Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF STEFAN GRUENERT

I, Dr Stefan Martin Gruenert MAPS, Chief Executive Officer of Odyssey House, of 660 Bridge Rd, Richmond, Victoria, 3121, say as follows:

Professional background

1 I am a registered psychologist, having obtained a Doctorate in Psychology (Counselling), from Swinburne University, a course on Strategic Perspectives in Non-Profit Management from Harvard Business School, a Diploma in Community Services (Drug & Alcohol) from Odyssey Institute of Studies, and a Bachelor of Arts, Honours (Psychology) from the University of Melbourne. I have worked in the alcohol and other drug (**AOD**) sector for 20 years, as a clinician and manager, supporting people with alcohol and other drug problems and their associated mental health issues. My brief CV is attached.

2 As CEO of Odyssey House Victoria, I am responsible for managing the delivery of a range of residential and community-based services to people seeking help for their alcohol and other substance use disorders, and their associated mental health problems. With over 200 staff, our services operate from more than 30 locations across Melbourne and regional Victoria, providing treatment, outreach and support to more than 16,000 adults, young people, families and children per year. As a Registered Training Organisation (**RTO**), I am also responsible for overseeing the training provided to more than 200 students completing courses in AOD and mental health.

3 I am giving evidence to the Royal Commission on behalf of Odyssey House Victoria and I am authorised to do so.

QUESTIONS FOR PANEL MEMBERS

Question 1: What does a best practice response and consumer experience entail for adults and young people with co-occurring mental illness and problematic AOD use?

4 In my view, many of the current issues and limitations of the service system faced by those presenting with a dual diagnosis, could be solved by two well-resourced sectors or systems. I consider having specialist and available capacity within a mental health system to be able to deal with drug and alcohol issues and, vice versa, having specialist and available capacity within the AOD system to deal with mental health issues, including complex mental health issues, is essential and represents a best-practice approach.

5 A best practice service response would also include integrated support for people with complex mental health issues, giving them care that is well coordinated. This care would limit the number of external services they need to access, reducing the need to jump across different sector boundaries (the idea of 'no wrong door'). To achieve this, there must be some coordination and secondary consultation across sectors, adequate specialist supervision within each sector, and communities of practice and training opportunities for staff, as well as some specialist direct work around complex cases. Avoiding too many different systems to be supporting any one individual is key, and if there is one system that can deal with the majority of a person's issues with a key worker, then that is the best sort of integrated model.

6 For the consumer experience to be as positive as possible, I consider it important to have consumers tell their story as few times as possible. This is because it can involve retelling their trauma and developing multiple, trusted relationships. In my view, a more positive consumer experience can occur with fewer assessment processes (so people do not have to relive their history multiple times), limiting the number of different staff members and new faces they have to learn, and less onerous eligibility criteria (which can make it difficult for people to access services).

Question 2: A significant number of stakeholders have called for greater 'integrated care' for people with co-occurring mental illness and problematic AOD use:

(a) how do you define 'integrated care'?

(b) what are the ways this can be achieved?

7 Integrated care often means having one key worker and one key care plan, with any care and interventions for mental health and drug and alcohol work being brought together into a single, mutually agreed response, together with other supports required (eg. housing, finances, health etc). There may be different components of this integrated care, but the major component should be that it does not require most people to go to multiple different services to receive treatment, and that multiple services should only be required in the most complex or challenging cases. If a large number of services are required to assist a single person to get the help they need, then the system is overly complex and it is not surprising that a person may feel overwhelmed.

8 In my view, integrated care does not, and should not, be experienced as a complexity for a client. It is often the system that is complex to navigate, not the person's needs. A person may have five or six issues to treat and those multiple needs should, as best as possible, be met within each system. It may be that in some cases people have to

continue traversing more than one system, even in an integrated care model – but that should be an exception, not the status quo.

9 If there is a primary issue, then a person should receive most of their support from the system that specialises in this issue, to ensure the right specialist knowledge is available to them. To achieve this, strong triage and referral protocols should exist within each service system, and they must have some generalist capacity, in addition to their specialisation. It could be argued that this approach is inefficient, or that it would be more advantageous if we had a single system that has all the capacity to support everyone's needs. Whilst it may seem that my arguments for integrated care (and those of other people) lead to this conclusion, it is my view, that a single, generalist system is not the way to go for people with a dual diagnosis or with multiple and complex needs.

10 To use a sporting analogy, a generalist athlete who wins a triathlon, is unlikely to be better at each individual event than a specialist runner, or specialist swimmer or specialist cyclist. The focus needed to be 'the best' at one thing requires sacrifices in other areas. Likewise, a specialist AOD system and a specialist mental health system will always be better at understanding, engaging and supporting outcomes for most of their clients, than a combined system. Anecdotal conversations with people in other jurisdictions where this combined system has been tried (for example, in NSW), also make this claim. In NSW's case, combining a mental health system geared around hospitals did not work well for AOD services which are mostly delivered in community rather than hospital settings. Further, while data is limited to show the extent of the overlap of clients mutually accessing AOD and mental health services, we believe there are significant differences in many clients who access the services and that there are many clients who only require a response from an AOD or mental health service, not both. Nevertheless, there are many things that can be done together between AOD and mental health in a much better way. These include shared commissioning, planning, and governance, as well as service delivery reviews, that can enhance integration when supporting people with both AOD and mental health issues, even within two independent systems.

11 Having co-located services or service hubs can make integrated care easier, but is not essential. This is because co-location does not ensure actual service integration. For example, each co-located service may have their own intake process or assessment form to be completed for each client. For this reason, it may be preferable for one organisation to offer different program types, in addition to their core services, and for services to have the ability to share case management information systems and processes. The information should be connected, and the care plans should be connected.

12 Communication between parts of a service is key but is often done poorly because of under-resourcing and capacity issues. For example, at Odyssey House we have had many experiences of referring someone into a residential care. However, when they are

discharged from that service, we are not notified that the person has been discharged (sometimes when they are still unwell), so we often miss picking them back up and providing the support they need then, or at a future point of time. We then have a situation where symptoms increase, mental health deteriorates, problematic AOD use increases, and the situation escalates. This often occurs because of the workload of current staff, not because of a lack of concern or desire. As such, a well-resourced system that allows investment into staff capacity will, in my view, implement a lot of these measures naturally. If the AOD sector builds in specialist work around mental health and the mental health service builds in specialist work around AOD, these practices are more likely to work automatically.

Question 3: In a future redesigned system, what would be the specific components, structures or processes that would need to be in place to enable an experience of integrated care for people living with both mental illness and problematic AOD use from the consumer perspective?

13 I consider that ongoing staff training and capacity building will be required to develop and then maintain expertise, even at a general level. The development of shared communities of practice would also assist. For example, we saw Commonwealth initiatives some years ago around dual diagnosis and there was a lot of capacity building in the AOD treatment sector around mental health. This lifted everyone's standards and ability, but staff turnover will gradually erode this investment over time if it is not maintained. Many staff move on, and junior staff with little experience replace these trained staff and our capacity drops. This was our experience after our staff received dual diagnosis capacity training by the Commonwealth initiatives. Funding levels are also insufficient to sustain experienced practitioners who are often very attractive employees to other sectors. This is particularly so where staff in the mental health sector receive higher remuneration than those in the AOD sector. Practically this means that we often see staff move from the AOD to mental health sector to get paid more.

14 The skills for the AOD workforce around mental health need to be enhanced. Currently most staff tend to have experience and training with higher prevalence mental health issues such as depression and anxiety, however ongoing training is needed around low prevalence mental health issues such as schizophrenia, bipolar, eating disorders and suicide. Clinicians also need broader knowledge around trauma and experience in different ways of partnering with, and supporting consumers, including consumer led healing and recovery.

15 There also needs to be increased secondary consultation, mentorship and supervision of staff, both from mental health experts within the AOD sector, but also from mental health specialists, including those with a lived experience, and those from recovery oriented

services. Currently AOD staff can wait for 1 to 2 hours on hold waiting for assistance from their mental health peers.

16 For integrated care, there needs to be practicalities in process such as shared language, forms and electronic information (for example, electronic referrals, with mechanisms for referral acceptance and referral outcomes).

Question 4: What else should be in place for a future system to deliver more integrated care to people living with both mental illness and problematic AOD use, including from the perspective of governance, operations or funding?

17 Integrated care could be better achieved if there was clarity around governance and a breakdown of power imbalances and structures. Certain professionals or sectors will take responsibility or accountability for a client, but consideration is not always given about how the person is also linked up with other sectors who may have more detailed knowledge about them. For example, there might be a rehabilitation program delivering services to people with dual diagnoses, in which staff have conducted assessments for a long period of time and have good knowledge of who will do well in their programs. If a person has a history of mental illness with stable symptoms at present, it is often everyone's expectation that they still require a mental health assessment to be conducted by a psychiatrist or mental health nurse who may be very difficult to access, because no one else in the workforce has been given accountability for making a decision about the mental health of this client. So, we have situations where someone has to wait a long time for this, or where under-resourced medical staff must make very quick assessments and decisions based on limited information about a person's mental health treatment. It is unfortunate that this may be given more precedence than a consumer's case worker or AOD worker, who has known and supported a person for a significant period of time, and the focus of the care plan is on more medical-type interventions.

18 Further, some members of the workforce (often those that have a medical approach), tend to focus on a person's history and past. This can sometimes hold a consumer back from moving forwards. Naturally, we know a person's past is sometimes very predictive of their future behaviours and it can provide important information for building a safety net. However, hope and expectation that change is possible also impacts positively on outcomes. In my experience, AOD workers and community-based mental health workers are often attempting to work with what a person is currently presenting with as their issue, or what they would like help with, rather than their diagnosis. These imbalanced practices are embedded in many parts of the system, and the expertise and experience of other types of workers may not be recognised.

19 I also consider that having a crisis response that is similar to an emergency department for people displaying behavioural issues, including mental health and AOD issues, may

be useful. Such services for people with mental health and AOD issues need to look different to a medical (physical crisis) setting, and have appropriately trained staff who can triage.

20 We also need to create sufficient, integrated, step-up and step-down options for people with mental health and AOD issues. For many young people, headspace provides a platform from which step-up care can be sourced if required. The service offers a simple front door for young people, and a person's basic or mild mental health needs may be met by simple engagement with a headspace service. For escalated mental health issues, there are tertiary mental health services. However, there is not much in the middle for people who may require more support than headspace can provide, but are ineligible for tertiary mental health services. There is some Commonwealth funding to try and support this gap, however, eligibility criteria often gets in the way of people accessing the services they need. A good system would have an overlap of eligibility, not a gap between its parts.

21 An example around the need to reconsider the step up and down options for people with AOD issues, is that the most heavily resourced part of the AOD system is its residential services. It is assumed that the people with the most complex needs require residential services. However, at Odyssey House, our residential programs (like most AOD residential programs) require active engagement of residents because they are "change focussed", and not simply focussed on containment for people in crisis. So a person needs to be reasonably well or have stabilised symptoms to be able to participate in residential services. About 80% of people in these services also have a diagnosed mental health issue, but these are mostly being well managed. But when symptoms escalate and people become unwell, we did not, until recently, have the capacity to step a person up and move them to a more specialist, enhanced dual diagnosis facility. A step-up model for a dual diagnosis client experiencing a current crisis is a smaller service with a higher staff ratio where the focus changes to assisting the person to stabilise and manage their symptoms. There is no expectation that a person must participate in all the psychoeducation, social and recreation aspects of typical residential programs. This step-up option has been an incredible option because prior to this, the only alternative would have been acute psychiatric care where people's gains often completely unravelled. Having this 'in between' step-up option has been very critical and has allowed people to return to our service when they need to step down again.

Question 5: Are different service responses required depending on the severity and complexity of the clients support needs? If so, how do you 'stream' clients for these responses?

22 Different service responses are required depending on the severity and complexity of client needs, but they should remain co-ordinated. Currently, services are often siloed

and have a narrow focus. A range of services need to be provided to people based on their needs. For example, services considered to be more of the 'lighter touch' that include self-help, online support or apps, and telephone outreach or counselling, may be sufficient for some people, and can be provided in an efficient and low-cost way. These can be increased to provide in-person counselling (or at-home counselling for people struggling to leave their home and engage). Peer led support and healing groups also play a crucial role for some people, either complementing other care, or being sufficient supports in their own right. For further increased care, outpatient or residential services may be required. For people who are very unwell, then there are other more serious options like acute psychiatric services. As mentioned previously, a crisis response with more capacity is also required, and one within an emergency department setting should be considered.

23 If the capacity of a service expanded and there was an increased flexibility in funding within that service, then this complexity around streaming would fall away and it would become easier to get someone assistance for their AOD and mental health needs. This assistance would also ideally link a person into housing services and to enable them to meet other recovery goals such as employment. However, for a service to offer holistic and flexible care, it must have workers who are trained and experienced to provide a holistic response. Additionally, partnerships between services may be an approach in terms of streaming services.

Question 6: What are the knowledge, skills and attitudes needed in a complexity capable workforce providing holistic, person-centred support?

24 I consider attitude to be a very important consideration when talking about a capable workforce providing holistic and person-centred care. In my view, there remains incredible stigma in certain sectors of the workforce that deal with people with mental illness who also have issues around AOD. There is particular stigma in the mental health workforce in relation to people who have problematic issues with AOD. This is depicted through the language that is often used to describe people with problematic AOD issues (negative words such as 'addicts' or 'junkies' and reinforcing rare behaviour or incidences of violence). I consider this stigma is based on the fear or lack of confidence by members of the workforce, or based on negative experiences of the workforce with people who are using drugs. This may have coloured a worker's views about a whole group of people.

25 To try and break down this stigma, I consider good education, including 'hands on' experiences and training are needed as are the building up of knowledge about people and their different needs. The workforce needs to ensure that they have experience and exposure to people who may have AOD issues. For example, Odyssey House works with about 16,000 people a year and we have never, in my 18 years of employment there, had an incident of physical violence from a client directed to a staff member. It may be that

our focus is not to work with people when they are experiencing a crisis. However, it may be that our approach to situations in our service, and the attitudes and experience of our staff, who are trained to be able to deescalate situations, has also assisted here. I also think we make our physical environments very welcoming spaces that the clients feel are theirs. If we were to create walls or barriers at our services and keep staff separate, we consider there would be a real risk our clients would often escalate their behaviours to get attention or to feel valued. In my view, this means that there needs to be a large body of work completed about the attitudes and training required for a dual diagnosis capable workforce.

Question 7: What are the opportunities for joint mental health and AOD drug workforce training and development?

(a) Are there examples of where this is being done successfully?

(b) How do you implement joint training approaches at scale?

26 In my experience, joint mental health and AOD training has not been successful in the past. For the mental health workforce, they need to start off with foundational training about AOD because, as I understand it, AOD is not often taught to people who undertake most clinical or social service degrees. For the AOD workforce, they may need training in relation to basic mental health. As such, it is often very difficult to pitch a joint training session at the right level for two different sectors for education purposes. As such, I am not able to provide any examples where I consider joint training and development has been done successfully. I suggest that it is more appropriate to provide separate training to specialist workforces.

27 However, having said that, I believe joint opportunities for professional development can work well when actual work and reflective practice is done together. For example, when case reviews, case studies, and case formulations are conducted across sectors and when colleagues from both sectors can provide input and learn from one another. For example, Odyssey House has benefited from having a Child and Adolescent Mental Health Services psychiatrist giving input into case reviews at our residential child and family program for about 30 years. That has brought a different lens to the child and family work that is being done and has been very successful in my view, rather than just a focus on the AOD part of a consumer's experience. Likewise, discussing case studies in large forums or with review panels can lead to great care and professional development opportunities if done well.

Question 8: What new roles, training and development are needed for MH and AOD workforces to enable integrated practice?

28 One of the obvious parts missing from training, is that in many undergraduate university courses that train the emerging members of our workforce, do not teach basics around AOD and mental health, let alone hear from any consumer experiences. In my view, matters relating to dual diagnosis should be taught in these curriculums. However, education without real life exposure to actual clients is also not sufficient when working in the AOD/mental health – the dual diagnosis space. Those with a lived-experience need greater training and support to share their stories, and provide greater input into training staff and students. Staff in the workforce need to have rotations where they meet and support the care for people with a dual diagnosis. One proviso I would make is the importance of the retention of staff in AOD services where these rotations occur. We have had experiences where cross-sector rotations of staff between the mental health and AOD field appeared to work well. The mental health staff in particular, enjoyed the AOD rotation and took important knowledge and experience back to their services. However, most AOD services lost every AOD staff member to the mental health sector because of the demand for these skills in the mental health space, in addition to the higher rates of remuneration offered. This was highly detrimental to the AOD sector and it will continue to be an issue where inequity between the sectors remains.

29 Additionally, within the AOD sector, we lose many good senior clinicians to management because there is not a pathway for specialist career advancement. There are also limited resources to be able to appropriately remunerate senior clinicians in the field. This means that the makeup of the workforce in an AOD service is one or two senior clinicians and then a predominantly junior workforce who are unlikely to have extensive work experience and who may not stay with an organisation very long. Accordingly, in my view, in terms or resourcing for AOD services, we need to support roles for senior practitioners, including senior counsellors and psychologists with detailed mental health experience and knowledge, and senior nurse practitioners. I consider that some credentialing in drug treatment would assist in the lifting of the standard. I also consider appropriate funding would support the sector's ability to retain staff within the AOD sector who have good mental health knowledge.

30 I am not really in a position to speak about what new roles may be beneficial for the mental health sector, other than recommending that there should be dedicated AOD clinicians working in mental health who could enhance the dual diagnosis capacity within mental health services for most consumers, and could connect services for more complex cases, reduce stigma, and support AOD policies.

31 Finally, I consider that we require more addiction medicine specialists in Victoria because currently there are very few, including psychiatrists with drug and alcohol knowledge, and pharmacotherapy prescribers. However, senior mental health nurses and nurse practitioners can often fill these gaps and it is in my view, essential to invest in more of these roles too.

ODYSSEY HOUSE VICTORIA

Odyssey House and its services

32 Odyssey House is a specialist alcohol and other drug treatment, training and support organisation that has been operating for more than 40 years. We work with approximately 16,000 people each year across a range of different residential and community-based services and programs, offering holistic support to individuals and families experiencing AOD issues.

33 Odyssey House offers multiple services including:

(a) providing primary healthcare services, particularly within residential services, including general practitioners who can prescribe medication. The people we treat often need medication to support and manage their addiction and mental health issues. We also offer psychiatric care in our residential settings;

(b) psychological treatment (particularly around assessment, motivational interviewing, and cognitive behavioural therapy) and substantial counselling services (including individual and group counselling);

(c) prevention and early intervention services including in schools with young people where we teach health and wellbeing in the curriculum;

(d) intake and assessments on behalf of the broader drug treatment sector in Victoria (this starts from telephone intake through to face to face assessments and then referral to programs and other services);

(e) psycho-social group programs, including day programs with recovery focused supports. Some of these are psycho-education groups, particularly for forensic clients with AOD issues;

(f) residential rehabilitation services. Odyssey House is the largest provider of adult AOD residential rehabilitation in Victoria;

(g) child and family specific services. We work with family members of people who have got AOD issues, including their children, and parents with addiction issues. For example, in-home parenting support and camps where parents may have an AOD issue, family violence and/or mental health issue, and our family residential program providing reunification and parenting skills development;

(h) programs for young people. For example, we provide counselling services in schools, youth outreach, and operate camps for young people;

(i) financial counselling and gambling services for people with addiction issues; and

(j) educational and training services, including drink drive and drug drive programs. Odyssey House is a Registered Training Organisation and we have about 400 students per annum.

Odyssey House's service approach and its strengths and limitations

34 Odyssey House takes a holistic and bio-psycho-social approach to provide people with insight, strategies and skills to manage their issues through a trauma informed and solution focused approach. This means that we have access to primary health and prescribers to offer medical-type assistance and pharmacotherapy for addiction and mental health issues, and we understand the biological predispositions of people and individual differences. We provide psychological and evidence-based skills development and interventions, and importantly, we have a strong emphasis on developing people's positive relationships and social skills. At least 80% of the people we see in our residential services at Odyssey House have a diagnosed mental health issue, and around 60-70% are on a form of medication for their mental health issues (approximately a third of this cohort are on medication for schizophrenia/thought disorder-type illnesses). We also commonly deal with substantial issues around depression, anxiety, and other mood disorders, personality disorders, and some eating disorders. Dual diagnosis rates in our community services are also high, but slightly lower than in residential services, and their mental health issues are mostly high prevalence disorders.

35 The approach, in my view, that defines Odyssey House is the significant emphasis on family, relationships and social issues, combined with holistic support that is evidence informed and continually evolving through innovations and feedback, combined with peer support and lived-experience input. In my experience, the social aspect of recovery can often be underdone in other AOD treatment services.

36 Odyssey House grew out of a combination of social psychiatry and peer support/self-help and attempted to bring these together in order to provide a therapeutic benefit to our clients in the AOD space. In my view, at Odyssey House we have a real appreciation and understanding of the behavioural issues that are connected to people's addiction issues, and a belief that positive, pro-social relationships are the main predictors of sustainable outcomes for people. International thinking and research also supports this approach (eg. Recovery as a social phenomenon: what is the role of the community in supporting and enabling recovery? BEST, David; BIRD, Karen; and HUNTON, Lucy 2015 Available from Sheffield Hallam University Research Archive (SHURA) at: http://shura.shu.ac.uk/9442/). As such, our service delivery emphasises relationship development, relationship

maintenance, a focus on interpersonal skills with partners and children and work around emotional regulation (which underpins both treatment that is required for issues around addiction, mental health and enhancing a persons' social supports/relationships). Another aspect of our holistic approach is how we intersect with other services. We have many relationships and consortia partnerships with other providers including child and family services and several research institutions. At times we are co-located with other employment, mental health or multi-service agencies.

37 Another strength of Odyssey Housing in our sector is the family work we have undertaken. I consider that we have been a champion for family inclusive practice which has enabled us to work with children and parents, influence others in the sector to also undertake family work, and to work around the important issue of family violence. Family work can support people into treatment, and can be informative and complement treatment by utilising families as an additional support. Family support can also enhance treatment effectiveness and can help sustain positive changes and recovery goals. It can also be treatment for effected family members in their own right.

38 Limitations to Odyssey House are the fact that we have had a lot of growth in the last three to five years and there has been an increase in having to employ new and younger workers. A real challenge in the AOD sector is the ability to find appropriately skilled and trained employees. As such, we have had to provide significant training to junior staff internally in order to grow graduates with the right attitudes and values, and capacity build and upskill our workforce. As indicated, there is an inability in the AOD sector to retain senior clinical staff, particularly, when we rely on them to provide supervision to more junior staff. There is also a limitation in our ability to provide upskilling in terms of senior staff that we promote to managerial levels. As such, Odyssey House is investing a substantial work and energy around training its entire workforce, at whatever level, and must do so within very limited and tight budgets.

39 Another limitation to Odyssey House may be that we have not sought substantial funding from outside the AOD sector. That obviously limits what services and work Odyssey House can undertake. Overall, AOD funding tends to be very limited in its scope so we lack flexible funding to afford senior staff or the ability to offer multiple specialist treatment for multiple problems. Some exceptions to this have been around family support, financial and gambling counselling, and vocational services.

Odyssey House's clients

40 The largest cohort of people we work with at Odyssey House are adults in their mid-to-late 30s or 40s. However, we also work with infants, children, and young people through to older people in our community. I have noticed that our service is seeing fewer young people than we may have seen approximately 15-20 years ago. My impression is that

when looking at national data, AOD issues among young people are declining, whilst concerns for young people currently appear to be mental health issues, especially anxiety, depression and suicidality. There is, however, a very large population of untreated middle to older age Victorians.

41 A key criteria to access Odyssey House's services, is that a person must be experiencing an AOD issue or be a family member of a person with an AOD issue (for example, a parent or partner, or a child of parents with problematic AOD issues). For Odyssey House's residential services, there is additional eligibility criteria. We must be mindful of the safety of all clients in our residential services, when we place people there. For example, we would not place people convicted of serious physical violence or sexual offences, especially when there are parents with children residing in our facilities.

Access to Odyssey House Victoria

42 Odyssey House Victoria services can be accessed through any referral pathway, including self-referral. To comply with state funded AOD services, people seeking help are first directed through telephone intake in their relevant geographical area, then assessed and directed into an appropriate service. Odyssey House Victoria operates this intake and assessment function in many areas (but not all) on behalf of all AOD providers. There is no charge for most of our services, although people entering a residential service are asked to make a contribution from their Centrelink payments if they receive any. Additionally, many of our education programs are fee-for-service programs, with some government subsidies available. We offer some Commonwealth funded AOD programs also with more flexible entry options.

Odyssey House's engagement with other service providers

43 Odyssey House has very strong relationships and partnerships with other service providers. For example, last year Odyssey House Victoria partnered with more than 70 other community organisations, seven research institutions, and multiple other businesses to deliver our programs. We are part of five major consortiums with formal Memorandums of Understandings and service agreements in place.

44 We have co-located with housing and vocational services, with headspace, with child and family services and with hospitals and with community health services. Odyssey House Victoria also has strong partnerships with the Austin Hospital and Alfred Hospital and area-west mental health services.

Odyssey House's engagement with families, carers and other client supports

45 I refer to paragraphs 37 about how Odyssey House engages with families, carers and broader relationships of support.

46 In relation to the residential services, in my view, it is important that the clinicians and staff at Odyssey House have contact with almost every member of the client's family at some point. In residential services, about half of that family contact is initiated by a family member themselves who wants information about their family member and how they are progressing. We are particularly focused on family contact in our youth services and estimate that we coordinate family contact with about 70% of our youth client's families (noting we must also respect the agency and views of a young person if they would prefer to not have family contact). For our adult services, family contact is much lower and sits at around 25%. This lower rate is often based on a real desire by our adult clients to not communicate with their families. Our impression is that for our adult clients they may have complex issues with families, having 'burnt' their relationships, and that we need to assist them in establishing family/carer relationships in the future. For some clients, family members have been and continue to be a source of trauma for them, and their involvement can be detrimental.

CO-OCCURRING MENTAL ILLNESS AND PROBLEMATIC AOD USE

Challenges faced by people with co-occurring mental illness and problematic AOD use

47 Some challenges identified by Odyssey House are in relation to a lack of resourcing to allow for capacity building for drug treatment services and AOD/mental health services. The challenge is around the substantial increase in demand for mental health services where the resources have not kept up or matched this demand. This often means that only the most severe clients are treated and other clients miss out on treatment offerings. The experience of Odyssey House is that often when people miss out on mental health services, the consequence of this is that they enter other systems for support, including the AOD system when they have co-occurring AOD issues. Likewise, it is estimated that more than 500,000 Australians are unable to access AOD treatment due to a shortage of services (Ritter, A, et al., 2014, New Horizons: The review of alcohol and other drug treatment services in Australia, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW.) Due to these resource difficulties in the AOD sector, only people with more severe issues get prioritised, and a person may not receive quality AOD treatment in some services or agencies, particularly depending on the level of staff training and education. For Odyssey House, this means that we are often overwhelmed with dual diagnosis clients as a priority group.

48 Odyssey House identifies a challenge around crisis response for our clients. It is often difficult for us to access crisis services, including from CAT teams or from psychiatric triage services in the local area. Even when clinicians from Odyssey House seek a secondary consult, for a crisis situation in relation to a mental health issue, they may wait up to two hours for a response. This is not a sufficiently fast response for a crisis situation.

49 A further challenge recognised by Odyssey House is that cost of allied services can be a big barrier for our clients accessing integrated treatment. For example, we are often required to obtain psychiatric assessments for our clients. However, often to obtain quality psychiatric assessments, in a timely way, public service wait times make this impractical, and our clients need to utilise the private system, which is a financial burden. Likewise, there are limits to the sessions people can access pursuant to mental health plans from their GPs.

Challenges for mental health services in supporting people with problematic AOD use and challenges for AOD services in supporting people with mental health problems

50 The various interactions between mental health and AOD use are not widely understood by workers across both sectors, and this often leads to confusion about how best to integrate treatment, and whether support needs to be concurrent or sequential. For some people with mental health issues, AOD use may be an attempt to self-medicate or treat the symptoms of their illness, with mixed results (some positive and some not). On a practical level, this means that when some people stop taking drugs, their mental health may in fact deteriorate, and that adverse symptoms of their mental health may escalate. However, it is also the case that a person's mental health symptoms may increase when they take particular drugs or when they take more than usual. Likewise, someone's AOD use may increase or decrease with improvements in their mental health issues, depending on individual circumstances and characteristics.

51 Consequently, there is no 'one size fits all' approach to the effects and interrelationship of AOD and mental health issues for any one person. In my view, this remains one of the great challenges in supporting people with a dual diagnosis. It also means that to really help people, they need to be treated by staff with sufficient knowledge and experience in both the mental health and AOD issues, in order to best understand what a person's underlying issues are, how to best formulate treatment plans, and what individualised service offerings are required to best treat that person's needs, as well as being able to monitor changes and increase support if things get worse before they get better.

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

52 Currently, when someone presents with multiple issues to any one sector, there is often considerable anxiety from less experienced or dual diagnosis competent staff about whether any work they undertake in one area (either AOD or mental health) will ameliorate or exacerbate the issues in the other area. This can lead to some level of inaction until treatment or assessments from an expert in the other area is undertaken.

This can be inefficient, create unnecessary bottlenecks, and give the client the experience of being bounced back and forth between two systems before any real help is offered.

53 I have also discussed the challenges in relation to the AOD sector's current funding and refer to my comments in paragraphs 13, 23 and 29 above.

UNDERSTANDING THE AOD SYSTEM

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

54 There are many similarities between the AOD and mental health sectors. Our clients are both often stigmatised and are often dealing with systems that are under-resourced. As indicated, there is a group of clients that overlap with the mental health and AOD sectors and often these clients are transferred back and forward between the mental health and AOD sectors, each believing that treatment (or at least assessment) is required from the other system before it can proceed in their system.

55 Voluntary engagement, treatment and self-help is a driving element of most AOD services. As indicated at paragraph 36 above, Odyssey House grew out of a combination of psychiatrist and peer-support or self-help services. This voluntary engagement in the AOD sector appears to me have been driven by the history of the sector where many people may have had their own journey and lived experience of AOD treatment, and services prioritise agency and the ability for a person to make their own decisions around treatment. There are also more voluntary clients in the AOD system because there is a very limited scope for mandatory treatment in the AOD space. There are more involuntary clients in the mental health space because it is much easier to be sectioned under the *Mental Health Act 2014*. From what we see at Odyssey House, some of the involuntary mental health clients we see may act out when they are mandated into treatment, including acting out by using and abusing AOD. A further difference is the high proportion of clients in the AOD sector that have some type of court order or legal pressure requiring them to attend AOD services (referred to as "forensic" clients). Whilst not technically compulsory, there can be significant legal ramifications if court ordered treatments are breached. Forensic clients make up around 20-30% of clients in AOD services.

56 It appears to me that in mental health, the divide between the clinical and community services is stark. In my experience, the AOD sector bridges the gap between the clinical and community services better, and the clinical or addiction medicine and the psycho-social parts of community services are more integrated. From my perspective, drug treatment appears to have the capacity (or perhaps needs to be), more holistic in order to deliver sustainable positive outcomes, and is much more behaviourally focused. In mental health, it appears to me that the clinical services, and by this I mean a focus on

pharmacotherapy and symptom management or containment, tend to take precedence rather than a focus on holistic support to a person, including support around social issues and consumer defined recovery or healing. I also consider that the more holistic type of work being performed in the community mental health sector has been reduced, to some extent due to the transition to the NDIS. My view is that there are lessons to be learned about respecting a spectrum of service approaches and treatment offerings that cater for different needs or choice. For example, peer support work from people with lived experience, all the way to psychiatric input. All provide important and vital components of treatment offerings. This means that the contribution offered by all treaters must be valued.

57 I consider that that there is much that the AOD sector could learn from the mental health sector in terms of clinical governance processes. The AOD sector in my view can be somewhat cavalier around these more formal processes. This appears to me to because the history of drug treatment has grown from peer support from people with lived experience, and has resisted overly bureaucratic systems, especially if medically dominated. This means that the staff in the AOD sector can see a person in need and go and try and support them without necessarily following systems and processes and ensuring that there is an empirical evidence base to the care being offered. There is a risk in that approach, although it can also be positive in that it can offer quicker, practical, and less expensive treatments and rapid implementation of new programs and initiatives as a result. Consequently, the AOD system is often perceived as more flexible and evolves quickly in response to changing circumstances, feedback, or new evidence.

YOUTH

Barriers to help-seeking and service access for young people with problematic AOD use

58 The predominant barrier for youth accessing AOD work is that youth directed services are under-resourced. Additionally, in the youth sector, there are age limits where a young person suddenly may not continue to be eligible for certain supports or have to move from one part of the system (youth) to the other (adult services). In my view, these set age limits are arbitrary and ought to be more flexible to ensure that clinicians and treaters can continue working with a person after they turn 21. Additionally, young people can all present differently and may have different needs based on their age. For example, you may have a 22-year-old who may for various reasons not be able to cope in the adult system but can make gains in the youth system. Fortunately, the adult AOD system can accept younger people as appropriate in many circumstances.

59 A secondary barrier in my view, is that younger workers tend to be drawn to working with youth in the AOD space, but may not have the skills or experience because they are junior

in their careers. In my experience, voluntary AOD treatment for young people can be very complex and there is a strong risk that young people will not sustain engagement, because there is a sense for a young person that they are invincible. If help is sought, motivation can change quickly once the initial distress is reduced, and so work on underlying and other behavioural issues does not occur. Further, many young people may not have had extensive negative experiences associated with their drug use, in comparison to older clients. This can also affect a young person's motivation to change.

60 Another barrier we face is specifically in relation to young people who may be in care. Unfortunately, these young people may go missing from care and treatment regularly, and find themselves in prison or secure welfare environments. A barrier for this cohort of young people is that there is difficulty in them developing trusting relationships (because of recent trauma), and therefore getting therapeutic supports. This in turn can mean that their AOD use can escalate and that their mental health deteriorates.

Tailoring addiction and problematic AOD interventions and programs for young people

Question 12: How can addiction and problematic alcohol and other drug use interventions and programs be tailored and made attractive to young people?

61 Social connections and activities are critical for young people in relation to AOD interventions and programs. Odyssey House offers programs for young people such as camps, hip hop classes and graffiti lessons (including those taught by high profile people in their field). Odyssey House has been criticised for offering these types of programs because some see it as not a proper treatment mechanism. However, I consider that these types of programs are incredible learning opportunities for young people, and it can also provide them with an important ability to engage and connect with counsellors (in attendance) that will go on to offer/provide them treatment and care. These social activities can also engage different communities, for example CALD communities. Social activities also initially attracts young people into our service, but may also mean that once they meet our staff, they will engage with other supports offered by Odyssey House so we can offer the young person more holistic, flexible services that are tailored to the individual person in whatever stage of motivation they are in. These services are not just about AOD or mental health treatment, but include support for housing, family, vocational, and other social issues. Holistic, flexible care that is tailored to a person is essential, as is ensuring that treatment does not just focus on a person's negative history but is forward focussed considering a young person's future aspirations and goals.

Compulsory treatment for young people living with addiction

62 I consider some compulsory treatment for young people living with addiction is necessary and would be beneficial. I consider it would ensure that some young people, who currently do not engage well with the voluntary system, are better supported and are provided with integrated care in one facility. I also consider that for a cohort of young people, they may stabilise just with developing a sense of safety, belonging, and making positive relationships. My view is that young people often do not engage with voluntary AOD treatment, and that behaviours will escalate without support until they end up in prison.

63 I am part of the "What Can Be Done" steering committee. This steering committee was established by Magistrate Jenny Bowles in 2015 and is comprised of many professionals including CEOs of the Youth Support + Advocacy Service, Windana, senior medical/addiction specialists from St Vincent's Hospital, the Director of the Children's Court Clinic, AOD clinical specialists, clinical and forensic psychiatrists, the community service agency sector, education/training, Legal Aid lawyers and advocacy groups. The Steering Committee was established following Magistrate Bowles Churchill Fellowship in 2014. Following extensive research, Magistrate Bowles recommended that compulsory orders to attend therapeutic facilities be made necessary for some vulnerable young people with significant substance dependency/related mental health issues, because it ensured the safety and security of these young people, dealt with their addiction and improved their mental and physical health. The *What Can Be Done* steering committee is trying to get a compulsory treatment initiative supported and funded for young people based on Magistrate Bowles' research. In my view, programs offering compulsory therapeutic treatment for a set time period, with good judicial and clinical oversight, are beneficial, particularly as it may keep a young a person out of a custodial setting.

64 Internationally we have seen that young people who participate in compulsory treatment programs indicate that they initially did not want help. However, after the program, they realised that they needed help and supports, and that their participation in the program prevented them from going down the particularly negative path they were on. As part of her Churchill Fellowship, Magistrate Bowles conducted extensive research about substance dependency/mental health issues for young people involved in youth justice and/or child protection systems who were not engaging in voluntary treatment. She travelled to Sweden, England, Scotland and New Zealand to conduct best practice research observing treatment services in these countries – from inpatient psychiatric wards, to secure homes and community outreach services, in addition to visiting courts, youth detention centres, residential programs for sexual offenders and AOD residential programs.

65 Magistrate Bowles' fellowship report found that in all the countries she visited, the opinion from numerous experts and practitioners was that for some young people, compulsory treatment was necessary for young people to ensure they were safe and engaged in AOD and/or treatment for physical or mental health issues. Magistrate Bowles ultimately developed a model of mandated therapeutic residential services for troubled young people in Victoria. She recommended that any compulsory treatment facilities not be draconian, and that they include continued education and training facilities on site. She also recommended that accountability mechanisms be implemented for this type of compulsory treatment including that the orders be made and supervised by a court and other external agencies (for example, an Ombudsman for Children as they have in Sweden, a Care Quality Commission from England or a Mental Welfare Commission from Scotland).

Compulsory treatment for young people with addiction and comorbid mental health challenges

66 Odyssey House in New Zealand has a dual diagnosis unit which I consider to be a beneficial model. This unit is similar, although less medically oriented, to the new enhanced dual diagnosis units that have been established recently in Victoria by Western Health (Westside lodge) and by Bendigo Health. The Odyssey New Zealand model has a greater emphasis on social and peer support and recovery. There are also step up options into mental health beds, and step-down options back into AOD residential rehabilitation. These enhanced dual diagnosis units, are better funded than traditional AOD residential rehabilitation which all have some dual diagnosis capacity, with higher staff to client ratios, smaller numbers of consumers, and less expectations on residents about their level of participation and engagement in group treatment when not well. The focus of the units is for people to get well and stabilise and to also offer them security.

Multi-disciplinary, consumer-focussed and family-centred care and recovery oriented practice in relation to adolescent and youth mental health

67 Multi-disciplinary care for adolescents and young persons, must generally involve teachers and parents. To do multi-disciplinary work with an adult client currently, you often need a team of 12-15 different types of professionals. A team of that size for a young person is not workable as it is often overwhelming. That means to offer multi-disciplinary care for a young person you need to bring professionals together from different disciplines but need to offer one care-coordinator or case-manager to be the young persons' main contact with input from different people. This necessarily means that staff must have excellent communication skills and the ability to follow up and have knowledge of, and negotiate, different parts of the system. However, currently, the system and its staff are

siloed and under-resourced, so there is insufficient time and capacity for people to work and link in like this, in order to offer a young person multi-disciplinary care.

68 To be consumer focussed, there needs to be a focus on recovery-oriented practice and to offer services such as vocational training, support and meaningful engagement with hobbies and other community-based activities. Broadening a persons' social connections and relationship skills, assists in sustaining a young person's recovery. These meaningful activities also give someone a reason to not use drugs. The reasons for using drugs can be very compelling for many young people, and include having a temporary break or relief from their histories of trauma, poor relationships, consequences and judgement from limited educational success, unstable and unsafe housing, childhood abuse, and poor self-image and confidence.

69 Recovery oriented practice in AOD is not simply about people being abstinent from drug use in a sustainable way, as it can be provided while people are still using drugs in less harmful or dependent ways. Fundamentally, recovery is self-determined and is usually also about the development of life conditions that enhance wellbeing and meaningful engagement in the world, and support people to work towards self-generated goals.

70 Family work and involving family in a young person's treatment appears to be particularly effective in assisting young people. For example, we ran a program called 'Family Eclipse' at Odyssey House for young people with mental health and problematic AOD issues (eg young people with a dual diagnosis). This program worked with the young person and their family, with a neutral family therapist, to enable the family to talk about issues without escalating into arguments or fights. With these family therapy sessions, we often see significant and measurable increases in family communication, an exchange about the stress that parents are facing, and discussions around personal boundaries and behaviours in the family home. Often these family therapy sessions present an opportunity for a young person to provide basic information about what is going on for them. More details are provided about this in paragraph 74 below.

Professional mindsets, capabilities and skills required for working with young people in mental health

71 Predominantly, the AOD and mental health sectors need to have trained staff with a good understanding and education around both AOD and mental health. In my view, the mindset of patience and tolerance is essential when dealing with anyone requiring AOD and mental health work, but particularly when providing treatment to young people. Engagement may be more difficult, and treatment may be shorter and more episodic with young people, whilst their negative behaviours may be more overt and reactive. Apart from this, in my view, there are no particular differences between the mindsets and skills needed for staff working with young people versus working with adults. There are more

specific challenges around confidentiality for young people, particularly as there is a general expectation that the young person's family will be involved in their treatment and with family work. Staff that work as family therapists or have experience dealing with families are much needed in the sector. Further, there must be supervision and communities of practice to support staff in engaging in family therapy sessions because it can be very challenging.

Barriers and improvements to existing workforces providing optimal care, treatment and support to young people

72 As I have mentioned, a younger workforce is often attracted to working with young people. Whilst this often enhances engagement, it can also create some barriers to optimal care. These include a lack of life and work experience, the ability to relate well to families and carers, high turnover rates and lower salaries, and some deficiencies in their ability to hold strong boundaries and not collude around problematic behaviours. Individuals who are young enough in spirit and connection to youth culture (regardless of age), but old enough to carry some authority, some experience and clinical skills, are difficult to find and/or develop. Recruiting on values and attitudes, and rewarding high performing senior clinicians is critical to a successful system, and this requires sufficient funding. It may also require some credentialing or dedicated funding for senior roles to ensure any increased funding is not lost to system inefficiencies or agency overheads, or to avoid great clinicians from being required to become managers to afford to buy homes and have families.

Workforce capability and skill enhancement for engagement with parents and carers of young people

73 Due to the young age of the workforce, their ability to engage and work effectively with parents and carers of young people is not as strong as it could be. Many staff lack the skills and confidence when dealing with family members who are often much older than they are. Training in single session family work has been effective in the past, and had a strong impact on outcomes, when it was delivered to both the AOD and mental health workforce. However, it has not been sustained through government initiatives and has become less consistent through staff turnover.

74 Evidence from a Deakin University study of family work undertaken by Odyssey House with young people (15-25 years old) experiencing a dual diagnosis together with their families, revealed significant improvements in communication, family functioning, mental health symptoms and quality of life. These improvements were sustained over time. However, funding for this Family Eclipse Program was time limited, provided by the commonwealth government, and required significant upskilling of senior staff prior to it being delivered. Once funding was ceased, the program itself could not be sustained.

More details can be found at https://www.odyssey.org.au/wp-content/uploads/2016/09/Family-Eclipse-evaluation-report-2010.pdf

POTENTIAL REFORMS

An ideal response to people in crisis with co-occurring mental illness and problematic AOD use

75 There is currently a very poor response to people in crisis with co-occurring mental illness and problematic AOD use. Families, carers and the general community members will typically call emergency services (for example, the police) because other options are either not available or not promoted. Often hospitals will be asked to manage the immediate crisis and are not well equipped to do this, as accident and emergency departments are designed for medical (physical) emergencies and not behavioural ones. People experiencing a crisis often respond poorly to medical environments and the security staff there. As previously indicated, a better option would include a separate stream within emergency departments, in a different (low stimulus) physical environment, with staff who are trained in behavioural de-escalation and in mental health and AOD.

76 Access to this service could be through walk up, or by a rapid response outreach team, with good clinical assessment skills and with mental health and AOD knowledge. Stays within the behaviour emergency department would be short with step-up options into secure mental health beds and step-down into a range of services across mental health and AOD.

77 A key issue that requires addressing in Victoria is how AOD treatment and mental health issues are treated in prison. In my view, it is currently being done very poorly. Our community has developed a more risk averse approach to bail, sentencing and parole based on a handful of high-profile cases. However, if a person with AOD and mental health issues is currently incarcerated in Victoria, I consider their conditions often deteriorate and get worse. We should consider international examples where rather than imprisonment, the first priority for supporting people who may have committed crimes and who also have mental health and AOD issues, is to deal with treatment for mental health and problematic AOD use and to build a proper support network first. An ideal system would have most of the funding directed to frontline services, including crisis support, as a priority. Prisons should be seen as a last resort, especially for people whose offences relate to their mental health or AOD issues. There should not be people in prisons who have made poor choices under compromised circumstances.

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

78 I consider that before we can tackle double stigma in the general community for mental health and AOD issues, the stigma needs to be addressed in respect to general health and the mental health workforce. In my experience, without proper training and education or experiences that expose students to real clients, when people first work in the AOD space, their fear and stigma sometimes increase. However, hearing the stories of those with a dual diagnosis and working alongside them can be powerful, and in my experience, it starts breaking down stigma. It must be acknowledged by the community that there is stigma across both sectors of the community and within that, we must be better at the language we use around people with AOD and mental health treatment needs.

79 I also consider that some sort of large anti-stigma campaign done at the whole population level would be beneficial.

EXPLORING INTEGRATION

Streaming clients, including in times of acute needs

80 I consider that in all parts of the mental health system, people should be screened briefly for AOD and assessed further if needed. Likewise, I consider that those clients in the AOD sector should also be screened and then assessed if necessary for any mental health needs (although, most people involved in AOD treatment would currently receive at least a brief mental health assessment). I additionally consider there needs to be better coordination between the two sectors about how to respond to those assessments, and how to gain access to services from another sector if required.

Physical environments and streaming

81 In my view, there are physical requirements that are needed within a service, to try and make clients feel like they are welcome in the services they attend. The idea that a person can come into a service, with staff being present, with no locked doors or screens, and to be offered, or be able to make themselves a cup of tea or coffee is important. My experience is that the more a service puts up screens and barriers, the more people act out. It is almost if a person thinks, 'if you expect me to be violent, then I will be'. For example, the only incident I am aware of in my 18 years at Odyssey House, was when a client felt frustrated at not being provided the service they wanted and threw a chair in an outdoor smoking area. He was someone known to us and was intoxicated at the time, and we were able to quickly de-escalate the situation. The client came back the next day to apologise to our staff. However, if we were to screw down the tables and chairs because of this rare and isolated incident, it would just set up a risk averse culture and

make the service feel less homely and less like it belongs to our clients. Clearly, this physical environment may not be appropriate in the acute or crisis end of the spectrum, however, a more relaxed and friendly environment may also serve to destigmatise a space and make it appear less clinical and intimidating. For families, CALD clients, LGBTQI clients, and for Aboriginal and Torres Strait Islander peoples, images, art and recognition of their culture in the physical environment, can assist in making these spaces more culturally safe and welcoming, especially if staff also receive awareness and sensitively training, and reflect the diversity of the clients that seek support.

Workforce profiles and streaming clients

82 The workforce across both sectors needs to be provided with sufficient foundational training in both AOD and mental health. There needs to be mentorship and supervision of staff and students, so that skills and training can also to be achieved 'on the job' and not just in the classroom, to increase genuine understanding, and to reduce stigma and fear. Services should be provided in the least intrusive and formal way necessary to provide the level of support that is needed.

Integration of service responses without compromising strategy and policy integrity at the state and federal level

83 Flexibility of funding is key to service integration in my view, as is the simplification of the processes around how a service operates to ensure that the service can offer what is best for a client. Efforts to coordinate state and federal commissioning, planning and monitoring of performance should be increased.

Local, national or international examples of effective commissioning and their ability to be replicated in Victoria

84 Much has been debated over the years as to whether AOD and mental health should be commissioned and governed together or not. Some argue that as AOD and mental health, both fall under the umbrella of mental health disorders, that treatment for AOD and mental health is best funded, governed and provided for together and that it is the system rather than the disorders that have created a "dual track". Intuitively this seems reasonable, but feedback from NSW where this has been tried, suggest that mental health becomes the dominant approach and that services become more clinical. This does not work for most AOD services. Experts from North America, K. Minkoff and C. Cline, have presented strong views and arguments for the separation of AOD and MH services, but with integrated care being offered to clients. Evidence around this approach, suggests it works best. Minkoff and Cline distinguish dual diagnosis capable services (required of all AOD and mental health services as a base standard), from dual diagnosis enhanced (step-up) services which are a specialised combination of both AOD and mental health expertise

that and cater for people with more complex dual diagnosis issues and more severe symptoms. More on this can be found at "Developing Welcoming Systems for Individuals with Co-Occurring Disorders: The Role of the Comprehensive Continuous Integrated System of Care Model. Kenneth Minkoff, & Christie A. Cline, Journal of Dual Diagnosis, Vol. 1(1) 2004, accessed here (http://kenminkoff.com/articles/dualdx2004-1-devwelcomingsys.pdf)

85 In my view, a distinction should be made between "one system" that attempts to incorporate both mental health and AOD services (which does not seem to work), and "one governance and funding body" that continues to maintain two systems, but provides shared accountability and clinical governance for operation and performance, some shared planning and coordination functions, and that has real and meaningful representation from both AOD and MH, including non-medical and lived experience input. To me, these shared functions provide the ideal commissioning and monitoring environment to ensure that integration (when needed), occurs from the top down, as well as from the bottom up.

WORKFORCE CAPABILITIES

Specialist AOD or addiction expertise embedded within mental health services and mental health expertise/services embedded in AOD services

86 I consider that AOD expertise and services should be embedded in mental health services and vice versa, that mental health expertise and services needs to be embedded in AOD services.

87 I consider the AOD sector needs improvement in its approach to partnerships with mental health, especially around assessment and treatment. I consider that these partnerships should be formalised to ensure that a person does get an integrated experience of care, wherever they access treatment. As indicated, in the AOD treatment sector, service and treatment models are less standardised, utilising a broad range of approaches and methods.

88 Peer support workers, and those with a lived experience, ought to play a bigger role in both the AOD and mental health workforce. At Odyssey House, we pride ourselves on, and prioritise, having people with lived experience partake in roles across different levels of the organisation – whether it be frontline clinicians, senior management or being a board member. It is also very important to offer all staff, and particularly staff with a lived experience, career pathway opportunities so that people do not get stuck in one, usually junior, roles (e.g. a duty worker or peer support role). We aim to provide further training, education, and support, so people with lived experience are given the opportunity for promotion and career progression within Odyssey, and external to us. I consider this

focus on having people with lived experience at all levels within a service also provides important training and mentorship opportunity for younger members of the workforce, especially in the early parts of their careers as it provides essential 'on the job' training.

Skills and expertise required of the mental health and AOD workforce

89 A degree of technical knowledge and experience is required for most roles in the AOD sector. In the past, however, this has been prioritised over other characteristics of the workforce that have been shown to be as, if not more, important and effective such as attitude and values, openness to feedback, and a desire for life-long learning. Whilst the technical skills can be developed over time, and experience grows over time, we have found that attitudes around stigma, class, fear of clients etc have been more difficult to change. As a result, I stress the importance of attitude and values when recruiting. With this as a foundation, then developing broad and generalist skills in frontline workers is required across mental health, AOD, family violence, relationships, housing, health and so on, to ensure holistic case formulations and treatment plans are put in place, rather than narrow management strategies for symptoms. This can then be supported by more senior and specialist staff in some areas where this is required.

Organisation of workforces to best provide holistic supports for consumers with co-occurring needs

90 Without knowledge about the levels of resources available, this is difficult to discuss. This is because a service may not have access to a whole group of skilled and experience clinicians at all levels based on resourcing limits. The workforce is made up of a large number of junior staff supported by more senior and experience staff that are continually building up the junior staff's capacity. It assists if the workforce is quite generalist when they leave university so they can be trained 'on the job'. Having more generalist graduates would also allow for us to have specialists from other sectors to train and supervise them. For example, it may allow a graduate staff member to be supervised and taught about family therapy for a period of time and then do a period of time in relation to mental health. Further, services need to be sufficiently resourced so they can carve out time away from service delivery, to allocate to professional development and supervision of more junior staff in order to make them dual diagnosis capable.

The impacts of COVID-19

91 As a result of COVID-19, we have observed some changes in the delivery of support to those experiencing AOD and mental health issues. The changed environment appears to have amplified underlying issues and symptoms, including anxiety, urges to use drugs or alcohol, and family conflicts, tensions and violence. Some clients, and indeed staff, have coped very well with the restrictions, and the changed ways in which support has been

provided. Some have expressed preference for the online delivery of counselling and case management (via phone and video calls), and have found receiving support remotely a positive due to less travel, ease of managing childcaring and other family responsibilities, and not having to manage anxiety on public transport and in social settings. Likewise, some clients have also enjoyed online groups where they have felt safer whilst still benefitting from the feedback and shared experiences of interacting with other participants. Others have expressed the opposite feedback and are very much looking forward to the resumption of face-to-face support, seeing this as more satisfying, engaging and effective for them.

92 Whilst higher productively and efficiencies were made early on as a result of providing remote support, it was quickly recognised that staff found this method of service delivery very draining, especially if they had back-to-back meetings with clients. Our staff needed to build in regular breaks and informal conversations will colleagues to manage their own wellbeing and fatigue. It is very important to note that at this stage, that these observations are anecdotal, and they require rigorous evaluation on the effectiveness and acceptability of alternative service delivery methods like telehealth, and for whom these alternate approaches can work for.

93 Some staff have reported difficulties in being able to accurately assess both AOD and mental health presentations, together with clients' broader health and wellbeing (including family violence), without sighting clients directly or assessing their home environment as is typical on outreach visits. Consequently, whilst I expect all services will consider what flexibility will be afforded to both clients and staff to work remotely in the future and incorporate some use of telehealth and remote support, these modes of service delivery will only be used to compliment, but not replace, all face-to-face and outreach work. This will enhance client choice and may improve efficiency, but it will also incur additional costs if organisations continue to support staff at home, and may miss some of the hardest to reach and vulnerable clients, for whom technology will be unreliable and unaffordable, and for whom help seeking is often not a priority.

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

sign here ► 

print name Stefan Gruenert

date 28/05/2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SG-1

This is the attachment marked 'SG-1' referred to in the witness statement of Stefan Gruenert dated May 2020.

Dr. Stefan Martin Gruenert MAPS

- Doctorate in Psychology (Counselling), Swinburne University
- Strategic Perspectives in Non-Profit Management, Harvard Business School
- Diploma in Community Services (Drug & Alcohol), Odyssey Institute of Studies
- Bachelor of Arts, Honours (Psychology), University of Melbourne

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Stefan Gruenert is the father of two boys, a registered psychologist, and the Chief Executive Officer for Odyssey House Victoria. He manages a number of intensive treatment, training, research, and support programs for people affected by drug and alcohol and mental health problems, and their families.

Stefan has worked in the alcohol and other drug sector for 20 years, as a clinician and manager. He contributed to International Drug Policy at a 2008 meeting of the United Nations in Vienna, and won a Harvard Fellowship to attend Harvard Business School in 2014.

Stefan was President of the Victorian Alcohol & Drug Association from 2016-19, and is a current Director of the Victorian Council of Social Service and Vice President of the Northcote High School Council.

Stefan has contributed to the development and establishment of a number of community-based and residential AOD treatment programs for adults, young people, parents and children in a variety of settings. He has been a strong advocate for better responses to families and has developed resources to better address parenting and family violence.

In the past, Stefan has worked as a senior counsellor in a range of settings and has conducted research on alcohol use, men's issues, intimacy, family work, and fathers. He has delivered workshops to more than 5,000 young people in football and netball clubs across regional Victoria. Stefan has also taught courses in counselling, statistics, drug and alcohol, family work, and personality disorders, has published journal articles and books, and has presented papers and workshops at several National and International conferences.