in crisis and unwell the next. The system must be flexible enough to accommodate that, so that a truly client-centred approach is adopted.

109 Minkoff et al in their soon to be published journal article called *Ideal Behavioural Health Crisis System*[43] describe a good example of a streaming response by having the availability of crisis "hubs" to support the needs of people presenting with severe and acute problems. These hubs would be a physical location (separate from a hospital) where a person could go (or be brought by police and first responders). They describe the Crisis Response Center in Tucson, Arizona as being an example of such a facility.

[42] McDonell et al., (2012), Validation of the Co-occurring Disorder Quadrant Model, *Journal of Psychoactive Drugs*, 44(3), pp 266–273.
[43] This document was referenced in paragraph 79 of Gary Croton's published witness statement to the Mental Health Royal Commission dated 21 May 2020.

The hubs would include crisis co-ordination, a mobile crisis assessment team, call centre, co-response teams with first responders, medical screening and intervention, crisis/respite housing, substance use stabilisation and treatment and 23 observation beds.

110 A loosening of eligibility criteria is required across the board. Many people present to services (both AOD and mental health) with behavioural issues (common with personality disorders) but with no specific "diagnosis" and therefore they are excluded from treatment and bounced to other services.

Service response for 'streamed clients' including those in acute need

111 The service response must remain flexible enough that people can be assessed in environments that best suit their needs. As noted above the range of options should include:

(a) mobile assessment teams for people at home and without transport. These would be similar to the CATT, however eligibility for services would be significantly broadened to at least include AOD and other types of behavioural issues – not just psychosis;

(b) crisis hubs;

(c) adequately resourced AOD, emergency departments and mental health services utilising assessment tools and procedures that align with one another;

(d) helplines that can activate a range of resources to assist the client;

(e) physical environments that would include mobile and telephone;

(f) a multi-disciplinary team that would include AOD clinicians across intake, assessment, counselling, withdrawal, and residential rehabilitation (trained in mental health), mental health clinicians (trained in AOD), psychologists, social workers, nurses, general practitioners and consumer representatives (peer workers etc); and

(g) addiction specialists and psychiatrists who can provide both primary and secondary consultations across both sectors.

Examples of successful models of system or service integration across mental health and AOD in Australia or internationally

112 There are a number of jurisdictions worldwide that have successfully implemented models of integrated care. One such example is the development of an Integrated

system of care model in the state of Maine in the USA.[44] Work commenced on the project in 2002, and by the mid-2000s, the majority of providers had been exposed to the CCISC model. Practice changes were addressed by engaging 30 pilot sites, across all areas of screening, assessment and treatment. Agency audit tools were also utilised to measure baseline co-occurring capability and any subsequent improvements. However, the changes at that stage were localised only, and were not consistent across the state. This changed however when the support of the Commissioner of the Maine Department of Health and Human Services to implement the CCISC model was gained.

113 To get departmental buy-in, the Commissioner made a statement to all staff across all departments, both AOD and mental health sectors that the provision of an integrated approach was now the business of everyone. This emphasized the commitment for change, and that a top-down approach is necessary to instigate change at the lower levels of management and clinical practice. It was also noted that any resistance to the changes by staff in either the AOD or mental health departments was based on a lack of understanding of what integration actually meant. It seemed that the administrative departments considered that integration mental merging of mental health and AOD departments rather than 'integration' meaning a holistic, integrated client-centred approach for clients presenting with co-occurring disorders (which could be enabled by a model such as the CCISC).The requirements (for example, deliverables and associated performance indicators) to provide integrated services for clients presenting with AOD and mental health issues were inserted into every contract that the department had with providers, and within other state regulations, and work was continuing to embed the recommended policies and standards into each of the service providers at the coal-face.

114 The project evaluation of the care model in Maine, USA, was conducted by external consultants, and the data indicated an improvement in both client and agency outcomes. The clients who remained in treatment had positive outcomes across a range of domains, including increased employment and reduced criminal justice involvement. At the agency levels, the analysis of audits (pre and post) revealed that all agencies had improved their capacity to provide integrated care, and that a third were now operating at an advanced level.[45]

115 An additional example from Queensland, Australia, is the development of the Stretch2Engage Partnership[46] beginning in 2015. The objective of this project was to develop and implement an overarching framework that agencies can use to better engage clients presenting with co-occurring AOD and mental health issues. Similar to Minkoff and Cline's CCISC model, the framework outlines a series of principles

[44] Chichester, Catherine et al,. *I*mplementing an Integrated System of Care Model in the State of Maine, *Journal of Dual Diagnosis* (Nov 2009), 5(3), pp 436-446.
[45] Ibid.
[46] See http://www.stretch2engage.com/.

designed to influence agency culture. The Queensland Mental Health Commission (**QMHC**) engaged this partnership to develop best practice engagement principles for engaging people using services in Queensland's mental health and AOD sectors. The principles were developed after extensive consultation across Queensland, including a series of think-tanks and online forums, during the first stage of this project. Following the development and testing of the principles, the second implementation phase of the project commenced in 2018. Implementation has involved the formulation of a range of activities and resources to assist the pilot agencies to understand and embed the principles. All stakeholders have also had opportunities across the whole project to provide feedback and to contribute to the design and re-design of the project where possible.

116 An independent evaluation of the project was commissioned by QMHC. Some of the findings are now available from QMHC, however the full evaluation report is yet to be formally released. Early indications are that all the agencies involved in the pilot remained well engaged with the partnership throughout the project, and they reported improved engagement with, and more positive feedback from their clients and their families.

Integration of service responses without compromising state and federal strategy or policy

117 While the overall policies and strategies at both state and federal level use different language (for example, variable definitions of integration and care-coordination), the concepts and intent are essentially the same. All policies and strategies share the same vision and aim - that the delivery of services should be client-centred, with outcomes that directly benefit the client. The federally funded ISI/SMSDGF project was a direct example of how federal policy can support state policy and vice-versa. The real issues are the inflexible funding models previously noted, together with a failure (at both state and federal level) to translate good policy into practice.

118 A potential redesign of the Victorian mental health system together with overarching policy should be seen as an opportunity to approach federal authorities to work together to reduce any inconsistencies in approach.

National or international examples of successful commissioning

119 Successful commissioning must address the following: the policy, planning and service commissioning environment must support service integration that delivers outcomes through multiple specialist service collaborations and care coordination. This form of

service integration both recognises, and supports the sustainment of, the strengths of each respective specialist sector.[47]

120 Commissioning should involve both vertical and horizontal integration of models of care. The vertical captures the specialisation necessary to respond to more specific presenting issues. Horizontal to build the necessary supports and collaborations to achieve broad based positive community health.[48] Achieving the necessary balance between these two imperatives requires a practice of oversight which enables agencies to establish service entry points and developing place-based solutions to presenting cohorts. It also supports a population planning model which reflects on the demand (both met and unmet) to inform the funding model rather than the development of a funding model which dictates service engagement.

121 Commissioning should also include consumer participation (not just consultation) in the development of all aspects of the commissioning process as well as at agency level. Commissioning should also encapsulate the notion of 'one system, one budget' to encourage models of care which prevent deeper and more acute service engagement; for instance, processes where people at risk of acute AOD related health crisis resulting in emergency department (**ED**) engagement could be supported to engage in AOD treatment which has shown a reduction in future ED attendances.[49]

122 To replicate this in Victorian commissioning models, we consider the following factors are important:

(a) 5 year contacts to foster organisational funding stability, so as to ensure certainty for strategic planning, staff development and investment and to embed the service within the local community.

(b) Streamlining state and Commonwealth funded activity by way of commissioning processes, timelines, duration of contracts and eliminating duplication.

(c) Enhancing workforce training, capacity building, cross sector integration and accounting for capital works.

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[47] WANADA (2019), WANADA Submission to Productivity Commission Inquiry on the Social and Economic Benefits of Improving Mental Health, http://www.wanada.org.au/index.php?option=com_docman&view=download&alias=207-wanada-submission-to-productivity-commission-inquiry-on-the-social-and-economic-benefits-of-improving-mental-health&category_slug=current-submissions&Itemid=265.

[48] Thomas et al. (2008), Combined horizontal and vertical integration of care: a goal of practice-based Commissioning, *Quality in Primary Care*;16, pp 425–32.

[49] V Manning et al, (2017), 'Substance use outcomes following treatment: findings from the Australian Patient Pathways Study', *Australia and New Zealand Journal of Psychiatry,* vol 51(2), p 11.

(d) Flexibility in funding models to both respond to local needs as well as trial innovations and conduct robust evaluations of practice to progress continuous improvement.

(e) Providing regular and accurate updates to the community on the service configuration to minimise service user attrition.

(f) Ensuring that the funding model allows for sustainability in rural and remote regions, where service provision may be impacted through the tyranny of distance, challenges in workforce retention and specific health and welfare presentations among service users in rural and regional areas.

(g) Ensuring that the commissioning process does not deter pre-existing good practice, effective collaborations or consumer engagement.

(h) Addressing sector wide issues rather than responding to issues that may be evident with only a smaller segment of providers.

(i) Ensuring commissioned services have the flexibility to respond proactively to emerging challenges, such as changing drug use trends and evolving new at-risk cohorts.

WORKFORCE

Improvements in the expertise of the AOD and mental health workforces

123 The prevalence of co-occurring disorders in both AOD and mental health services is well-known. Maree Teesson estimated that up to 90% of clients presenting to AOD services have co-occurring mental health issues, and up to 71% of clients presenting to mental health services have co-occurring AOD issues.[50] Further, Odyssey House in New South Wales identified that 77% of its clients in residential services, and 53% of community clients had co-occurring mental health issues in its 2019 Annual Report.[51]

124 Current Victorian policy stipulates that:

> …[t]he development of dual diagnosis capable staff is a fundamental requirement for establishing dual diagnosis as core business in each sector and is the primary service development task. All staff in both mental health and alcohol and other drug services should, at the most basic level, be able to administer a screening tool appropriate to their service age group, undertake a dual diagnosis assessment, and consult others with more advanced knowledge and skills in making decisions about the most appropriate

[50] Mark Deady, Emma L Barrett, Katherine L Mills, Frances Kay-Lambkin, Paul Haber, Fiona Shand, Amanda Baker, Andrew Baillie, Helen Christensen, Leonie Manns, Maree Teesson. (2015) *Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check* review brokered by the Sax Institute for the NSW Mental Health and Drug and Alcohol Office, https://www.health.nsw.gov.au/mentalhealth/resources/Publications/comorbid-mental-care-review.pdf.
[51] Odyssey House (2019) *Reconnecting Lives* Annual Report, http://www.odysseyhouse.com.au/about-us/annual-report.

course of action to be taken. At the advanced level, dual diagnosis capable will mean being able to assess and effectively treat dual diagnosis clients in an integrated manner within service and practice guidelines. [52]

125 VAADA supports this approach and notes that the AOD service sector, over many years, has undertaken and engaged in a process of becoming dual diagnosis capable. A number of structured initiatives such as the Victorian Dual Diagnosis Initiative (**VDDI**) and the ISI have driven this. Systemic reforms along with investment in staff training, education and development will ultimately reap significant rewards. Development of a dual diagnosis competent workforce is achievable in both sectors given the correct environment and support. Planning for the sort of workforce required needs to occur along with a mutually agreed industry plan that meets both system change requirements and transformation of the workforce.

126 Further, as recognition of its ongoing commitment to address the need for an enhanced dual diagnosis service approach VAADA specifically recommended that three specialist dual diagnosis clinicians be employed in each state catchment region in both AOD and mental health settings in its 2020/2021 Budget Submission.[53]

127 Both the mental health and AOD sector should be able to assess for and manage individuals with lower to mid-level AOD use and presentations and vice versa as stipulated in the DHHS policy. At the same time, where symptomatology requires greater expertise, each respective sector needs to be able to have available 'in-house' expertise to draw on before referring into the respective service system if or as required.

128 An agreed set of joint principles (for clients to be engaged into a welcoming environment and as outlined as part of the CCISC system) should be formulated and embedded into the AOD and mental health sectors in order to promote a common vision to treating these clients, and facilitate the culture that supporting clients with co-occurring disorders should be the "expectation and not the exception".

To what extent do mental health services need specialist AOD expertise to support clients and vice versa

129 The mental health sector should be able to assess for and manage individuals with lower to mid-level AOD use and presentations and vice versa. At the same time, where symptomatology requires greater expertise, each respective sector needs to be able to

[52] DHS., (2007) *Key Directions: key directions and priorities for service development,* https://www2.health.vic.gov.au/Api/downloadmedia/%7BCA006246-2A26-4CD3-A3EB-3D2244CE3686%7D.

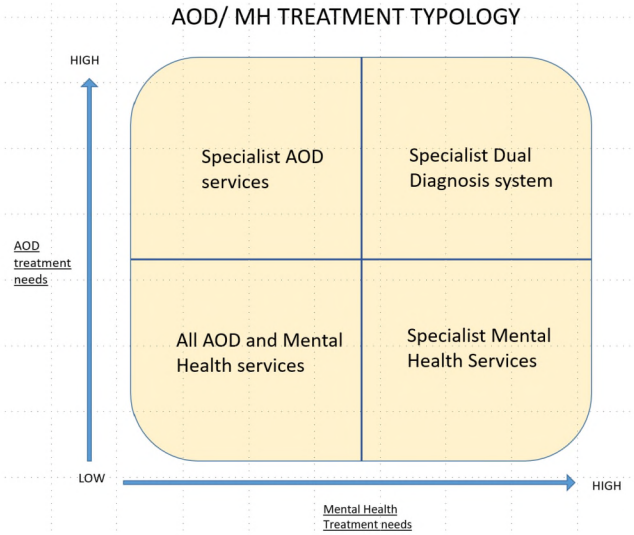
[53] VAADA (2020) *VAADA State Budget Submission 2020-2021,* https://www.vaada.org.au/wp-content/uploads/2018/06/SUB_state-budget-submission_19122016.pdf.

have available 'in-house' expertise to draw on before referring into the respective service system if and as required.

130 In this way, there needs to remain specialist AOD and mental health services respectively to manage clients whose main presentation and need is either mental health or AOD. Where clients present with complex dual diagnosis, (mental health and AOD needs) there needs to be dedicated dual diagnosis services and coordination of treatment. Too often there is a lack of case coordination between the sectors. It makes life much simpler for the client when they have someone who is coordinating their treatment needs.

131 In relation to AOD services requiring specialist mental health expertise, this response is a mirror to paragraphs 128-129 (i.e. that AOD services requiring mental health expertise mirrors the mental health services required AOD expertise) above with variations based on the AOD sector.

132 A treatment typology similar to the Forensic AOD Treatment Typology developed for Victorian forensic AOD treatment[54] might provide a pathway for considering workforce needs and treatment responses by level of mental health and AOD treatment need (see below). This typology, or similar structured approach, would help address dual diagnosis in a more coordinated way (see below).



133 The level of expertise required in either setting is dependent upon the setting, and role of the worker. For example, the skills required in an AOD counselling position will differ from those in an inpatient withdrawal unit.

[54] DHHS and the Department of Justice and Regulation (2018), *Forensic Alcohol and Other Drugs service delivery model*, https://www2.health.vic.gov.au/about/publications/policiesandguidelines/forensic-aod-service-delivery-model

134 However, base level AOD expertise should be embedded within all mental health services at all levels (especially assessment, brief intervention, and effective referral). Likewise, AOD services should have a base level understanding of high prevalence mental health disorders and comorbidity relevant to their work and have skills in mental health assessment, brief mental health intervention and referral. A range of competencies should reside in each sector which could be called upon to advise and support treatment in each sector based on the mental health and or drug need of the individual. Both AOD and mental health clinicians should have access to specialist advisors in all settings who can provide primary and secondary consultations. These could include advanced dual-diagnosis clinicians (in both sectors) and/or addiction specialists in the mental health sector and consultant psychiatrists and psychiatric nurses in the AOD sector. All AOD services should have developed referral pathways (best supported by partnership agreements and/or protocols) in their local catchment areas with mental health services and vice versa.

135 To be dual diagnosis "capable", all AOD and mental health agencies should be assessed as such. In some jurisdictions performance measures directly relate to agencies deliverables and outcomes in their funding and service agreements. The federally funded ISI project required AOD agencies to audit their performance on a yearly basis and report their improvements against a series of domains.

New capabilities, functions and roles to integrate mental health and AOD workforces

136 Coordinating service systems should be prioritised. Potential new roles that should be considered include:

(a) The expansion of the peer worker workforce. Peer workers provide an invaluable service to both sectors already in assisting consumers and their families to engage in treatment, and via the provision of other support services. The need for greater involvement of consumers in the workforce is acknowledged and supported by current Victorian policy which states "[t]he value of peer workers in the AOD sector is immense and often quoted as a necessary part of recovery. People seeking help are less likely to feel judged or stigmatised by those who have a similar experience."[55]

(b) Portfolio holders in agencies across both the AOD and mental health sectors. Their roles would involve assisting their services to plan, develop better dual diagnosis service responses and to mitigate change management issues. These roles would include service development, in particular, increasing

[55] DHHS., (2018) *Victoria's alcohol and other drugs workforce strategy 2018–2022* Victorian Government, https://www2.health.vic.gov.au/Api/downloadmedia/%7B83DF3B9A-DD77-42C4-84BD-52717694EA16%7D.

agencies capacity to respond to dual diagnosis issues. These roles must be senior enough to ensure buy-in from senior managers and have the authority to implement the identified services at all levels of the organisation.

(c) Senior dual diagnosis practitioners in both AOD and mental health agencies to assist with embedding practice change and with providing a consultative role to clinicians in addition to managing and supporting complex clients.

The level of mental health skills and expertise for the AOD workforce

137 The level of mental health skills and expertise for the AOD workforce will depend on role and function, but generally what is required is knowledge of the respective mental health service systems and how to access them and referral pathways. There needs to be an overview of mental health treatment approaches and a recognition of stigma and discrimination. The AOD workforce must have knowledge of mental health disorders, including both high and low prevalence disorders and personality disorders. Knowledge is required as to how substance use impacts on mental health and vice versa. This includes all mental health disorders with all substances (for example, alcohol and anxiety, amphetamines and psychosis, smoking and mental health medications).

138 There must be integrated screening for mental health issues (such as the use of tools, signs and symptoms) including how to conduct detailed assessments and obtain the information required to develop integrated and shared care plans. There must be knowledge around brief interventions, motivational interviewing and relapse prevention.

139 Advanced practitioners in either the AOD or mental health sector should he required to have the knowledge and skills to deliver treatment to clients with co-occurring issues and provide support and guidance and secondary consultations to other staff.

The level of AOD skills and expertise for the mental health workforce

140 The level of AOD skills for the mental health workforce is again dependent upon the type of role a person has. Generally, the mental health workforce must have knowledge of the AOD service system, how to access it and referral pathways and have an overview of AOD treatment approaches and be aware of the stigma and discrimination that exists for those requiring treatment who have AOD and mental health concerns. There should be integrated screening for AOD issues and knowledge around the use of tools for AOD issues and the signs and symptoms around problematic AOD use. There should be knowledge around how to conduct detailed assessments and obtain the information required to develop integrated and shared care plans. The mental health workforce should have knowledge of all substances (alcohol and drug types) and their impact on mental health. This includes the interaction between smoking and some mental health medications. Training should be conducted to enable the mental health

workforce to be able to conduct brief interventions, motivational interviewing and relapse prevention.

Opportunities for joint mental health and AOD workforce training and development

141 Training and development is required to support all of the subject areas listed above. Additionally, there should be AOD and mental health specific specialist training (for example, around withdrawal and inpatient settings). Dual diagnosis training around co-occurring mental health and substance use issues, could be provided jointly after areas of commonality are identified and mapped.

142 Joint training opportunities would benefit both AOD and mental health clinicians alike. They promote the building of cross-sectoral relationships between clinical workers and the provision of more consistent information and skills to both. In local areas this can assist in the maintenance of referral pathways for clients. Joint training also assists in breaking down the barriers of stigma via the promotion of a joint understanding of their clients and behaviours. The routine use of the previously mentioned agency and clinician self-assessment tools and checklists would provide valuable information as to where the gaps in skills and knowledge are across both sectors. Identification of the gaps would then inform the potential content of joint training, the best learning methods (online, face-to-face) and all other components.

143 The current situation regarding the availability of different training/education courses from different providers (some accredited and some not) requires clarification and better consistency. It would be beneficial to convene a high-level cross-sectoral working group to explore dual diagnosis training content and establish a consensus on what training providers should be promoting. New Zealand's accreditation and registration of agencies and staff could be explored for its applicability in Victoria.

144 Joint training and development for clinicians/workers across both sectors needs to be supported by agency policies and procedures that support the implementation of the knowledge and skills gained and any changes to clinical practice. This could include the provision of joint clinical supervision for dual-diagnosis workers.

Examples of joint mental health and AOD workforce training and development being done successfully

145 In 2017/18, the (then) Department of Justice and Regulation and DHHS developed a joint Forensic AOD service delivery model.[56] The model was founded on a set of core principles that bridged AOD treatment and offender case management – two largely

[56] See https://www2.health.vic.gov.au/about/publications/policiesandguidelines/forensic-aod-service-delivery-model.

separate treatment philosophies and approaches. The model was developed in consultation with both sectors through a comprehensive consultation process. The combined principles focused on best practice in case management and treatment and recognised the need for strong collaboration. A collaborative practice framework was also developed. There is an argument for developing a similar framework to better bridge the gap between mental health services and AOD treatment services.

146 VAADA has convened numerous trauma-informed care training sessions that have been attended by both AOD and mental health workers, however these sessions have been confined to metropolitan areas due to funding constraints. Additionally, over the past 2.5 years, VAADA has been working with three PHNs – North Western Metropolitan, Murray and Western Victoria - to establish communities of practice within each region.

147 VAADA is also aware that the VDDI conducts regular training workshops that are open to staff in both the AOD and mental health sectors. These occur on a regular basis throughout the VDDI regional areas including rural locations.

148 Another example of joint training being done successfully is at Matua Raki, the New Zealand national centre for addiction workforce development.[57] Matua Raki support innovation and work towards evidence-based workforce development solutions through a broad range of activities such as policy development, training programmes, boosting sector relationships and networking, resource development, research and competency development. They develop effective training initiatives, work with high levels of cultural competency (Māori and Pacific) and place a strong emphasis on consumer involvement. Matua Raki is working to support the development of person-centred, wellbeing oriented co-existing problem responsive mental health and addiction services. They have developed two guiding documents on co-existing mental health and substance use problems (CEP) as follows:

(a) Te Ariari o te Oranga: This is a clinical framework to assist health professionals working with co-existing substance use and mental health problems[58]; and

(b) Service Delivery for People with Co-existing Mental Health and Addiction Problems: Integrated Solutions 2010. This is a service delivery guidance document, and companion document to Te Ariari O te Oranga, that supports

[57] See https://www.matuaraki.org.nz/

[58] The Assessment and Management of People with Co-existing Mental Health and Drug Problems (New Zealand Ministry of Health, 2010). See http://www.dualdiagnosis.org.au/home/index.php/clinical-guidelines/dual-diagnosis/7-te-ariari-o-te-oranga-the-assessment-and-management-of-people-with-co-existing-mental-health-and-drug-problems

more integrated care for people with co-existing mental health and addiction problems.[59]

Joint training approaches and implementation across a whole system

149 Prior to the implementation of joint training approaches, it is important to have an agreed set of goals and objectives shared by both sectors, and formal agreements and protocols to support these. Once this is established, training needs should be explored as described above. This could occur via agency and worker dual diagnosis capability self-assessments and audit tools.

150 The challenges to this are being able to have the AOD and mental health sectors come together to develop a shared approach and understanding. Where it occurs 'co-location of services' also supports cross-pollination of informal learning.. Further, whenever VAADA trains and sets up communities of practice across sectors, we find that people learn from each other.

Joint training approaches at scale

151 If joint training at scale were to occur, it would need to be well resourced, effectively planned and part of a well-developed industry plan across all parties. A good example is the 'Matua Raki ' Centralised Training entity from New Zealand. It provides national addiction workforce development, produces evidence based workforce development solutions and provides support to staff with a key focus on capacity building and training around mental health and addiction issues.

152 Furthermore, for joint training to work at scale, I consider the following would be required:

(a) The establishment of a high level working group that sits across both sectors (with 'buy-in' from all sector managers) where agreed goals and objectives are identified through protocols.

(b) Workforces should be mapped across sectors including roles and service types. Likewise, skills and knowledge deficits in the workforces must also be mapped (this could be from agency and clinician self-assessment tools).

(c) All the current providers of dual-diagnosis training ought to be mapped so the differences in dual diagnosis approaches could be identified. This would enable consistency to be reached on the content of dual diagnosis training for different knowledge and skill levels across all training providers.

[59] See https://www.health.govt.nz/publication/service-delivery-people-co-existing-mental-health-and-addiction-problems-integrated-solutions-2010

(d) The consumer voice (preferably via a co-design model) should be present at all levels and stages of the project.

(e) Mental health and AOD training needs by role/service type must be identified and be linked to goals and objectives. For example, AOD workers will need mental health modules, and vice-versa. There are also already identified common modalities, such as trauma-informed care, that would be applicable to all workers.

(f) Training programs would be required to be developed and implemented. It may not be that all training is developed at scale to all workforces, but perhaps it could identify what training programs would be most efficient and cost effective to meet the needs of consumers.

COMMISSIONING

Commissioning approaches to encourage the provision of treatment, care and support to people with complex needs

153 Commissioning encompasses a large number of activities from planning and purchasing services, to monitoring and holding providers to account for the delivery of agreed outcomes. Services may be commissioned for a whole population (for example, a geographically defined population), a subpopulation (for example, people with diabetes in a given region) or an individual (for example, the coordination of a range of services for one person).

154 Effective commissioning rests on identifying where the need is: be it by whole population, a subpopulation or an individual. The first step for effective commissioning is to work out what is the aim of the commissioning. This analysis will help inform what, and how, to commission. For the commissioning in the AOD sector, the commissioning aim and the 'what' and 'how' may not have been effectively identified yet.

Commissioning approaches to encourage the greater coordination between service providers

155 Specific differences exist between AOD and mental health systems. For numerous practical reasons, such as specialist expertise, these differences need to be retained. While the respective systems have not worked well together to date, there is both scope and precedent for improvement. Improvements in both mental health and AOD areas are required to better manage the needs of the community and increasingly there seems to me to be more support between the sectors around working together more effectively and harmoniously. For there to be greater coordination between AOD and mental health service providers, they need to agree to a common vision and purpose, and plan and consider agreed internal and external frameworks and policies. This will

require agreed messaging and aspirational pursuits amongst all partners. It will also require requisite resourcing, support and stable investment over a long period of time to embed culture change and achievement of objectives. There must also be respect for each sectors' expertise and specialisation. Mutually agreed, planned and implemented systemic reforms are the foundation to a genuine partnership dominated by no single profession but respectful of what the other brings to the resolution of complex issues. However, integral to the commissioning process in respect of AOD and mental health, is the concept that all agencies tendering should be able to demonstrate that they are dual diagnosis capable or committed to becoming so. Positive efforts and achievements under VDDI and the ISI programs clearly show that progress can be made in working with dual diagnosis.

156 Agencies will not necessarily work together until they are given incentives to do so. The previously mentioned federal ISI project is a clear example of this. Some AOD agencies were funded under the ISI project to improve their capacity to manage clients with co-occurring AOD and mental health issues and to develop collaborative relationships with their local mental health organisations. As noted previously the funded AOD agencies (please refer to paragraph 65) were required to demonstrate their progress in developing relationships with local mental health providers as part of the performance indicators outlined in their funding and service agreements. However, mental health organisations did not receive the same funding under the ISI project, and as a result had no incentive to reciprocate in developing formal relationships with AOD[60]. Nevertheless, some very effective relationships were ultimately developed between AOD and mental health agencies in some regions across Australia, although these relationships were nationally inconsistent and entirely dependent upon factors such as goodwill and familiarity between individual staff at the local level. An evaluation of the capacity building activities completed by the AOD peak bodies was undertaken by David McDonald in 2015.[61] This report noted a series of positive findings from the peaks' work in that the project had met its objectives, was implemented well, provided value for money and produced positive changes throughout each state AOD sector.

157 Any commitment to greater coordination between services needs to be formalised via partnership agreements between AOD and mental health agencies that set out the joint vision of work to be undertaken for people presenting with dual diagnosis issues. This

[60] National Improved Services Initiative Forum (2010). *Outcomes from the National Improved Services Initiative Forum: A Tale of Two Systems. A Report Prepared by the Australian State and Territory Peak Alcohol and Other Drugs (AOD) Non-Government Organisations.* Adelaide 2011 pp 22. pp8http://www.atoda.org.au/wp-content/uploads/National-ISI-Forum-Report-2010.pdf

[61] McDonald, D 2015, *Evaluation of AOD peak bodies' roles in building capacity in the Australian non-government alcohol and other drugs sector: final report*, Social Research & Evaluation, Wamboin, NSW. pp 4 - 7 http://www.atoda.org.au/wp-content/uploads/2017/08/national_aod_peaks_cb_evaluation_final.pdf

should reflect on the roles of organisations with regard to screening, assessment shared care-planning and treatment must be clearly delineated.

158 Once effective programs and initiatives are in place, any commissioning approaches need to be mindful to retain positive innovations and effective practices that have been established during the prior funding period. When agencies lose funding in a recommissioning process, this often results in a disruption of referral pathways, and to any joint clinical practices with their partners. The new agencies must be given the same directives in their funding agreements to re-establish commensurate agreements and services with one-another. Commissioning approaches also need to include mechanisms for better evaluating and retaining programs that have already demonstrated success to promote sustainability. Too often extremely valuable programs have been lost (at both the state and federal level) because the agencies that operate and deliver them are unable to illustrate their value via rigid tendering processes.

EMPLOYMENT

159 VAADA's submissions to the Royal Commission identified the importance of employment as a key social determinant to reduce the harms of mental health and substance use.

160 Initiatives which can support employment of those in recovery into suitable employment are to be encouraged. However, these steps must be done carefully because it can also result in adverse outcomes in cases where the employment is unsuitable, the employer is not supportive or the person in recovery is too unwell to engage in employment. Identifying opportunities to co-locate employment and training support at such places as health and community services, drug and alcohol, Mental Health recovery settings, as well as other service should be encouraged.

The key issues or barriers for vulnerable Victorians accessing or sustaining employment

161 A key barrier for vulnerable Victorians accessing or sustaining employment is stigma. This includes the personal experience of stigma which erodes self-confidence as well as structural stigma manifesting as discrimination among employers. Stigma reduces help seeking behaviour, making it less likely for someone experiencing AOD and/or mental health issues to seek help (including workplace supports if any). This reduces the likelihood that people experiencing AOD and/or mental health issues will receive adequate support or reach out for help if employment is generating a level of duress which can trigger a relapse.

162 Other key issues or barriers in relation to employment include people receiving treatment on an episodic service model, rather than a continuum of care model. This

results in less opportunities for people to 'check in' to supports as they progress with recovery. There are also challenges around matching people with suitable employment and the fact that there are limited employment opportunities for people who have criminal records.

Effective models to support people with co-occurring mental illness and problematic AOD use to access and sustain employment

163 Federal employment programs are increasingly less supportive of those who experience AOD dependency.

164 Specific programs such as Disability Employment Services (**DES**) are not well designed to cater for the episodic nature of both substance dependence and mental health. The DES funding models are not aligned to the high risk of short-term employment due to relapse. The mainstream employment program is 'Jobactive'. As at March 2020, 722,777 people were accessing Jobactive (177,528 of this contingent experience disability, including mental health issues).[62] This employment program and other mainstream job consultants generally lack capacity to work with complex clients. Further, employment service providers delivering DES may also opt to prioritise those jobseekers without substance dependence or mental health issues who may be seen as more employable. This is because it will generate greater income faster for these employment service providers. As such, there remains a high risk that many people with complex AOD and mental health issues will remain subject to Jobactive as a primary source of income.

165 Further, there are also issues around the ongoing accessibility of the disability support pension (**DSP**) for those with a substance dependence based on the current prevailing narrative from the federal government. This means that many people who may have once been eligible for the DSP with mental health and/or AOD issues are now more likely to be required to engage employment services and be subject to mutual obligations. In our view, this is likely to exacerbate people's mental health and substance use issues because people may feel as if there are onerous expectations on them including high frequency job searching, attending appointments and non-compliance carrying the risk of payment suspension. This is likely to mean that these people will experience poverty.

166 A better approach would be to remove barriers to recovery such as punitive elements of mutual obligation employment services which would also reduce financial strain amongst a disadvantaged cohort of people. Wrap around support to address the causes

[62] https://lmip.gov.au/default.aspx?LMIP/Downloads/EmploymentRegion

of AOD dependency and the impacts of Mental Health of which employment will, for many, be an important part of the recovery process.

167 There are an array of Victorian employment programs which are to be commended. Second Chance is a Victorian government funded initiative which supports prisoners post release into employment and is currently run in Bendigo and Gippsland. Evaluations of this program will hopefully net positive results.

Guidance and support for employers in providing a mentally healthy workplace

168 While there are some supports to assist employers in catering for those experiencing disability, there is little support for those employees who experience mental health or AOD concerns. Internal workplace policies can vary, with some employers having a punitive approach to substance/dependence use and others having a therapeutic approach. Employee assistance programs can be a useful resource but may not be sufficient to assist people with substance use concerns. The stigma on individuals who may have AOD or mental health issues also weighs heavily in maintaining stability in the workplace. Employers should be encouraged to develop a suite of human resource policies which progress therapeutic supports to those experience mental illness or AOD issues.

sign here ►

print name Sam Biondo

date 7 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SB-1

This is the attachment marked 'SM-1' referred to in the witness statement of Sam Biondo dated 7 July 2020

CV – SAM BIONDO

FEBRUARY 2007 – PRESENT

Executive Officer Victorian Alcohol and Drug Association (VAADA)

As Executive Officer I am responsible for day to day management VAADA the Victorian AOD Peak. I Manage 9 staff, I have overall responsibility for financial and organisational matters and reporting to the VAADA Board. I oversight numerous projects, respective program funding and deal with an array of membership needs related to Victoria's AOD sector. I work with the board in delivering on our strategic objectives.

My endeavors during this time have been to build and enhance sector collaboration and engagement with membership. As a result I have sought to foster mechanisms such as our regular CEO & Managers forums, as well as a range of network meetings and communities of practice.

VAADA distributes daily enews bulletins and relevant information to the sector keeping it appraised of latest developments and AOD related news.

Presently we are responsible for a number of specific project grants from 3 Primary Health Networks, as well as a Federal grant focused on AOD Sector capacity building, training and cross sectoral engagement activities. Further, we are also in receipt of grants related to Family Violence, the AOD Data scheme, a large sector Innovation and research grants scheme. We are also in partnership with the Victorian Healthcare Association and the Centre for Excellence in Child and Family Welfare in a Tri-partite cross sectoral Scheme of collaborating across sectors.

In the course of my work I have been invited onto numerous Departmental Expert Advisory Committee's, Advisory Groups, and Taskforces. I have been on a wide range of committees across the sector over the years including the Human Services and Health Partnership Implementation Committee (HSHPIC) run jointly by VCOSS and DHHS. I was also awarded a life membership for my work with VCOSS a number of years ago.

In terms of outward focused advocacy I am regularly invited to comment in the media, and VAADA regularly responds to Committees of Inquiry with submissions or as a verbal witness.

AUGUST 1989 - 2007

Fitzroy Legal Service - Community Development Officer

Duties included:

UNDERTAKING AND SUPERVISING RESEARCH PROJECTS

> Principal activity in this area has included research into policing, legal aid, CLC volunteers, Access to Justice, and legal aid.

SUBMISSIONS & REPORT WRITING

Participation in a range of submissions, reports and talks across a range of socio-legal areas addressing issues impacting on the agency's target population. Some of the areas of covered included police powers, Drugs and the Law, Access to Justice, Legal Aid, Human Rights, Commercial Confidentiality, 'FOI and the Public Interest', prisons, and Technology and the Law.

DEVELOPMENT, PRODUCTION AND MARKETING OF PUBLICATIONS

A significant aspect of my work included addressing the structure and operation of the Fitzroy Legal Services in-house publications arm – The Law Handbook.

LIAISON WITH COMMUNITY GROUPS

Work involved considerable liaison with local and statewide agencies and community organizations.

PREPARATION OF EDUCATIONAL MATERIALS, TRAINING COURSES AND TALKS

A key focus of work activity focused on Community Legal Education. Development and marketing of Fitzroy Legal Service products.

- For 5 years I was a guest lecturer at the Victoria Police academy in the general area of "Young People, legal aid and community relations" and for 5 years a part time tutor in Community Development at Melbourne University Social Work Department. I have also taught at La Trobe University School of Legal Studies in "Law and Social Justice".
- I was Project Manager for the "Services Directory for Drug and Alcohol Users" 4 editions
- I was a consultant to a joint Australian Government (AUSAID) and Indonesian NGO (Indonesian Legal Aid Foundation) project in relation to establishing and producing an Indonesian version of the Law Handbook for Indonesia as well as issues related to improving access to justice and the creation of a 'Legal Aid Act' for Indonesia.

1982 – 1985

Project Officer - Jobwatch

Tasks involved the investigation and monitoring of dubious employment practices and training schemes. Activities and skills included

- Research (qualitative and quantitative)
- Negotiation
- Lobbying
- Policy Development
- Case Work
- Advocacy
- Mediation
- Report Writing
- Media Work

EDUCATION

Tertiary Education:

1997	Masters Thesis - Criminology (La Trobe Uni)
1980-1	University of Melbourne (Bachelor of Social Work)
1979	LaTrobe University (Dip Ed -Secondary)
1975-8	Latrobe University (BA- Sociology, Politics, Psychology)