Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR ENRICO CEMENTON

I, Dr Enrico Cementon MBBS, MMed (Psych), FRACGP, FRANZCP, FAChAM (RACP), Consultant Psychiatrist, of 35 Poplar Road Parkville VIC 3052, say as follows:

1 I am authorised by NorthWestern Mental Health to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND

Qualifications and experience

3 I am a consultant psychiatrist at Orygen, and in private practice.

4 My current appointments are:

(a) Lead consultant psychiatrist of Orygen (a part of NorthWestern Mental Health within Melbourne Health);

(b) Director of Addiction Psychiatry Training for Victoria the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) and Eastern Health (from 16 March 2020); and

(c) Honorary Principal Fellow, Department of Psychiatry, the University of Melbourne.

5 My previous clinical appointments include:

(a) Director Clinical Services, Substance Use, Mental Illness Treatment Team (**SUMITT**) (NorthWestern Mental Health, Melbourne Health);

(b) Consultant psychiatrist, Drug Health Services and Addiction Medicine Unit (Western Health); and

(c) Consultation-Liaison psychiatrist, Mid-West Area Mental Health Service (NorthWestern Mental Health) and Western Hospital, Footscray.

6 I have experience in a wide range of clinical psychiatry practice at a senior level, including inpatient and outpatient psychiatry, general adult psychiatry, youth psychiatry, addiction psychiatry, addiction medicine and consultation-liaison psychiatry.

7 I have experience in the training and education of medical students, psychiatry trainees and allied mental health staff.

8 My honorary professorial roles include:

(a) Director of the Advanced Training in Addiction Psychiatry Victoria, Royal Australian and New Zealand College of Psychiatrists (**RANZCP**); and

(b) Previously committee member and Treasurer of the Section of Addiction Psychiatry, RANZCP.

9 Attached to this statement and marked 'EC-1' is a copy of my curriculum vitae.

Current role

10 I am the lead consultant psychiatrist at Orygen, which is a specialist youth mental health service. Our patients are between 15 and 25 years of age.

11 The scientific literature indicates that at least 50% of consumers entering mental health services have substance use issues.[1] This is, in my view, probably an underestimate in the case of Orygen's patients.

12 One of the important goals of the Victorian Dual Diagnosis Initiative (**VDDI**) is to improve 'dual diagnosis capabilities' of mental health services through capacity-building strategies. In my role at Orygen, I have built the dual diagnosis capability (discussed below) of that service.

13 Dual diagnosis refers to the co-occurrence of mental health and substance use issues. Dual diagnosis capability refers to a service's ability to respond to the dual diagnosis needs and problems in the people and their families and carers that attend that service for treatment and support. My role in Orygen is to oversee and facilitate the development of the service and its staff's capacity to respond effectively to those dual diagnosis needs

[1] Siegfried N, "A review of comorbidity: major mental illness and problematic substance use", AustN Z J Psychiatry. 1998 Oct;32(5):707-17. https://www.ncbi.nlm.nih.gov/pubmed/9805595.

Dixon, L., "Dual diagnosis of substance abuse in schizophrenia: prevalence and impact on outcomes." Schizophrenia Research 1999 Mar 1;35 Supp S93-100, https://www.ncbi.nlm.nih.gov/pubmed/10190230.

Kavanagh DJ1, McGrath J, Saunders JB, Dore G, Clark D., "Substance misuse in patients with schizophrenia: epidemiology and management", Drugs. 2002;62(5):743-55. https://www.ncbi.nlm.nih.gov/pubmed/11929329.

Ogloff JR, Lemphers A, Dwyer C, "Dual diagnosis in an Australian forensic psychiatric hospital: prevalence and implications for services.. Behav Sci Law. 2004;22(4):543-62, https://www.ncbi.nlm.nih.gov/pubmed/15282839.

and problems. This specifically requires the ability to screen for, assess and diagnose and provide treatment and other interventions for dual diagnosis.

SUBSTANCE USE, MENTAL ILLNESS TREATMENT TEAM

SUMITT services

14 I was the Clinical Director of SUMITT from February 2000 until August 2014.

15 SUMITT began in 1998 and was the first team arising out of the VDDI.

16 The VDDI was a response to a number of reports throughout the 1990s in Victoria and the United States of America which found that outcomes were very poor for dual diagnosis patients (those who have co-occurring mental illness and a substance use disorder).

17 The Victorian government wanted to invest in improving outcomes for dual diagnosis patients and optimising the dual diagnosis capacity of the three key stakeholders:

(a) the State's mental health sector;

(b) the alcohol and other drug (**AOD**) sector; and

(c) the Psychiatric Disability Rehabilitation and Support Services (**PDRSS**), now called Mental Health Community Support Services (**MHCSS**).

18 Those three stakeholders provided services for dual diagnosis clients. The VDDI was intended to facilitate this process.

19 Along with the development of a framework and the 'Key Directions' policy, the Department of Health and Human Services evaluated the outcomes of SUMITT's first two years of work and introduced four, state-wide dual diagnosis teams as part of the VDDI and committed ongoing funding to those teams. The four teams are based in metropolitan Melbourne and there are also dual diagnosis clinicians based in key rural services.

20 SUMITT is the dual diagnosis team that represents North-Western Melbourne and Western Victoria.

21 In response to a local audit in 2016, two full-time EFT SUMITT positions were diverted to the NorthWestern Mental Health (**NWMH**) Mental Health Training and Development Unit to provide dual diagnosis training to the key stakeholders. The balance of the EFT were directed to provide a direct clinical service to the mental health stakeholders (primary consultation and shared care) and secondary consultations to the AOD and MHCSS sectors. This shift in practice was directed by the NWMH Executive and was different to the other three metropolitan dual diagnosis services as their focus is solely capacity-building.

SUMITT clients

22 The clients of SUMITT are really its three stakeholders. SUMITT provides primary, secondary and tertiary consultation and training and education about dual diagnosis to these three sectors. SUMITT clinicians provide these interventions to the different services and their teams to which they've been allocated in the SUMITT region. Clients with dual diagnosis could only be referred to SUMITT from these stakeholder services.

23 Clients with dual diagnosis are referred from the three stakeholder services to SUMITT. Area mental health services refer case-managed clients with severe mental illness and substance use issues; alcohol and other drug services refer people with severe substance use disorder and mental health issues and the PDRSS/MHCSS tended to request dual diagnosis training and education rather than refer individual clients.

SUMITT's service approach

24 The SUMITT approach of providing shared care, consultation and training and education aims to build the dual diagnosis capability of the referring service. Shared care involves working jointly with the case manager/key clinician to provide a more comprehensive and holistic intervention with people with complex and challenging presentations. Primary consultation involves the in-person assessment and provision of recommendations and some interventions for a client with dual diagnosis. Secondary consultation involves discussion of some clients with dual diagnosis and the provision of recommendations for interventions and responses without seeing the clients. Tertiary consultation refers to the provision of dual diagnosis advice, information, clinical guidelines, relevant policies and procedures and training and education for stakeholder services.

Limitations of the service

25 In relation to the VDDI more broadly, there is a question as to the extent to which it has achieved its primary objective of improving outcomes for dual diagnosis patients.

26 In my view, it has taken steps towards meeting that objective. At SUMITT, we always said that we wanted 'to work ourselves out of a job' by enabling services to become fully 'dual diagnosis capable'. SUMITT has existed now for over 20 years; I do not think this goal has been achieved. Services now recognise dual diagnosis as 'the expectation, not the exception' and have introduced integrated screening and assessment procedures for their clients with dual diagnosis. The extent to which this occurs in everyday practice varies considerably from clinician to clinician, from team to team and from service to service. Integrated treatment for dual diagnosis however occurs rarely in services as the expectation and the desire that another service will address 'the other problem' remains.

27 Consumers and their carers or families cannot refer themselves directly to and engage the expertise of dual diagnosis teams such as SUMITT. As outlined above, referrals can only come from mental health or AOD services or the MHCSS.

28 There is a lack of direction and leadership from the Victorian Department of Health and Human Services regarding dual diagnosis and the VDDI. The 2009 Key Directions document provided mental health services with KPIs to strive to achieve screening, assessment, diagnosis and treatment outcomes. Unfortunately, there has been no evaluation or follow-up regarding those KPIs or future strategic directions for the VDDI.

CO-OCCURRING MENTAL ILLNESS AND PROBLEMATIC ALCOHOL AND OTHER DRUG USE

The relationship between mental health and problematic alcohol and other drug use

29 There is a complex interplay and relationship between mental health and problematic alcohol and other drug (**AOD**) use.

30 The literature refers to multiple relationships: [2]

(a) mental health can contribute to AOD use and vice versa;

(b) underlying factors, such as trauma, personality factors such as impulsivity and antisocial personality disorder, neurodevelopmental issues, social problems, genetic factors and other environmental exposures, can contribute to both adverse mental health and AOD use; and

(c) the presence of mental health issues can cause or increase vulnerability to AOD exposure, and vice versa.

[2] Cementon E, Castle DJ and Murray RM. "Schizophrenia and substance abuse". Chapter 13 in "Comprehensive Care in Schizophrenia: A Textbook of Clinical Management" Lieberman JA, Murray RM (eds) 2012 Oxford University Press, Oxford.

Mueser KT, Drake RE, Wallach MA., "Dual diagnosis: a review of etiological theories", Addict Behav. 1998 Nov-Dec;23(6):717-34. https://www.ncbi.nlm.nih.gov/pubmed/9801712.

Thornicroft G, "Cannabis and psychosis. Is there epidemiological evidence for an association?", Br J Psychia-try. 1990 Jul;157:25-33. https://www.ncbi.nlm.nih.gov/pubmed/2204462.

W.J. Wayne Skinner [et al.], "Concurrent substance use and mental health disorders : an information guide" 2004, 2010 Centre for Addiction and Mental Health Canada https://www.camh.ca/-/media/files/guides-and-publications/concurrent-disorders-guide-en.pdf.

Canadian Centre on Substance abuse. (2009). Substance abuse in Canada: concurrent disorders. Ottawa, ON: Canadian Centre on Substance Abuse. https://ccsa.ca/sites/default/files/2019-04/ccsa-011811-2010.pdf.

Best Practices Concurrent Mental Health and Substance Use Disorders. Health Canada 2002. https://www.camh.ca/en/health-info/guides-and-publications?facets=alphabet_facet:C.

Impact of problematic alcohol and other drug use on the development, or exacerbation, of mental health problems

31 AOD use can have a variety of significant impacts on mental health problems, but the effect is almost always detrimental. Some examples include:

(a) a causative effect, particularly in the case of men with depression and alcohol use disorders where studies have demonstrated that the depression is often alcohol-induced; and

(b) exacerbation of existing mental health problems, such as the impact of cannabis use on schizophrenia, or the effect of methamphetamine use on mental health.

Impact of the consumption of alcohol and other drugs on the effectiveness of pharmacotherapy and other mental health treatments

32 AOD use can have an adverse impact on the effectiveness of mental health treatment in a number of ways, including by:

(a) complicating the assessment of mental illness, as it is difficult to assess the differential impacts of the mental illness and AOD use thereby making treatment selection complex;

(b) depriving a consumer of the opportunity to receive mental health treatment in the first place, as AOD use may be a reason for the exclusion or discharge of a patient;

(c) being misinterpreted as antisocial behaviour, rather than a mental health problem in its own right, or as a maladaptive coping mechanism;

(d) leading to unpredictable and complex pharmacological interactions between prescribed psychotropic drugs and the AOD used; and

(e) leading to poorer adherence to mental health treatment.

33 While the impact of AOD use on mental health is relevant to all consumers, it is particularly significant for:

(a) younger, male patients who have the highest rates of dual diagnosis (although often with paradoxically better pre-morbid functioning than their non-dual diagnosis peers);

(b) older patients, whose substance use problems are often under-recognised due to inadequate screening and assessment, particularly in the case of alcohol, benzodiazepine and tobacco use;

(c) people from indigenous backgrounds; and

(d) inpatients, who are characterised by more complex problems including AOD use. These patients have higher rates of co-morbidity and substance use that often precedes or precipitates hospitalisation.

Self-medication with alcohol and other drugs to manage mental illness and or the side effects of medication

Impact on consumers

34 Self-medication is a very common phenomenon. Self-medication to manage mental illness causes problems such as:

(a) complicating the assessment of mental illness, as it is difficult to assess the differential impacts of the mental illness and the AOD use;

(b) exacerbating the mental illness;

(c) adversely impacting responses to treatment; and

(d) short-term AOD use can relieve some symptoms and unpleasant feelings of mental illness, however long-term self-medication with AOD use leads to dependence on the drugs used and it becomes an unhealthy coping strategy.

35 With respect to self-medication being used to deal with side effects of prescribed medication, it can be difficult as a clinician when a patient reports side effects from medication to ascertain whether these are in fact residual symptoms of the underlying condition being treated, or whether they are indeed side effects associated with the medication.

36 It is quite uncommon, however, for patients to report that they are using AOD to counter act the effects of prescribed medication. People with mental illness use alcohol and other drugs for the same reasons that people without mental illness use drugs: it feels good.

37 A principle of psychiatry is to prescribe the minimum possible dose of psychotropic medication in order to minimise side effects. Furthermore, medications that have become available over the last 20 years, such as the second generation antipsychotics, have far fewer associated side effects than older, more conventional anti-psychotic medication. The current mental health system is relatively well-resourced, and it is now very uncommon to prescribe conventional anti-psychotic medication.

38 More broadly, our understanding of self-medication from the clinical perspective is undergoing a significant change. When I first became involved in the dual diagnosis area, what was known as the ‘self-medication hypothesis’ (that is, consumers would engage in AOD use to manage their mental health needs) was being disproved in the evidence and the literature.

39 The current evidence around self-medication, however, is changing. The reason for this is that the issue of trauma and its role in the development of AOD and other mental health problems is gaining a lot of traction in both the academic literature and in the cultures of mental health and AOD services.

40 The Adverse Childhood Experiences (**ACE**) study from the USA in the mid-1990s demonstrated that many adverse health outcomes have their antecedents in early childhood trauma. The role of trauma has been increasingly recognised as the origin and development of mental health and AOD-related problems.

41 The impact of AOD use as self-medication is especially important for female consumers, who have higher rates of mood and anxiety disorders, and higher rates of trauma experiences. For example, during my time at the Footscray Drug and Alcohol service, I observed that over 90% of female patients that were referred to me had a history of childhood sexual abuse and it was therefore clear to me that there was a relationship between sexual abuse and AOD-related and other mental health problems.

42 In that respect, consumer reports of self-medication are extremely important, as this may have become a way of managing the emotional sequelae of trauma.

43 Those exposed to trauma may not have been able to develop other healthier internal coping mechanisms for emotional regulation. Self-medication with AOD use becomes a way of dealing with trauma and a means by which to suppress or numb some of the symptoms of post-traumatic stress disorder such as horrific memories, anxiety, hypervigilance, depression and nightmares and other sleep problems.

Impact on treatment

44 Self-medication with AOD can complicate treatment, including by:

(a) creating uncertainty in the prioritisation of treatment and interventions. For example, it raises the question of whether AOD use stabilisation or mental health stabilisation should occur first;

(b) interacting with prescribed medications and causing effects like drowsiness, loss of co-ordination and reflexes, or a risk of overdose;

(c) exacerbating an instability in mental state, such as suicidality or violent behaviour;

(d) reducing the impact of psychotherapeutic efforts; and

(e) narrowing the treatment options available.

45 Psychiatry, in my view, has taken an overly simplistic approach towards self-medication and other forms of AOD use in people with mental illness. This approach has been that

AOD use makes mental health conditions worse and should therefore be stopped, or at least minimised, that is, taking an abstinence approach.

46 An abstinence approach however, can take away the patient's only coping mechanism for their trauma.

47 In my work in drug and alcohol services 15 years ago, there was no discussion of trauma. Today, clinicians are talking more about trauma-informed care.

48 In my view, clinicians do not yet have sufficient expertise or competency to provide such care.

49 Therapeutic interventions therefore need to be directed towards substance use, any underlying trauma and the other mental health issues.

Barriers to accessing suitable support experienced by people with co-occurring mental illness and problematic alcohol and other drug use

50 One of the greatest barriers to accessing suitable support for dual diagnosis patients is the stigma that surrounds AOD use and disorders.

51 I believe that a hierarchy exists in health generally, and stigma plays a large part in this. For example, due to its stigmatisation, mental health has traditionally been perceived as different and in some ways less 'important' than physical health.

52 While organisations such as Beyond Blue have made excellent progress in breaking down such stigma relating to mental illness, I would argue that addiction health remains at the bottom of the hierarchy and is laden with the most stigma of all health areas.

53 This stigma is also driven by the terminology we use in relation to addiction and substance use. For example, we frequently refer to urine samples as being 'clean' or 'dirty'. When a drug-dependent person has been sober or abstinent, we use the term 'clean' or 'good'.

54 We need to remove these pejorative and value-laden terms from our practice. This is beginning to happen. For example, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (**DSM-5**) removed the term substance 'abuse' and replaced it with 'substance use disorder'.

55 As a result of this language and stigma and as some forms of substance use are illegal, patients are often very reticent to talk about their substance use. Stigma discourages consumers from openly seeking help and support. Consumers with dual diagnosis are often able to speak openly about their experiences with mental illness, but are very reluctant to disclose their substance use issues.

56 Stigma also discourages and prevents clinicians from choosing to engage or specialise in AOD and addiction health. This stigma may also adversely affect the AOD sector's capacity to recruit adequate resources and funding.

57 Beyond the stigma associated with AOD use, the complexities of dual diagnosis are also another challenge in accessing suitable support. It is difficult to obtain an integrated assessment of patients which comprehensively addresses all of their presenting problems. This assessment sometimes requires a longitudinal approach, that is, seeing a person a number of times to discern the relationship between the person's drug use and their mental health.

58 Dual diagnosis is traditionally not considered to be 'core business', in either mental health or AOD services, and it is often seen as a reason for exclusion from treatment programmes. This may lead to patients being referred to other services, or ultimately falling through service 'gaps'.

59 This is problematic because often patients of mental health services have AOD disorders of lesser severity, which will not meet the threshold required to access AOD-specific services. Similarly, patients of AOD services commonly have high prevalence mental health issues which will not meet the threshold required to access relevant mental health services. Therefore, referral to another service is often ineffective.

60 In the worst case scenario, there can be disputes over who takes clinical responsibility for patients with co-occurring mental illness and AOD use, patients fall through these service 'gaps' and I've witnessed outcomes such as death as a consequence.

Challenges for mental health services supporting people with different types of problematic alcohol and other drug use

61 As set out above, there are difficulties faced by mental health services in providing integrated dual diagnosis care. The legacy of the historical separation of mental health and AOD services is that mental health services have redefined what is meant by mental illness and this often excludes AOD use problems and AOD services focus on the management of AOD problems and lack the expertise to manage other mental health problems in their clients. Dual diagnosis therefore may not be considered as part of the 'core business' of the service.

62 The capacity of mental health services to provide integrated treatment responses for dual diagnosis is still limited, especially where specific AOD-specific interventions are required such as pharmacotherapy for opioid, alcohol or tobacco use. For example, alcohol dependence relapse medications are underutilised by psychiatrists in my experience. Mental health services currently have psychiatrists on staff who have completed the training to provide opioid substitution therapies, however their service lacks the

infrastructure to oversee this potentially life-saving treatment, so patients with opioid dependence have to be referred elsewhere: an over-burdened GP system or an AOD service. Mental health services have a limited ability to provide other forms of longer-term interventions or to foster motivational change in consumers in relation to AOD use.

63 Clinical leaders in mental health services often hold negative and more moralistic attitudes towards AOD use in their patients. There may be a failure to recognise substance use disorders as another form of mental illness. There is often a belief that addressing dual diagnosis requires extra resources. At worst, there can still be the belief that AOD use disorders must treated elsewhere.

64 As discussed above, psychiatry has traditionally taken an abstinence-based approach to AOD use, rather than the harm reduction approach of the AOD sector. When a person with dual diagnosis declines the advice to abstain from AOD use, this leaves the psychiatric clinician and patient with no other treatment options.

65 The relationship between tobacco smoking, mental illness and psychiatry is historically long-standing and complex. Tobacco dependence is the most prevalent form of substance dependence in people with mental health issues and it is associated with physical ill health and the earlier mortality of people with mental illness relative to people without mental illness. While tobacco use has reduced across the general population, it has not reduced in people with mental illness. Mental health services have only very slowly responded to tobacco use in people who access their services.

66 More broadly, mental health services have slowly adopted change or modified their approach to all issues of dual diagnosis. They have not reached the point where they can define themselves as a ‘one-stop shop’ for people with dual diagnosis.

Challenges for alcohol and other drug services supporting people with different types of mental health problems or illness

67 As for mental health services, there are difficulties faced by AOD services in providing integrated responses to dual diagnosis. The historical separation and specialisation into mental health and AOD services and its consequences are outlined above. The separation in services led to the marginalisation and reduced numbers of psychiatrists in AOD services, although there has been a reversal of this in the last 10 years where some large metropolitan specialist AOD services now have psychiatrists on staff. AOD services therefore vary in their capacity to provide appropriate interventions for the other high prevalence mental disorders that they encounter. AOD services that lack any psychiatric expertise cannot manage their consumers that also have severe mental illness such as psychosis, severe mood disorder and severe personality disorder.

68 Specifically, there is a limited capacity of AOD services to respond to the needs of consumers in crisis and AOD personnel are often less rigorously trained in comparison to personnel in mental health services, thereby making them less able to manage the complexities of dual diagnosis. For example, AOD services are less able to respond to consumers with acute mental health crises such as suicidality, deliberate self-harm and other behavioural disturbances.

69 The importance of identifying adverse and traumatic life experiences in consumers presenting to AOD services and recognising their contribution to the development of substance use disorder was discussed above. AOD services must be better capable of assessing this and providing trauma-informed, evidence-based interventions.

70 The AOD sector as a whole is fragmented relative to the mental health sector and therefore lacks the systemic networks and supports that facilitate care between services for their consumers with complex needs such as dual diagnosis.

Challenges experienced by service organisations supporting people with co-occurring mental illness and problematic alcohol and other drug use

71 Both mental health and AOD services currently do not have sufficient resources and funding to provide adequate integrated responses to dual diagnosis. The main resource requirement is the possession of a workforce that has advanced competency in dual diagnosis, that is, the capacity to provide integrated clinical assessments and interventions.

72 I believe adequate funding of the services to recruit and train their own workforce competent in the management of dual diagnosis is imperative. The VDDI provided services with support, but did not achieve the goal of each service developing adequate dual diagnosis expertise, so that it could manage its own dual diagnosis challenges.

73 Few mental health and AOD services mention dual diagnosis as part of their 'core business' in their mission statements. Not all services possess policies and procedures regarding dual diagnosis as a result. Culture change is required to make dual diagnosis 'core business' of both mental health and AOD services. The historical division between mental health and AOD services led to 'silo' cultures which must be overcome to enable partnerships between mental health and AOD services in order to provide helpful responses to clients with dual diagnosis.

Challenges experienced by clinicians and support workers in supporting people with co-occurring mental illness and problematic alcohol and other drug use

74 Service organisations often lack personnel with the knowledge, skills and attitudes necessary to manage dual diagnosis problems and challenges. I recognise different

levels of clinical 'competence' in dual diagnosis. 'Basic' competence is required by all clinicians working in mental health and AOD service organisations. These clinicians can screen for, identify and assess dual diagnosis problems, which leads to a good understanding of the relationship between the consumer's substance use and their mental health symptoms. 'Advanced' dual diagnosis clinicians can perform these assessment tasks and develop and implement more complex treatment interventions.

75 For example, a mental health service may not have any addiction psychiatry expertise, or any nursing staff with AOD experience. This service must therefore refer their consumer to a service with the competence required to manage the substance use issue. The availability of and access to this type of specialist support is highly variable. Some metropolitan mental health services do receive support from addiction health. Rural mental health services are often more disadvantaged.

UNDERSTANDING THE ALCOHOL AND OTHER DRUG SYSTEM

Key similarities and differences in the treatment

76 Key differences between the approaches of the alcohol and other drug and mental health sector include the size and structure of the AOD service system and its approach to consumers, its responsiveness to consumers' needs, the use of compulsory treatment and the different levels of workforce training required in each sector. My experience was that the AOD sector was overall under-resourced relative to the mental health sector. The mental health sector is generally more effective at recruiting new resources due to its greater promotion and advocacy regarding 'mental health' issues, often without including AOD-related issues in the discourse. The AOD sector is in some ways the 'poor cousin' to mental health.

77 Substance use and all other mental health disorders require a biopsychosocial clinical approach in assessment and treatment. Both the AOD and mental health service sectors take this approach to their consumers, although there are relative differences in the composition of this between the sectors. Multidisciplinary teams often facilitate the biopsychosocial approach to consumers, however this is better developed in mental health services as they are larger and more structured.

78 The AOD sector is more fragmented and the different services vary in their composition. AOD services often provide only psychosocial approaches to their consumers' problems as they lack the medical and nursing personnel to provide biological treatments such as pharmacotherapies and therefore seek the support of other service sectors such as general practitioners. Access to the AOD system is similar to that for the mental health sector, that is, a regional central intake telephone system that triages the referral. It lacks the capacity to respond to consumers' crises. The DirectLine directory is a valuable state wide Victorian AOD resource that provides information about the sector to consumers,

families and clinicians. The Drug and Alcohol Clinical Advisory Service (**DACAS**) is also a valuable state wide resource. Mental health clinicians are often unaware of these two valuable AOD resources. I don't believe the mental health sector has equivalent resource service for the community.

Reconciling the alcohol and other drug sector philosophy of voluntary engagement, treatment and self-help with the mental health system's scheme for compulsory treatment

79 Recovery from severe substance use disorder is usually a long-term process where there is substantial internal emotional and psychological change that occurs in the consumer. Although this also is relevant to recovery from other mental health issues, it is essential in recovery from addiction. Consumers with addiction are very aware of this need, however their capacity and motivation to engage in this difficult process varies with time and circumstance thereby affecting their engagement in treatment and mutual help. Consumers with other severe forms of mental illness such as psychosis and severe mood disorder on the other hand, more often lack the understanding and acceptance of their issues and that adversely affects their engagement in treatment. I prefer the term 'mutual-help' to 'self-help' as this important treatment option in the addiction field enables the engagement with a sober social network, which can be a very important factor in recovery. The mental health sector is also utilising the resource of people in recovery from their mental health issues in more recent years.

80 The mental health sector is very familiar with compulsory treatment because of the relevant provisions in the *Mental Health Act 2014* (Vic). Compulsory treatment can be very useful for managing people with certain mental health problems.

81 In my view, compulsory treatment is underutilised in the AOD sector. There are consumers with very severe substance use disorders who lack the capacity to engage in the required treatment due to the severity of their disorder and their clinicians rarely invoke compulsory treatment.

82 The *Severe Substance Dependence Treatment Act 2010* (Vic) is too narrow, and was designed to allow for the provision of compulsory treatment to only ten patients a year. AOD use disorders are high prevalence disorders and within this group, there are consumers with severe disorders, I believe that planning for 10 compulsory treatment episodes a year is completely inadequate.

83 A particular setting where increased compulsory treatment of AOD use disorders would be useful is in the diversion of people from the justice system and into the AOD treatment

system by the use of treatment orders. There is some evidence that treatment orders produce good outcomes both in terms of recovery and reduction of criminal recidivism.[3]

Lessons that can be shared between Victoria's alcohol and other drug sector and mental health service system

84 Victoria's AOD sector and mental health service system need to share with each other their relative expertise. The AOD sector could show the mental health sector how they manage substance use disorders and vice versa.

85 The VDDI previously oversaw the 'Reciprocal rotation project' where clinicians from one sector were placed to work and observe in the other sector. In addition to providing training experiences to the clinicians who participated, this initiative also had the potential to reduce the separation and barriers between the two sectors.

86 A similar example is the mental health sector's provision of psychiatry trainees or registrars for rotation into AOD services. This provides the trainee with an addiction training experience and enables the development of a psychiatrist with the knowledge and skills to better manage their consumers' substance use issues. In my experience, mental health services are reluctant to allow their psychiatry trainees to be rotated to the AOD sector due to the requirement of keeping them as a resource in the mental health service and will only 'release' a trainee to work outside the service when the trainee is supernumerary.

Youth-specific risk factors that make young people vulnerable to mental health problems or problematic alcohol and other drug use

87 Late childhood, early adolescence and early adulthood are the life stages where AOD and other mental health issues most commonly begin and appear. The risk factors that make young people vulnerable are multiple and shared for AOD and other mental health problems alike. The biopsychosocial framework is useful for conceptualising these factors. We increasingly recognise that genetic factors underpin the vulnerability to

[3] Maume MO, Lanier C, DeVall K, "The Effect of Treatment Completion on Recidivism Among TASC Program Clients". Int J Offender Ther Comp Criminol. 2018 Nov;62(15):4776-4795. doi: 10.1177/0306624X18780421. Epub 2018 Jun 17, https://www.ncbi.nlm.nih.gov/pubmed/29911445

Peters RH, Young MS, Rojas EC, Gorey CM, "Evidence-based treatment and supervision practices for co-occurring mental and substance use disorders in the criminal justice system", Am J Drug Alcohol Abuse. 2017 Jul;43(4):475-488. doi: 10.1080/00952990.2017.1303838. Epub 2017 Apr 4. https://www.ncbi.nlm.nih.gov/pubmed/28375656

Hayhurst KP, Leitner M, Davies L, Flentje R, Millar T, Jones A, King C, Donmall M, Farrell M, Fazel S, Harris R, Hickman M, Lennox C, Mayet S, Senior J, Shaw J., "The effectiveness and cost-effectiveness of diversion and aftercare programmes for offenders using class A drugs: a systematic review and economic evaluation",Health Technol Assess. 2015 Jan;19(6):1-168, vii-viii. doi: 10.3310/hta19060. https://www.ncbi.nlm.nih.gov/pubmed/25619533.

developing problems. Family factors impact on young people's AOD use and mental health issues in multiple ways. The impact of traumatic life experiences in the development of AOD and mental health problems was previously discussed in this statement. The youth-specific developmental challenges include the formation of a stable identity and sense of self. It is during this period that AOD use and its potential harms can have a severe impact on the young person's development.

Relationship between mental health and problematic alcohol and other drug use in young people

88 The issues described in sections above in this submission are relevant in young people. Often substance use is the way that a young person manages their emotional problems. Dual diagnosis in a young person often exists within their family system rather than within the individual young person. For example, the young person has some mental health issues and a parent has the substance use issue, which in turn has an adverse impact on the young person's mental health.

Differences between adults and young people

89 These years are usually the time when young people are introduced to substance use through their families, friends and peers. The influence of these social relationships are in some ways more important for young people as their identities and sense of self is still in development. The harmful impacts of the psychosocial factors that lead to AOD and mental health issues such as abuse, neglect and trauma can be more readily identified and addressed in young people relative to adults where the factors took place more remotely and the consequences are more established and less modifiable.

90 The earlier identification of family problems such as domestic violence, the various forms of child abuse, substance misuse and other mental health problems within the family and the presence of different social problems within families and young people's peer networks represents an important opportunity for early intervention in order to modify those risk factors and reduce their impact on young people's development and the onset of AOD and other mental health issues.

Barriers faced by young people to help seeking and service access in relation to addiction and problematic alcohol and other drug use

91 From my work in a youth mental health service, a specific barrier is that dual diagnosis in young people is often a problem in the family system and clinicians find it difficult to intervene when a member of the family system such as a parent also has a problem like a substance use issue. Mental health clinicians are unsure as to how to approach this situation and facilitate the adult's access to appropriate help.

92 Young people are generally less likely to seek help for mental health or AOD issues compared to older Australians. Confidentiality issues and low trust in treating clinicians may prevent young people from requesting help for AOD issues. Another common problem is that young people with AOD issues will not disclose this to their family thereby limiting the mental health clinician's capacity to address the problematic AOD use.

93 Finally, some young people and their families engaged in mental health services do not expect that the service will ask about or intervene with AOD issues and respond negatively to attempts to do this. I had the experience of providing a group intervention for substance use in my youth mental health service and we were unable to recruit an adequate number of participants to the programme.

Tailoring addiction and problematic alcohol and other drug use interventions and programs to young people

94 Delayed access to treatment worsens long-term outcomes and is associated with greater lifetime impairment and poorer life expectancy. Earlier access to intervention is therefore an important principle as it seeks to prevent these adverse longer-term outcomes.

95 Young people, who have mental health and AOD issues, experience developmental disruption. This is in contrast to their peers unaffected by mental health and AOD problems, whose lives, education, career and relationships will continue to progress according to developmental norms. Consequently, a developmental 'gap' forms between young people affected by mental health and AOD issues and their peers.

96 Interventions and treatment programs for young people should therefore take place as early as possible and focus on their recovery, not only from substance use, but of their developmental trajectory. Programs should aim to get young people back onto developmental pathways closest to that followed by their peers.

97 The established youth AOD treatment model has the capacity to engage the young person by outreach in the community and focuses on their different social issues. This is a strength of the model.

Secure residential therapeutic treatment programs to support young people living with addiction

Merits and risks

98 I am not familiar with the secure residential sector for young people, but my understanding is that we already have similar services for wards of the state, and young people with behavioural problems.

99 I would be in favour of the secure residential sector incorporating and integrating interventions for substance misuse and other mental health issues and developing their capacities in this regard. More broadly, this sector should incorporate and develop therapeutic capacity in all mental health areas, including substance misuse.

100 In doing so, it would be important to look at any evidence relating to the outcomes of similar arrangements elsewhere, and this evidence should inform relevant policy.

101 For example, there are two new dual diagnosis residential-based rehabilitation units for adults at Sunshine Hospital and in Bendigo. They currently have a waiting list of approximately 130 clients seeking admission reflecting the high need for this type of intervention.

102 I also visited a similar residential-based unit in Vancouver, Canada, while on a sabbatical (discussed further below). This unit was originally established as a short-term initiative when Vancouver hosted the Winter Olympics in an attempt to get vulnerable people off the street, however, the outcomes were so positive that this programme has continued.

103 I am an advocate of youth health and for promoting an early intervention paradigm, as adopted by Orygen. And so establishing something similar to the Sunshine, Bendigo and Vancouver units for young people makes intuitive sense to me. As mentioned above, however, the approach to such a residential treatment programme must be integrated and incorporate all health needs.

104 One concern I have in regard to the proposal is that the public health sector is limited in its recovery focus as being often more short-term, than long-term.

105 The more severe a mental health problem is, the more likely it is to be a lifelong problem.

106 I am concerned that secure residential treatment would be directed towards short-term episodic problems of young people, and would not focus on their long-term developmental trajectory, as discussed above.

107 The treatment and its recovery focus would therefore need to be informed by a developmental perspective.

108 These considerations do not differ if consumers also have comorbid mental health challenges. As discussed above, the secure residential facilities should incorporate and develop therapeutic capacity in dual diagnosis and all health needs of residents.

Services available to people with severe alcohol and other drug problems

109 People with severe AOD problems usually receive care at specialist AOD services, where there are addiction medical specialists. These services are situated alongside the major

metropolitan general hospitals. The rural and regional general hospitals have much less addiction specialists' support. There is a paucity of addiction medical specialists in Victoria. The separation of mental health and AOD services 30 years ago in Victoria led to the marginalisation of and reduction in psychiatrists in the AOD services. I have been the Director of Addiction Psychiatry Training in this state for over ten years and observed other states such as New South Wales and Queensland training 20 to 30 addiction psychiatrists every two years, while Victoria had between none and two trainees. There has been a corresponding paucity of addiction medicine trainees in Victoria.

110 The afore-mentioned Severe Substance Dependence Treatment Act (2010) provides for only one treatment centre. Patients in general hospitals with severe substance use problems are now cared for by addiction medical specialists that provide AOD consultation-liaison services to hospitals.

Extent of integration of supports for mental health problems

111 As discussed in detail below, AOD services and mental health services currently do not offer adequate integrated care for dual diagnosis patients. There are some examples of partnerships between youth AOD and mental health services. For example, there have been partnerships between Orygen and the Adolescent Community Program (**ACP**) of the Drug Health Services of Western Health. The current partnership dates six years between the acute services of Orygen and the ACP and facilitates the referral and at times, seamless transfer of patients between services so that an integrated response to consumers' dual diagnosis needs can be provided. Orygen's Community Development Team provides regular secondary and tertiary consultation to the ACP. Research projects' partnerships have now also been developed between the services. These examples rely on the initiative and goodwill of the participating services and extra resources are required.

Improving integration

112 Improvements to integrated care are discussed from paragraph 119 below. Commitment and investment of resources are required to develop appropriate, effective and evidence-based integrated supports.

POTENTIAL REFORMS

Best practice service response and consumer experience for people with co-occurring mental illness and problematic alcohol and other drug use

113 There are three treatment approaches to dual diagnosis patients:

(a) **Integrated treatment.** This involves an integrated assessment of all the person's mental health and AOD problems. A problem list is constructed determining

priority and diagnoses. A treatment plan is devised to address all problems on the problem list. The treatment interventions come from the mental and addiction health fields and are brought together. This may be by the individual clinician, the team or within the same service. This 'one-stop shop' approach is usually the preference of consumers with dual diagnosis.

(b) **Sequential treatment.** In this model, a patient first receives treatment for either their substance use or mental health problem and later receives treatment for the other issue. This model is commonly used when there is a primary and secondary relationship between substance abuse and mental health, for example, alcohol-induced depression.

(c) **Parallel treatment.** This is the prevalent model in Victoria where AOD and mental health services are separated. A patient will attend one service for the management of their mental health and, at the same time, attend another for their AOD issues.

114 Integrated treatment is regarded as best practice and has a developing evidence base.

115 The problems associated with parallel treatment and referral to other services are discussed above. Parallel treatment is further complicated by the inconsistent approaches that can exist between AOD and mental health services leading to contrasting and confusing messages being provided to consumers with dual diagnosis.

Ideal responses to people in crisis who have both mental health problems and problematic alcohol and other drug use

116 Ideal responses to people in crisis presenting with acute dual diagnosis problems are discussed below under 'Exploring Integration'.

Strategies to address the discrimination and 'double stigma' of mental health and problematic alcohol and other drug use

117 For discussion of stigma and pejorative language, see paragraphs 50 to 56 above.

EXPLORING INTEGRATION

Greater 'integrated care' for people with co-occurring mental illness and problematic alcohol and other drug use

Definition of 'integrated care'

118 Integrated care involves the integrated assessment and formulation of a person's AOD use and their mental health and the development and implementation of an integrated treatment plan. See the definition of integrated treatment set out above in a dual diagnosis context. Integrated care can be provided at the level of an individual clinician,

a team, a service and a service system. The latter requires good communication, collaboration and coordination. The existing separation between AOD and mental health services is likely to remain, so a strategy for achieving integrated care must take this separation of services into account.

Ways to achieve integrated care

119 The first thing that is required in order to achieve integrated care is clinical leadership to drive cultural change. Responding to people with dual diagnosis with integrated care must be recognised as 'core business' for both the AOD and mental sectors.

120 For example, I was recruited by the clinical management of Orygen due to my specialisation and expertise in addiction psychiatry, so that dual diagnosis capacity of the service could be prioritised and increased.

121 My recommendation is that all mental health services take a similar approach and invest in addiction health expertise.

122 The mental health sector needs to recognise that psychiatry training is now producing addiction medical specialists, and services must have a recruitment strategy so that they are engaging staff (addiction psychiatrists and other addiction medical specialists, nurses and allied mental health workers) who have competence in dual diagnosis.

123 With respect to the AOD sector, it is currently more fragmented than the mental health sector and needs to undergo significant restructuring if it to build its capacity to provide integrated care for dual diagnosis. The problem of paucity of addiction medical specialists applies equally to many services in the AOD sector.

124 As discussed above, the personnel in the AOD sector are generally less trained and qualified than their mental health counterparts. Personnel in mental health services are generally required to have a Masters-level qualification. While the Department of Health and Human Services introduced a policy for a baseline qualification of Certificate IV for people working in AOD services, this was not actually achieved in my experience.

125 AOD services have limited capacity to respond to the needs of patients in crisis, especially mental health crisis. The mental health sector responds more rapidly to these crises when they are psychiatric in nature and the acute care/primary care /general practitioners intervene when the crises concern physical health.

126 The proposed establishment of 'Mental health – AOD hubs' in hospital emergency departments has good face validity. This is based on the assumption that the Victorian health sector will continue to direct consumers with acute mental health and AOD-related

crises to the emergency departments of our hospitals. Such hubs must be capable of providing integrated support to people with dual diagnosis.

127 For consumers that directly approach the AOD system's intake service, there is generally a significant wait for an assessment after a consumer makes an initial phone call. If, after assessment, the consumer requires detoxification admission, there will be another wait, often a number of weeks. The sector has limited capacity to provide a care opportunity to people when their motivation levels are highest.

128 This system places a lot of responsibility on the consumer to follow-up with the service. Often they are too impaired to do so. This means that it is often those consumers with better prognoses and who are less impaired get access to treatment.

129 In my experience, many services in the AOD sector lack any addiction medical specialist or nurse practitioner personnel or they place medical interventions such as pharmacotherapies and treatments for the physical harms of substance use at the periphery of the service. Some AOD services rely on the consumer's general practitioner to provide medical care.

130 Overall, there needs to be greater incentive for integrated care in both the AOD and mental health sectors. It must be recognised and accepted that dual diagnosis is the expectation, not the exception and that integrated interventions for both mental health and AOD issues are compatible and effective.

131 Currently, there seems to be an assumption that patients will or should receive parallel treatment. This should not be our assumption. As discussed above, parallel treatment through referral is often ineffective due to the differing severity thresholds required for access across the sectors.

132 We should therefore focus on how we can improve the dual diagnosis capability of both sectors to provide integrated treatment. All services need to have dual diagnosis competencies and skills, and management must view dual diagnosis as their core business.

133 This will, of course, require increased resources. However, it will require change in the cultures of both the mental health and AOD sectors and changes in the way they do their work. The provision of financial incentives is an important means by which services can be persuaded to provide a particular form of intervention or change their mode of operation.

134 For example, I have been involved in the 'Tackling Tobacco' initiative at Orygen and NWMH, which seeks to reduce smoking in consumers of the services with mental illness. A similar Queensland project is supported by Queensland Health, which has provided

financial incentives for mental services to identify tobacco issues faced by their consumers.

Enabling integrated care for people living with both mental illness and problematic alcohol and other drug use in a future system

135 Mental health and AOD services will in future welcome dual diagnosis patients, rather than making them feel as if they have come to the wrong place or that they will be sent elsewhere when they seek help. When services are welcoming, integrated care can be fostered through engagement with patients. If services fail to engage patients, then treatment and recovery can never be successfully provided. Engagement of the consumer to a service is the necessary first step towards treatment and recovery.

136 For services to provide integrated treatment, they must adopt a culture of acceptance and a 'no wrong door' attitude. Given that dual diagnosis is so common, services must accept that it is something they have to manage.

137 As discussed above, a key way to ensure this welcoming and non-judgmental culture is reducing the stigma associated with substance abuse. The mental health sector must recognise substance use disorders as a form of mental illness and substance use disorder cognitions and behaviours as manifestations or signs and symptoms of disorder.

138 I would note, however, that although we know that an integrated approach is what consumers want, the highest-level evidence base to support this approach is somewhat lacking.

139 Three Cochrane Collaboration reviews of integrated psychosocial treatments for co-occurring low prevalence psychotic disorders and substance use disorders did not conclude that an integrated approach provides superior outcomes.[4]

140 There were, however, methodological issues with these studies evaluated in these three Cochrane reviews. It is a very difficult area to evaluate scientifically, given that dual

[4] Ley A, Jeffery DP, McLaren S, Siegfried N, "Treatment programmes for people with both severe mental illness and substance misuse", Cochrane Database Syst Rev. 2000;(4):CD001088. https://www.ncbi.nlm.nih.gov/pubmed/11034697?log$=activity.

Cleary M, Hunt G, Matheson S, Siegfried N, Walter G., "Psychosocial interventions for people with both severe mental illness and substance misuse", Cochrane Database Syst Rev. 2008 Jan 23;(1):CD001088. doi: 10.1002/14651858.CD001088.pub2. https://www.ncbi.nlm.nih.gov/pubmed/18253984.

Hunt GE, Siegfried N, Morley K, Brooke-Sumner C, Cleary M., "Psychosocial interventions for people with both severe mental illness and substance misuse", Cochrane Database Syst Rev. 2019 Dec 12;12:CD001088. doi: 10.1002/14651858.CD001088.pub4. https://www.ncbi.nlm.nih.gov/pubmed/31829430?log$=activity.

diagnosis involves many variables. It is difficult to control for all of these variables in the way that scientific analysis requires.

Best operational model for assessing clients for 'streaming'

141 When a consumer comes to the service, they undergo an initial or 'front-end' assessment. The front-end assessment determines the needs of the consumer in relation to both their mental and substance use issues, the risks that are present and the urgency with which the responses are required. This initial assessment determines the 'streaming' of consumers.

142 The first step in any health intervention is acute stabilisation. This process should be seamless and should be responsive to all presenting problems of the consumer with dual diagnosis. The front-end of a streamed service system therefore needs to be able to identify and stabilise all acute issues and risks that a person presents with, including in both mental health and substance use conditions.

143 For example, suicidality must be stabilised in the case of an acutely suicidal person, or in the case of a severe substance use problem, detoxification may be required to prevent potential life-threatening complications of substance withdrawal.

144 Once stabilisation has occurred and acute risks have been addressed, individuals can be streamed into different programs depending on the severity and diagnostic nature of the consumer's presenting problems.

145 If the person is deemed to have a high severity substance use disorder, it makes sense to place them into a stream that has expertise in this area. Similarly, if they have a high severity mood disorder, they may be placed in a stream that specialises in that area.

146 As emphasised above, it is crucial, however, that all streams have dual diagnosis capacity and competency, that is able to provide integrated care.

147 While I am in favour of streaming, a key consideration is what the consumer desires: a 'one-stop-shop' where they are listened to and where all their problems will be addressed in an integrated way.

Physical environments required for streaming

148 Integrated care requires being able to respond to all the physical, mental and behavioural health needs for consumers with both AOD and other mental health issues. The environment must provide safety for all consumers and staff. Consumers with dual diagnosis have more prevalent physical health problems and the environment must support these needs.

Workforce profile required for streaming

149 As discussed above, an integrated approach requires a workforce that has competency and capacity in dual diagnosis, with expertise in both mental health and AOD and some competency in providing care of physical health problems when they arise.

Successful models of system or service integration across mental health and alcohol and other drug in other jurisdictions

150 I completed a sabbatical in 2014 to observe approaches to dual diagnosis in Switzerland, Italy, the UK and Canada. One highlight of the systems I visited during the sabbatical was that the co-location of mental health and addiction health services best placed a system in the position to provide integrated care.

151 As an example, at the University of Zurich in Switzerland, the Department of Psychiatry was divided into sub-departments which included mood disorders and addiction health. Addiction health was on an equal footing with the rest of psychiatry, and was not positioned as 'lower' in the psychiatry hierarchy.

152 This system of co-locating facilitates, co-ordination and collaboration of care, reduces any incongruities and inconsistencies between treatment approaches when care is provided by a number of clinicians or practitioners.

153 The Swiss model was funded by the state insurance scheme, which suggests to me this integrated care approach was more adequately resourced by the state.

154 In Canada, I observed the function of a residential dual diagnosis rehabilitation unit and I am grateful that similar units have now been established in Victoria, however I am not sure how these units were modelled and established. Research of interventions for dual diagnosis was an important feature of the Canadian unit. In addition to having a workforce competent in co-occurring disorders, any dual diagnosis unit must also evaluate its interventions and outcomes.

WORKFORCE CAPABILITIES

Access of mental health services to specialist alcohol and other drug or addiction expertise

155 Orygen has embedded specialist addiction expertise within the service, including by engaging me as the consultant addiction psychiatrist thereby improving the service's dual diagnosis capability.

156 As discussed above, other mental health services should also employ addiction psychiatrists and other addiction health clinicians to provide an integrated response to dual diagnosis.

157 As the system currently exists however, there are complex situations of severe substance use disorder that require the mental health service to access the AOD sector's expertise. For example, we have forged a partnership between Orygen and the local youth AOD service, the Adolescent Community Program (**ACP**) of Western Health's Drug Health Services, whereby young people can be transferred from the mental health inpatient unit directly to the ACP's residential withdrawal unit which can provide the young consumer with further AOD support. The referral of patients with severe opioid use disorders to AOD services for opioid substitution therapy is another example of the need to access the expertise and infrastructure of AOD services. I believe mental health services should also be able to provide this important intervention when required.

Access of alcohol and other drug services to access specialist mental health or psychiatric expertise

158 As for mental health services, AOD services should also develop dual diagnosis expertise. There will be cases of severe mental illness where the expertise of mental health services is required. The current AOD service structure is not capable of providing supportive care in some cases where patients are suicidal, self-harming or psychotic for example and referral to a mental health service is required. This referral and transfer of care must be coordinated and seamless.

Required workforce capabilities

159 The AOD workforce requires the expertise to manage the other high prevalence mental health issues that occur in its consumers such as depression, anxiety, post-traumatic stress disorder.

160 The mental health workforce must also possess the expertise to manage the more common, less severe forms of AOD issues in its consumers. The more common substances of misuse in consumers of mental health services are tobacco, alcohol, cannabis and methamphetamine. Less severe forms of AOD disorder often require and respond well to the so-called 'brief interventions for AOD 'issues'. I believe all mental health services must be proficient in the provision of brief interventions for AOD.

Features of existing workforces stymieing multidisciplinary and consumer-focused practice

161 As discussed above, there are numerous existing workforce factors that stymie multidisciplinary and consumer-focused care. The separation of the workforce into AOD

and mental health sectors produces separate workforces that have developed within a single culture that artificially separates substance use disorder and mental illness treatment. Clinicians that train within a particular sector are skilled mostly, if not only, in either AOD or mental health interventions. This leads to the parallel treatment of dual diagnosis, which is neither multidisciplinary nor consumer-focused. Furthermore, the stigma historically associated with addiction and AOD use has prevented clinicians from becoming involved in dual diagnosis and addiction health.

Overcoming these problems

162 A service needs to develop its own dual diagnosis workforce capability. This is relevant to both mental health and AOD services. A service becomes dual diagnosis capable as it develops a dual diagnosis network within it, which is comprised of clinicians with dual diagnosis knowledge and expertise. These clinicians can be called 'dual diagnosis champions'.

163 Within the RANZCP, I oversee the training of Victorian psychiatrists who make the decision to specialise in addiction psychiatry.

164 Fifteen years ago there were no trainees in this area. Now there are 16 trainees in addiction psychiatry and 9 psychiatrists in Victoria who have attained their Certificate of Completion of Advanced Training in Addiction Psychiatry.

165 I have therefore observed a recent growth of this speciality in the workforce. These addiction psychiatrists must subsequently become part of both the AOD and mental health sector workforces in order to demonstrate the clinical leadership that psychiatrists are trained to provide with a particular focus to the provision of integrated care for dual diagnosis.

166 I have been giving lectures to medical students and psychiatry trainees in their Master's program on the topic of addiction psychiatry, ultimately with the goal of de-stigmatising and de-mystifying substance use, addiction and mental health and increasing their interest in the field.

167 Younger psychiatrists and psychiatry students view addiction health as a much more attractive and interesting field, and have recognised that dual diagnosis is the expectation, rather than the exception, when working in the mental health sector. They commonly attribute their increasing interest in training in addiction psychiatry to their recognition of the high prevalence of dual diagnosis in their patients.

168 Beyond early training, provision of incentives to clinicians to take on dual diagnosis is another way by which to increase engagement in this area.

169 Clinicians feel rewarded if they receive positive praise and feedback from managers. Dual diagnosis should therefore be recognised in organisational Key Performance Indicators. Examples of indicators of dual diagnosis clinical practice indicators include the accurate recording of substance use disorder diagnoses in mental health databases and the provision of dual diagnosis integrated interventions.

170 Professional development opportunities need to be advanced, so that medical practitioners can see that addiction psychiatry and addiction medicine are viable career paths to pursue.

Roles, training and development required for integrated care

171 The current workforce lacks the personnel and expertise in providing integrated care. A strategy to build this workforce is required and new roles, training and development are crucial. For example, a project to develop an addiction medical specialists' workforce strategy for Victoria is already underway. Medical specialists provide clinical leadership within and between health services. Nurse practitioners are increasingly becoming an important part of the AOD workforce, however they are less common within the mental health services. Nurse practitioners in mental health services would be well placed to lead integrated interventions for people with dual diagnosis. Finally, I believe that separate AOD and mental health services will continue into the future. Each sector must develop its own dual diagnosis capacity so that integrated and multidisciplinary care can be provided within the same service. Each service therefore requires a core workforce of 'dual diagnosis expert' clinicians. The system by which dual diagnosis-capable clinicians are to be trained requires adequate resourcing, so that ample training opportunities exist. Where integrated care must be provided by separate AOD and mental health services, memoranda of understandings are required, so that the services collaborate, communicate and coordinate their interventions under the single integrated intervention plan.

Opportunities for joint mental health and alcohol and other drug workforce training and development

172 The training of addiction medical specialists such as addiction psychiatrists, addiction medicine specialists and addiction general practitioners that occurs within specialist AOD services is an example of joint workforce training. As discussed above, this medical specialist training is increasingly popular. Some addiction psychiatry trainees are electing to undergo joint specialty training in addiction and consultation-liaison psychiatry and this will produce a workforce of psychiatrists working in the general hospital setting who have competence in caring for those patients with dual diagnosis in general hospitals with acute illness. In a similar vein, non-psychiatric trainees in addiction medicine must be given opportunities to work and train in mental health settings in order to develop knowledge

and skills in mental health problems. The VDDI's previous 'Reciprocal Rotation' training was an example of a joint training opportunity that was under-utilised as it was never prioritised by services in spite of adequate resourcing.

Successful examples of joint training

173 The addiction medical specialists' training discussed above is an example of successful joint training. More such training opportunities are required, so that generalist psychiatry trainees may also gain experience in the addiction setting and develop the relevant skills. Turning Point hosts a monthly joint scientific 'Addiction Journal Club' that is attended by addiction physicians and psychiatrists and trainees in addiction medicine and psychiatry. Trainees in addiction medicine and addiction psychiatry from Australia and New Zealand jointly attended a formal education course hosted by the New South Wales Director of Addiction Psychiatry Training until the completion of 2018. We await the formation of another similar education programme as the reports from the trainees who attended and the addiction medical specialists that provided the content of the course was very good. A third joint local training example is the biennial 'International Medicine in Addiction Conference'. It is a joint initiative organised by combining the resources of the RANZCP, the Royal Australasian College of Physicians and the Royal Australian College of General Practitioners and is attended by medical and other practitioners with an interest in addiction medicine for clinical updates in the field.

Implementing joint training approaches across a whole system

174 The implementation of joint training approaches requires the support of the all the leaders of the different parts of the system. This starts with the broad acceptance that dual diagnosis and integrated care require integration of the system. All parts of the system need to work together, share their resources and have the common goal to produce a workforce that is competent with respect to dual diagnosis. Although the examples I provide above concern the joint training of addiction medical specialists, the same joint training approaches should also be provided for non-medical health practitioners. Training resources must be shared across the system, so that motivated and suitable trainees can be selected into the valuable training positions.

COVID-19

The emerging changes in mental health service delivery as a consequence of COVID-19

175 Many changes have emerged with COVID-19; I think they are general in nature and there aren't many specific to dual diagnosis or people with AOD-related problems.

176 As a provider of mental health service delivery, we have endeavoured to continue providing identical quality and standards of care in spite of the changes that COVID-19

has forced on us. My observations are from the perspective of outpatient treatment provision, where the majority of interventions are now provided via telehealth.

Consumer factors

177 Many consumers have 'gone to ground', that is, not presented for treatment, often because they have increased reluctance to take the help and support that has been offered. This may be related to fears and anxiety directly related to the COVID-19 infection issues.

178 Other people have engaged well with telehealth options as they can remain home and receive consultations; leaving home was previously difficult for these people.

179 Video forms of telehealth are preferable. However consumers' access to internet is variable.

180 Consumers' substance use issues have not changed dramatically. The availability of illicit drugs hardly appears to have changed. If there is a problem accessing a previously favoured substance, substitution to another drug is common.

181 Overall, we have observed a reduction in community care consultations and meetings with clients. We are therefore are concerned that consumers are not presenting for help in the case of the more common and less severe mental health issues and they are enduring their difficulties. People with more severe forms of mental illness such as psychosis, severe mood disorder and severe AOD disorders and their carers and families are still requesting support. However, the reduction in admissions to our inpatients units is likely an indicator that even the most severe and complex mental health presentations are not presenting for support or treatment, at least during the early stages of the COVID-19 period.

182 There has been an overall reduction in the involvement of carers and families in the management of younger patients. Telehealth consultations often occur in the setting of the young consumer's bedroom for example, and accompanying family members are less present. Family meetings are more complex over telehealth and it is more difficult to observe and assess dynamics and communications between family members.

183 AOD-specific mutual help group such as Alcoholics Anonymous (**AA**) and Narcotics Anonymous (**NA)** have changed to virtual/digital meetings. I do not know what impact this has had on the function of these groups.

Clinician factors

184 The following new policies and procedures have been implemented:

(a) COVID-19 screening and assessment when planning 'in person' consultations;

(b) organisational directives requiring telehealth to be the new consultation method and that 'in person' meetings occur after widespread consultation and discussion; and

(c) organisational directives that outreach to consumers' environments is preferred to centre-based consultations if 'in person' meetings required.

185 Clinicians' anxiety re travel to conduct outreach assessments and meetings of consumers where screening and assessment of COVID-19 factors is more problematic and because the risk of COVID-19 infection increases with travel to multiple sites. This is at odds with the organisational directive that preferences outreach to centre-based care.

Systemic factors

186 Within the organisation, travel has been restricted between sites, so that individual clinicians now work from the one location. This has reduced the service's flexibility and capacity for clinicians to work across different teams.

187 Meetings previously required frequent travel between sites and locations. The widespread and successful adoption of digital communication methods has facilitated these meetings and saved on travel time resources. This has also improved clinicians' capacities and opportunities to attend meetings and educational forums that previously were difficult to access.

188 Some structural changes of the mental health service due to COVID-19 have been detrimental to the provision of integrated care for some forms of dual diagnosis. In recent years for example, smoking has been prohibited within hospital units, including psychiatric inpatient units, and inpatients have been supported to stop smoking during admission. This has been part of a well-considered effort to reduce smoking among people with mental health problems. COVID-19 changes in psychiatric inpatient units have permitted the reintroduction of smoking in some units.

189 Partnerships and collaborative work with stakeholders has reduced, mostly as services have adopted changes in their work and have not considered yet how they might work with other services and organisations.

190 AOD services appear to have greatly changed their services, for example reduction in capacity to provide residential drug withdrawal interventions and support. This has further reduced their capacity to respond rapidly to patient needs in times of crisis.

191 There has been an increase in the communications with pharmacies in the case of medication-based treatments as prescriptions are not provided directly to consumers unless 'in-person' consultations take place. There has therefore also been an increase in administrative activities such as faxing prescriptions and mailing the original script as per regulatory requirements.

192 Direct communication with some regulatory authorities has been problematic as they have been directed to attend to other COVID-19-related activities. For example, the Drug & Poisons Unit (**DPU**) at the Department of Health and Human Services receives applications and issues permits for Schedule 8 drugs such as methadone and buprenorphine. The DPU is currently not taking telephone inquiries regarding urgent permits and this led to a delay in the provision of treatment to consumers in a personal clinical case in my private practice early in the COVID-19 period.

Impact on longer term opportunities for new approaches to service delivery

193 There are few changes that I would consider would lead to longer term opportunities for new approaches consumers with mental health and AOD-related issues and their carers, apart from the obvious potential benefits from the demystification and improvement in the use of telecommunications platforms with respect to the metropolitan services. I believe regional and rural services have long been acquainted with the utility and advantages of telecommunications platforms.

194 It is probably still too early to say whether any of the changes in our methods of providing assessment and interventions due to COVID-19 have afforded any advantages over previous methods. There may be some consumers that prefer telehealth, but I would say that these people are in the minority.

195 Working from home is possible for clinicians in solo practice, however the provision of multidisciplinary care has been difficult and more complex when practitioners are not co-located. Internet services have not been good enough to support seamless telecommunications.

196 It may be that opportunities for partnership and collaboration with other services that reduced during COVID-19 will continue to be reduced into the longer-term, thereby making the provision of integrated care for more complex clients with dual diagnosis more difficult. Services that provide integrated support for people with dual diagnosis will need to utilise their own knowledge and resources in order to provide integrated treatment and interventions. This would be consistent with the integrated approach's ideal that a service provide a 'one-stop-shop' for its consumers with dual diagnosis.

197 The improvements in digital telecommunications that have occurred should be maintained in the longer-term and applied to training and education interventions to make

the mental health and AOD workforces more dual diagnosis capable. The broader development and use of webinars and other online training media are examples of this. For example, Turning Point has hosted a scientific 'Addiction Journal Club' for addiction psychiatrists and addiction physicians from both mental health and AOD services for several years. The attendance has recently increased as a result of the change from in-person attendance and participation to web-conferencing platforms.

198 The use of the term 'social distancing' has been an unfortunate consequence of the public health approach to COVID-19. I believe the more appropriate term is 'physical distancing'. Social connection and social cohesion are very important factors in society's overcoming the challenges of COVID-19. I would argue that these factors are the most critical in a person's psychosocial recovery from mental illness and addiction. The term 'social distancing' has only impeded the attainment of the social connection that is required for people with mental health and AOD issues.

199 The traditional methods of developing a social network to support one's recovery have had to cease e.g. AA/NA meetings at specific locations to support one's sober social network. It would very important to inquire as to whether the change to digital meetings has had an overall negative or positive impact on these mutual-help groups.

200 If there are changes resulting from COVID-19 that represent opportunities for service delivery and eventual benefit for consumers and carers, they should facilitate improvements in social connectedness.

sign here ►

print name ENRICO CEMENTON

Date 25 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT EC-1

This is the attachment marked 'EC-1' referred to in the witness statement of Dr Enrico Cementon dated 25 May 2020.

Dr Enrico Cementon
MBBS MMed (Psych) FRACGP FRANZCP FAChAM (RACP)
Orygen
35 Poplar Rd Parkville VIC 3052
P: 9966 9100

PERSONAL PROFILE

Enrico is a consultant psychiatrist with 20 years' sub-speciality addiction and dual diagnosis psychiatry experience. In the last five years, he has also broadened his expertise in youth psychiatry. Enrico has great communication skills with a track record of delivering the highest standards in clinical care as well as a commitment to training, workforce development and senior administrative experience. He is outcome-oriented and has an ability to quickly adapt to new environments and lead change.

Committed to the fields of youth and addiction psychiatry, Enrico has a breadth of experience leading teams in the public mental health and alcohol and other drugs' settings, teaching for the University of Melbourne and he has led training activities in the major psychiatric medical group, the Royal Australian and New Zealand College of Psychiatrists.

Enrico has also conducted and managed his own private psychiatric practice since 1999 and he is fluent in Italian language.

KEY CAPABILITIES

- Continuous track record of 20 years in senior psychiatric leadership positions delivering programme leadership and management and ensuring a high quality of patient care within the ranks
- Passion for delivering youth, general and addiction psychiatric services, including an ability to balance people/cultural impacts and business/technology outcomes
- Training and teaching-orientated – recognises and develops talent to satisfy future workforce needs Enjoys teaching, lecturing, mentoring and supervising people through significant development and change in their professional lives
- Belief in building capacity in MH and AOD services to provide better dual diagnosis outcomes
- Ability to manage people, lead teams and be a trusted advisor to Senior Executives, assisting with clear communication between medical, nursing and allied health staff
- An open, common sense approach suited to the teamwork required to work within the multidisciplinary teams
- Strong commitment to supporting research in mental health and addiction

CAREER SUMMARY

NorthWestern Mental Health, Melbourne Health	Lead consultant psychiatrist, Orygen Youth Health	2014 – current
Eastern Health	Director of Addiction Psychiatry Training	2020 – current
NorthWestern Mental Health, Melbourne Health	Director Clinical Services Substance Use, Mental Illness Treatment Team (SUMITT)	2000 – 2014
NorthWestern Mental Health, Melbourne Health	Consultant psychiatrist, Midwest Area Mental Health Service	1999 – 2014
Western Health	Consultant psychiatrist, Drug Health Services (previously DAS West) and Addiction Medicine Unit, Western Health	2000 – 2014

Australian Health Practitioners Regulation Agency	Independent health assessor	2008 – current
University of Melbourne	Honorary Principal Fellow, Faculty of Medicine, Dentistry and Health Sciences	2012 – current
	Casual staff	2002 – 2012
	Member Board of Examiners and Course Committee, Postgraduate Psychiatry Program, Coordinator of Drug & Alcohol Use Disorders Selective	2002 – 2014
NorthWestern Mental Health, Melbourne Health	Consultant psychiatrist, Consultation-Liaison Psychiatry, Western Hospital	1998 – 2006
NorthWestern Mental Health, Melbourne Health	Psychiatry registrar, Early Psychosis & Prevention Intervention Centre (EPPIC) and Midwest Area Mental Health Service	1997 – 1998
Charter Nightingale Hospital, London UK	Psychiatry medical officer	1996
Royal Free Hospital, London UK	Psychiatry registrar, West Hampstead Day Hospital	1996
Footscray Psychiatric Hospital	Psychiatry registrar	1993 – 1995
Royal Park Psychiatric Hospital	Psychiatry registrar	1995
Family Medicine Programme	General Practice registrar	1989 – 1993
Box Hill Hospital	Intern	1988

QUALIFICATIONS

RACP	FAChAM	2002
RANZCP	FRANZCP	1999
RACGP	FRACGP	1993
University of Melbourne	Masters of Medicine (Psychiatry)	2000
University of Melbourne	MBBS	1987

HONORARY PROFESSIONAL POSITIONS

ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS (RANZCP)

Director Advanced Training Addiction Psychiatry Victoria 2009 – current

Member Victorian Psychiatry Training Committee (VPTC) 2009 – current

Committee member Section of Addiction Psychiatry 2002 – 2017
Treasurer Section of Addiction Psychiatry 2011 – 2017

Deputy Chair Subcommittee for Advanced Training Addiction Psychiatry (SATADD) 2010 – 2017

Member Western Region Training Committee (WRTC) 2009 – 2014

Member Local Scientific Committee RANZCP 2012 Congress 2011– 2012

Key informant Parliament of Australia Senate Joint Select Committee on Gambling Reform, Inquiry in the prevention and treatment of problem gambling 3 May 2012

UNIVERSITY OF MELBOURNE – DEPARTMENT OF PSYCHIATRY

Honorary Principal Fellow 2018 – current
Clinical Senior Lecturer 2012 – 2018
Member of Board of Examiners 2002 – 2014

MEDICAL JOURNAL OF AUSTRALIA

Reviewer

DRUG AND ALCOHOL REVIEW

Reviewer

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

Reviewer

JOURNAL OF NERVOUS AND MENTAL DISEASE

Reviewer

WORLD PSYCHIATRIC ASSOCIATION

Member Local Scientific Program Committee WPA 2007 International Congress Melbourne 2006 - 2007

VICTORIAN DUAL DIAGNOSIS INITIATIVE (VDDI)

Organiser “Building the Systems for Helping Clients with Dual Diagnosis: a Conference with Dr’s Kenneth Minkoff & Christie Cline” Melbourne 2007
Member VDDI Leadership Group 2008 – 2014

ITALIAN MEDICAL SOCIETY OF VICTORIA

Commentator on mental health issues *Retitalia* radio

PUBLICATIONS

Depression and anxiety symptoms in a sample of Australian methadone maintenance treatment patients
Masters thesis 1998

The impact of co-occurring mood and anxiety disorders among substance-abusing youth
Lubman DI, Allen NB, Rogers N, Cementon E, Bonomo Y, J Affect Disord. 2007 Nov;103(1-3):105-12

Dual Diagnosis: Orientation and Resources Manual for NWMH Medical Officers
E Cementon & S Sweeney, NorthWestern Mental Health 2010

Alcohol and Other Drug Withdrawal Practice Guidelines: Acute Inpatient and Residential Services
E Cementon, NorthWestern Mental Health 2011

Suicide Attempt Presentations at the Emergency Department: Outcomes From a Pilot Study Examining Precipitating Factors in Deliberate Self-Harm and Issues in Primary Care Physician Management
L Joubert, M Petrakis & E Cementon, Social Work in Health Care 2012, 51:1, 66-76

Schizophrenia and Substance Abuse
E Cementon, D Castle & R Murray, in Comprehensive care of schizophrenia: a textbook of clinical management (2nd ed.) edited by JA Lieberman & R Murray Oxford University Press 2012

ORAL AND POSTER PRESENTATIONS

Substance Use and Mental Illness Treatment Team (SUMITT): A limited integrated treatment model for dual diagnosis and its evaluation
APSAD Conference 2005

Substance Use and Mental Illness Treatment Team (SUMITT): A limited integrated treatment model for dual diagnosis and its evaluation
RANZCP Congress 2006

Interactions between drugs of abuse and psychotropic medications
Anex 2007 Australian Drugs Conference: Drugs & Mental Health

Interactions between drugs of abuse and psychotropic medications
World Psychiatric Association International Congress 2008 Oral Communication

Smoking and mental illness: The psychiatrist's role
E Cementon, B Hocking, J Brewster, R Pols, S Lawn & S Kisely
Symposium organiser & chair RANZCP 2008 Conference

Interactions between drugs of abuse and psychotropic medications: focus on the elderly
Winter Conference Beechworth 2008

Rehabilitation, Recovery and Dual Diagnosis: Rising to the challenge in Victoria
Social & Cultural Psychiatry Section, RANZCP Western Australia Branch 2009

What's new in Drugs & Alcohol? And Dual Diagnosis?
Mental Health in the City Conference, St Vincent's Hospital Melbourne 2009

Risk factors for prescription drug dependence and the management of patients addicted to benzodiazepines
Anex 2010 Australian Drugs Conference: Public Health and Harm Reduction

Dual Diagnosis: Integrated treatment is the key - but what is it and how has it shaped up?
Grampians Mental Health Conference 2011

The Dual Diagnosis Orientation & Resources Manual for NorthWestern Mental Health Medical Officers
Eastern Health Mental Health Forum 2011

Inpatient treatment & care of people withdrawing from alcohol & other substances
Office of Chief Psychiatrist's Leadership Forum 2012

Evidence-based Interventions for Comorbidity: Substance Use, Mental Health and Physical Health: Pharmacological Aspects of Healthy Lifestyle Interventions
Symposium presentation RANZCP Congress 2014

Smoking cessation in clinical practice symposium 2014: What are the core issues for smokers with mental illness?
Symposium presentation RANZCP Congress 2014

Contrasting dual diagnosis approaches in Australia to approaches in other continents
Symposium presentation IV International Congress on Dual Disorders 2015

Addressing comorbid substance use and mental disorders: diagnostic challenges and service responses
Symposium presentation RANZCP Congress 2016

An Integrated Model of Care for Dual Diagnosis in a Specialist Youth Mental Health Clinic
Poster presentation International Early Intervention in Psychosis Association Conference 2016

"Highways" – a mutual-help, recovery group for young people with dual diagnosis
Poster presentation International Association for Youth Mental Health Conference 2017

Young people that smoke at Orygen Youth Health – let's intervene early
Brief report Oceania Tobacco Control Conference 2017

Establishing a clozapine service within an early intervention service for psychosis
Co-author for poster by L. Mora, T. Bridson, N. Garland, L. Foote, J. Sherlock, S. Young, E. Cementon, J. Cocks & B. O'Donoghue Early Intervention in Psychosis Association Conference 2018

Tobacco use in a mental health service for young people – let's intervene early and clear the haze
Oral presentation International Congress of Dual Disorders 2019

Smoking in mental health: what has Australia done?
Symposium presentation World Psychiatric Association Congress of Psychiatry 2019

RESEARCH

Deliberate Self Harm Project, Western Hospital
Committee Member 1999 – 2001

Western Area Suicide Prevention Strategy (WASPS), Western Hospital
Member Operations & Steering Committees 2001 – 2004
Chair Operations & Steering Committees 2004 – 2006

Suicide Prevention in the Emergency Department (SPED)
Partner Investigator representing Western Health in Australia Research Council-funded Linkage Study 2007 – current

STAGES study Orygen Youth Health
Clinical investigator 2015 – 2016

Online Survey of Tobacco Smoking attitudes, behaviour and knowledge of young people attending Orygen Services
Clinical investigator 2016 – 2019

Orygen Substance Use Research Group
Member 2019 - current

Young people with Methamphetamine use presenting to an Emergency Department: A mixed-methods study (YoMED)
Chief investigator 2018 – current

AWARDS

Certificate of Outstanding Teaching in the Master of Psychiatry, University of Melbourne 2017
First Year Core Psychiatry Two Lecture in Addiction & Dual Diagnosis