Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF PATRICK LAWRENCE

I, Patrick Lawrence, Chief Executive Officer of First Step, of 42 Carlisle Street, St Kilda, Victoria 3182, say as follows:

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

2 I am the Chief Executive Officer of First Step. I have been associated with First Step for 18 years, first as a volunteer and now as the CEO for a little over two years.

3 Prior to taking up that position I worked at the Asylum Seeker Resource Centre for 10 years, finally in the role of Director of Humanitarian Services.

First Step

First Step's services

4 First Step is a not for profit mental health, addiction and legal services hub in St Kilda with a current staff of 26 people. It is a single site multi-disciplinary service. First Step's mission is the accessible and free delivery of compassionate and non-judgmental treatment of people living with mental illness and substance use disorders.

5 At First Step we believe that everybody deserves every chance to turn their lives around. We believe that chronic addiction is generally a long-term adaptation to childhood trauma and that it must be treated with respect and dignity. We also believe that addiction and poor mental health are concentrated in areas of great disadvantage and that their timely and effective treatment is a matter of social justice that benefits the entire community.

6 First Step provides a range of services across mental health, general medicine, addiction, legal services (we operate the only criminal law practice built in to a health service anywhere in the country outside of Indigenous health), psychosocial wellbeing and meaningful engagement in relation to areas such as work, study and parenting.

7 Specific offerings include:

(a) general practitioner (**GP**) services. We have four GPs doing opiate substitution therapies (**OST**), general medicine, women's health and indigenous health;

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

(b) clinical and counselling psychological services; and

(c) outpatient psychiatric services.

8 We also have mental health nurses, care coordinators and psychosocial workers. We run a women's group, a men's group, a family education group, alcohol and other drug counselling (including group psycho-education) and art therapy.

9 First Step supports over 2,500 people each year in over 11,000 consultations. I believe that First Step supports more people through the provision of OST (such as methadone) than any other clinic in Victoria.

First Step's clients

10 Although the reality is far more complex, it is possible to view First Step as having two main cohorts of clients: people on OST whose lives are relatively stable, and people with multiple and complex needs. Our work with both of these groups, and everyone in between, is of equal importance both to individuals and their families, and also in terms of First Step's contribution to the community health sector generally.

(a) **OST clients**: First Step has many clients who are quite stable (in respect of their mental health, addiction and their social connectedness), hold down jobs, live with families and generally have a good quality of life despite challenges. First Step is ideally positioned to work with these clients because our GPs possess the qualifications and experience to provide excellent addiction support and low-level mental health support, while the clinic also has the skills to enhance the team should the need arise, including a worsening of known areas of concern or the introduction of new complications (for example, legal issues).

(b) **Complex clients**: First Step's clients in the complex mental health and addiction space are often survivors of childhood trauma, abuse and neglect, including sexual abuse. While First Step seldom works with children as clients, many of our clients themselves grew up in out-of-home care. These clients therefore will not have grown up in a stable, loving and supportive environment. Although, First Step does not collect statistics on this, this over representation would seem to indicate, very clearly, that outcomes vis-a-vis mental health and substance use are very poor for people who grow up in out-of-home care. It is normal for our clients to have lived in up to 20, 30 or even 40 foster or group homes before their 18th birthday. That is traumatic in and of itself, regardless of the quality of parenting or care given. This experience and any associated untreated trauma too often leads to mental ill-health and among other issues, pre-teen illicit drug use (including pre-teen heroin use), childhood homelessness (including running

away from 'home'), criminal behaviour in childhood and adulthood, incarceration and early school leaving.

11 Out-of-home care or other inherently traumatic childhood experiences are not conducive to normative socio-emotional development which, when added to omnipresent challenges on multiple levels, means that professional assistance is required in multiple areas of a person's life. These individuals will only improve or recover if they receive multi-faceted support that is 'whole-of-life' in nature. Such multi-disciplinary support is very hard to find, and within this context, many of our clients often have had decades-long histories of harmful alcohol and other drug (**AOD**) use before they find First Step.

12 I was recently amazed to hear the CEO of Berry Street, Michael Perusco, speaking at a conference on the topic of hard truths. Michael's hard truth was that the out-of-home care system is, by any metric, failing. The out-of-home care system is growing (there will soon be 26,000 children in out-of-home care in Australia) and simultaneously failing to create improvement in the outcomes for the children within the system, which have been shockingly bad for a very long time. I agree wholeheartedly in an investment to support parents at risk of losing their chidlren because out-of-home care really is not an acceptable option, nor is it ever likely to be. I am therefore looking very hard at what kind of contribution First Step may be able to have in this space. Given our client group and our expertise in whole-of-life, team care, it seems logical and inevitable that First Step must branch out into this area. We work with hundreds of at-risk parents and I hope that First Step will soon be making an enormous contribution to helping disadvantaged parents to take better care of their children, and therefore keep their families together.

13 First Step's clients are adults, mostly in their 30s or older and have poor mental and/or physical health. Many of our clients have had periods of incarceration in their histories, either as youths or adults. They may be homeless or at risk of homelessness. They are often unable to hold a steady job and are isolated from their families and have no daily meaningful engagement (I describe this as 'a reason to get out of bed'). My impression is that many of our clients come to First Step when they realise (sometimes after a rock-bottom experience) that they cannot continue in their current way of life and so seek help from us because of a genuine desire to turn their lives around.

14 Clients will often contact First Step by their own volition or are referred to us from another service. All services are free at the point of delivery (funded by Medicare, the Primary Health Network, philanthropy or self-funded by the organisation). No referral is required, although people are often referred to First Step (recognising First Step's expertise) by other GPs, the Alfred Hospital, the courts, housing services or other community health services.

15 There are no geographical or other formal eligibility criteria for our clients. Several of our clients travel from as far afield as Geelong or Ballarat. The only funding requirement we have is in relation to our services funded by the South East Melbourne Primary Health Network (**SEMPHN**). This funding is formally limited to people living in the City of Port Phillip (although in practice, First Step can take clients for these services from anywhere in the SEMPHN catchment (which covers about one-third of Melbourne)).

First Step's service approach

16 First Step strives for incremental, whole-of-life improvements in the lives of the people it supports. If, like so many First Step clients, an individual has multiple areas of their life (such as housing, mental health, addiction, physical health and social inclusion) that are adverse enough to be debilitating, then each area of deficit is likely to hinder improvements in each other area. In my view, the 'weakest link in the chain' metaphor is often apt. For instance, a rough sleeper with mental health and addiction issues is unlikely to experience any meaningful, long-term improvements until stable housing is secured. Similarly, a person diagnosed with mental illness is likely to be severely affected by extreme social isolation, and is therefore unlikely to improve no matter the expertise of the clinician, unless some level of social inclusion is achieved. Thus, individuals need help to achieve improvements in all of their areas of deficit. Sustainable and lasting improvements are nearly always secured on a gradual, incremental and non-linear basis. Treatment needs to be designed according to these realities.

17 First Step is a multi-disciplinary services hub for people with complex needs. Put simply, our approach is to provide people with the services they want, and the services they need, in one building, provided by one team. I define 'want' to mean 'what the client wants' and 'need' as 'what the treating team considers the client needs'.

18 The convenience of the integrated nature of services provided by First Step (one team, one site, no fee, usually no eligibility requirements) means people who require multiple or a diverse range of services are more readily able to access every one of them. This in turn increases their level of engagement, trust and treatment success in each area and overall. Practically, a real challenge for our clients in accessing suitable support is that they lead chaotic lives, and may struggle to obtain support and attend appointments, particularly if they have multiple appointments at different locations that are unfamiliar or distant from each other. The convenience First Step offers is crucially important to our service approach, and frequently the difference between life and death. Ease of access can be the difference between clients being able to access much-needed supports and not being able to receive those supports. The result of such services not being accessed is an example of the 'catastrophic failure to meet the expectations of the community' referred to in the Royal Commission's interim report.

19 In addition to this life-saving convenience around service delivery, our approach is also based on the building of trust that comes from team building rather than referring or directing clients to other service-providers ('hand-balling' a client). A referral, in both an etymological and practical sense, implies a handover of responsibility. Complex clients, however, do not need (or want) to be passed around from one worker to another in an attempt to find an individual or individuals better able to care for them, but rather want to be supported by a single team with sufficient skills within it.

20 An example of the First Step team's capacity to provide a range of services to a client, based on their individual needs, is as follows:

(a) an individual may see a mental health nurse as part of First Step's Mental Health Complex Care program (part of SEMPHN's Stepped Care model) subsequent to an external referral. That nurse and the client will develop trust over time;

(b) if that client also has a legal issue, they are much more likely to trust the lawyer at First Step Legal (**FSL**) if they are directly referred to the lawyer by a person they know and trust (the First Step mental health nurse). This is important because the client may have been reluctant to trust a lawyer based on their past experience of the justice system, and the two disciplines (mental health and legal services) need to act in concert to achieve the best possible outcomes for the client. An example of a good outcome might be a non-custodial sentence (after a guilty plea) in a criminal case that means the client can continue to receive treatment, comply with their treatment regime and stay connected to their family.

21 FSL, to my knowledge, is the only criminal law program built into a health service anywhere in Australia, with the possible exception of Indigenous health[1]. Many of First Step's clients have had problematic drug use for over 30 years, and as a result are far more likely than others in the community to have legal problems, including a higher risk of facing criminal prosecutions resulting in incarceration. The benefit of our multi-disciplinary approach is that our lawyers are able to receive useful information (including letters of assessment to the courts), in a direct and timely manner, from our mental health clinicians or GPs, which may assist in the resolution of the client's ongoing legal matters. In my view, this is a very beneficial model and seems like an obvious and common-sense model.

22 As First Step's staff members have varied expertise of a uniformly high calibre, they can operate with a higher risk profile of client (for example, serious violent offenders, convicted paedophiles, perpetrators and victims of family violence) compared with other AOD or community mental health services. Thanks to the team-based approach and level

[1] For further information about health justice partnerships, contact should be made with the CEO of Health Justice Australia, Dr Tessa Boyd-Caine.

of expertise of our staff, they know how to deal with both complex individuals and difficult situations. This means that more people in the community are able to receive support rather than being turned away by services that may not do that work, and possibly ending up hospitalised, incarcerated or dead. Despite the complexity of our client presentations, First Step would ban only two or three clients in an entire year. People come to First Step, often referred to by clients as a "home away from home", because they know that we have the skills, the patience, the persistence and the goal of unconditional positive regard for our clients.

23 Finally, a central component of First Step's service offering is our ability to 'get to know our clients' better, which is not simply because of our multi-faceted service offerings, but also because of the extensive communication within the team. I consider that there is an excellent level of communication between our staff, who communicate in three main ways:

(a) **All of staff meetings**. Current clients who are being seen by multiple staff members (sometimes as many as seven staff) can be discussed at these meetings and different perspectives may be offered in relation to their various treatment needs. This enables the collective development and amendment of recovery plans for clients. To my knowledge, meetings of this nature across mental health, addiction and psychosocial wellbeing are almost unheard of across mental health outside of the hospital sector.

(b) **Case conferences**. Under the Medicare regime, a case conference is a discussion held between a GP and two or more mental health practitioners (broadly defined) with or without the client. The benefit of these conferences is that they are funded by Medicare (unlike most forms of staff communication).

(c) **Informal, ad hoc conversations**. First Step prides itself on its 'open door' policy and the good relationships and lines of communication formed by our staff members. For example, there is an unwritten rule at First Step that if someone knocks on your door and says, "Do you have five minutes?" and you are not seeing a client, the answer should, wherever possible, be "yes". This rule requires no enforcing as the First Step staff group enjoys collaboration and has been recruited for that attitude. These informal discussions (which may last anywhere from five to 30 minutes) are every bit as important as the more structured forms of communication, because time is often of the essence with our more complex clients, whose needs and priorities may change from day to day. A settled individual on Monday can be an individual in crisis on Tuesday.

First Step's place within the mental health system

24 First Step looks and feels like an outpatient, primary care local GP clinic. In terms of accessibility, First Step is comparable to larger bulk-billing GP clinics. However, instead of having a large team of GPs, it has a small team of GPs (at most three on site) and a selection of secondary health and other service providers. Access to such a range of services would normally only be possible through extensive referrals and paying various out-of-pocket expenses to a range of service providers. Accessibility is key: one team, one location, no cost and, in most cases, no eligibility requirements.

25 First Step's strong reputation and accessibility has driven a significant demand for the organisation's services. Unfortunately, First Step has not been able to meet all of this demand and typically fields two to four calls per day from potential clients who we do not have capacity to assist. One reason for this is the length of the waiting times for our GP services. Referral pathways remain open through SEMPHN-funded programs, and First Step will always endeavour to work with the most complex clients who cannot get an adequate level of care elsewhere. Even if First Step was to double its staff numbers tomorrow, we would probably reach capacity again within six months.

26 First Step operates in parallel with local mental health services. First Step serves a similar client base to other local mental health services, but is also able to offer multi-disciplinary support in addition to mental health supports. In my view other local mental health services have greater mental health resources (in terms of qualifications and staff numbers), whereas First Step has greater multi-disciplinary resources. Therefore, a client with extremely complex mental health issues, but relatively few additional issues, may be more suited to another local mental health service. However, clients who need assistance in relation to a wide range of issues (such as addiction, legal and psychosocial issues) may fare better at First Step.

27 First Step is funded by the SEMPHN to deliver Mental Health Integrated Complex Care (**MHICC**), which is at the acute, complex and/or chronic end of the Mental Health Stepped Care Model adopted by the SEMPHN. People requiring less intensive support may be referred to Access to Psychological Interventions (**API**). Within our 'cluster', being the City of Port Phillip and the three surrounding local government areas (**LGAs**) (Bayside, Glen Eira and Stonnington), Star Health operates the remaining seven stepped care programs (MHICC in three LGAs and API in four LGAs). First Step therefore represents something of an island as an independent, single-site organisation specialising in multi-disciplinary teams. First Step's MHICC clinicians are able to engage a GP, lawyer, psychiatrist or other skilled professional as required by the team. The 'integrated' component is primarily relevant not to the program itself but its place in the team. The program itself is not 'integrated' by nature, but rather First Step has integrated it into our broader team.

28 While it is addressed earlier, it is also relevant to repeat that, to the best of my knowledge, First Step supports more people who are receiving OST (methadone, buprenorphine and suboxone) than any other clinic in Victoria, and quite possibly Australia. This is a service delivered by GPs at First Step who have access to the full suite of additional services that the team environment of First Step provides. In my opinion an environment like First Step is the ideal place for OST prescribers to work, where other service providers (mental health, legal, psychosocial) can be brought into the care team as required to the benefit of both the client and the workforce. As detailed above, most people with addictions have multiple needs, very few of which can be addressed in a traditional family general practice, even if the GP is an OST prescriber. Anecdotally, I have also heard that more traditional GP clinics may not want to treat complex clients who may have addiction issues, because they would prefer to not have these clients in their clinics or waiting rooms.

29 As stated above, FSL is the only criminal law program built into a health clinic in Australia that First Step knows of. This means that FSL lawyers do not, for example, refer clients to a clinical psychologist located elsewhere (which means it could take the client weeks or even months before they are able to see a psychologist, if indeed an available psychologist can be located at all). Rather, FSL lawyers work within the team at FSL to meet all of the client's needs. On the spectrum of health justice partnerships, in my view, FSL is at the cutting edge and stands alone as a pioneer of one of the most fully integrated services. FSL lawyers do not 'partner' with clinicians; rather, they are an integral part of the First Step team.

30 Family violence is an extremely common issue facing First Step's client group, and FSL has a specialist family violence lawyer who works both with victims and perpetrators (though not from the same family unit). Whilst FSL lawyers have capacity constraints, there is no formula restricting who they help or how much help (time spent) they can provide. FSL applies its team of case managers and lawyers as required to meet the individual circumstances of each client, combining FSL's expertise with that of the broader First Step team. Furthermore, through the system of meetings discussed above at paragraph #, the intensity of legal or other supports can be carefully calibrated so as to provide the right amount of care across multiple disciplines at any phase in a client's life. For example, as a court hearing approaches, mental health nursing can be increased (including support for anxiety management and mindfulness training) along with legal supports, both making way after the court case for longer term trauma counselling with a clinical psychologist.

31 First Step is one of the few organisations in Victoria to run the Victorian Government's Work and Development Permit (**WDP**) program.[2] This program enables infringement fines

[2] For more information about the program, see https://www.justice.vic.gov.au/wdp

to be paid (a little over $1,000 per compliant month, being a month where the client has attended at least one mental health appointment at First Step per week for that month). First Step was ideally positioned to implement the Victorian WDP program having worked (and still working) within the precursor WDP system in NSW. This allows clients who have been fined in NSW to 'pay off' their fines by attending the program in Victoria. This is a great incentive for our clients to attend their appointments as it effectively 'pays' clients to attend by allowing their fines to be paid off. It also allows First Step to get some real 'runs on the board' with our client base and establish a deep trust. First Step is in no way remunerated for this work (the clinician's time is unfunded); we do it purely because we think it is important as it helps our people a very great deal. Collectively, people have 'paid off' over $500,000 worth of infringement fines in this manner by attending First Step. Having these kinds of 'wins' also helps establish trust between staff and clients, developing a strong sense of what one of First Step's GPs, Dr Peter Wright, refers to as 'clinical capital'. Much like 'political capital', this refers to a level of trust and respect between a client and clinician that enables progress to be made. No-one benefits from therapy with someone they do not trust.

First Step's funding model

32 First Step receives 53% of its income (just over $2 million in FY20) from SEMPHN in the form of the following three commissions:

(a) MHICC as funded by the SEMPHN (see paragraph 27 above) – 1.5 Equivalent Full-Time (**EFT**) mental health nurses and 1.4 EFT care co-ordinators;

(b) Reset Life Program: a group psycho-education AOD recovery program that consists of group sessions (these cover early recovery skills, relapse prevention, family therapy and ongoing social supports) as well as individual sessions and family sessions. This program receives funding for 4.1 EFT staff, which includes 1 EFT Program Manager, 2 EFT Primary Therapists, 0.6 EFT Peer Coordinator and 0.5 Family Therapist; and

(c) National Psychosocial Services (**NPS**) Flexible Funding Brokerage. NPS is designed to help people with severe and complex mental health issues to overcome financial barriers to social inclusion. For example, First Step might support someone with a serious illness (bipolar disorder for instance), but that illness is almost always exacerbated by poor psychosocial circumstances. To further illustrate this, we often have clients who used to gain great physical, social and emotional benefits from sport/exercise which they can no longer access or afford. With several clients the first bit of expenditure has been to purchase a gym membership. The result is that the person gets fitter, has a reason to get out of the house, and starts to get their confidence back. Then we might look at getting a client's driver's licence renewed, enrol in a course of study/apprenticeship and

assist them with the equipment/uniform for the first day on the job. This program receives funding for 1.0 EFT and $140,000 in brokerage (up to $3,000 per client over 12 months) funding annually.

33 First Step GPs (3.0 EFT) and its psychiatrist (one day per week) pay a percentage of their Medicare billings to First Step to 'rent' their rooms. These fees (17.5%) combined with practice incentive payments (1.5%) and nurse incentive payments (1.5%) account for 20.5% of First Step's income

34 The remaining 26% of First Step's income is from government grants including grants from Victoria Legal Aid to FSL (12%), donations to FSL (6%) and philanthropic grants to other First Step programs (8%).

35 First Step is not currently in a sustainable financial position, primarily because some of our essential programs (such as the Work and Development Permit program) and functions (such as management, executive and reception staff) are not funded. However, our expenses are extraordinarily low, and a small amount of additional funding (for example, approximately 10% of our current funding) from state or federal sources that is not tied to new deliverables could make the organisation financially sustainable and remove the risk of becoming insolvent (an outcome that would be felt by each of the 2,500 people we support).

Engagement with other service providers in supporting clients

36 Given First Step offers a broad range of multi-disciplinary services, we often do not need to engage with other service providers in supporting clients. However, we commonly collaborate with:

(a) local tertiary mental health services (inpatient, outpatient, critical assessment teams);

(b) local housing services;

(c) addiction specialists (e.g. the Alfred Hospital or St Vincent's Hospital's Department of Addiction Medicine); and

(d) community health providers such as Star Health (referrals back and forth), especially in mental health and psychosocial services.

Limitations on First Step's approach

37 Our opening hours are between 9am and 5pm between Monday to Friday which can be quite limiting when people present out of these hours. However, where this occurs and urgent help is needed, we can refer people to another local mental health service or the hospitals referred to above.

38 First Step does not offer inpatient detox services, however, we conduct all complex assessments, which are a pre-requisite for admission to Windana Drug and Alcohol Recovery's detox and withdrawal unit (for example, where there is polydrug use or heavy drug use).

39 The needs of clients suffering from addiction can be broken down into six critical support areas: mental health, problematic AOD use/addiction, legal needs, social inclusion, meaningful engagement (for example, work, study and parenting) and housing. In my view, First Step is a leader in the country as a provider of the first five of these services in one location. However, it does not yet provide housing services. We are looking to partner with Launch Housing and Flagstaff Housing (Salvation Army) in a model (developed in partnership with Social Ventures Australia and funded by the Helen Macpherson Smith Trust) called Hub & Spoke. In this model, First Step is the hub and will provide a small team (a GP, lawyer and mental health nurse) to provide weekly services onsite at Launch Housing and Flagstaff Housing and integrate with their team through structured meetings and continuous communications. We are currently considering commencing Hub & Spoke services remotely due to the coronavirus pandemic. The benefit of this model is that residents using these services will be able to address a multitude of needs whilst being housed, which will maximise their chances of permanently exiting the emergency housing sector once they leave their current crisis accommodation. The rotating door of emergency housing can begin to be replaced by a system where people get the services they want and need onsite (where they are living) from one combined team (First Step integrating with the housing staff).

40 Finally, some of our limitations are due to the limited funding we receive. For example, it would be highly beneficial to employ a Clinical/Medical director to lead the clinical direction of the team, lead the clinical governance advisory sub-committee, consult on complex clinical decisions and concentrate on clinical partnerships and linkages. However, at this time, First Step cannot afford this level of staffing.

Co-occurring mental illness and problematic alcohol and other drug use

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

41 The artificial conceptualisation of addiction and mental illness as being separate, distinct disciplines has its origins in an historically poor understanding of both areas. Books have been written about the origins of the 'war on drugs' which made drugs used by the poor and by ethnic minorities illegal with heavy penalties, while other drugs, that are far more dangerous in terms of risk to health, were condoned (see for instance Johan Hari's *Chasing the Scream*, 2015). At the chronic and severe end of the spectrum especially, both mental illness and addiction typically have their origins in childhood trauma. 'Hard-

core' addicts almost universally have histories of terrible trauma (including childhood sexual abuse, extreme poverty and growing up in out-of-home care), a point movingly illustrated in Dr Gabor Maté's *In the Realm of Hungry Ghosts* (2010). In an anonymous survey of First Step's staff, over 90% agreed that childhood sexual abuse was the number one 'social determinant' of the poor health of people who we support at First Step.

42 Co-occurring mental illness and problematic AOD use are interdependent factors that can each heighten the severity and persistence of the other; the interaction between the two is unique to each individual. However, it is wrong to think that these two factors are inherently more important than psychosocial indicators such as poverty, social isolation, dysfunctional relationships, emotional under-development or homelessness. It is important to diagnose 'dual' mental illness and addiction, but a good service goes much further. We sometimes refer to this as 'dual diagnosis plus plus' at First Step. The term 'dual diagnosis' is almost never used at First Step because almost all of our clients have multiple treatment needs.

43 An understanding of the traumatic origins of a person's mental ill-health and addiction is fundamental to long-term recovery. Not every client needs or wants to process that trauma and it is something that is only addressed directly under controlled circumstances at a certain point in a person's recovery. However, understanding root causes is as fundamental to this work as any other area of medicine.

44 One of the great advantages of having a team with both clinical staff and non-clinical staff is that formal diagnoses (for example, for a mental illness) can be balanced with a broad understanding of a person's capacity and psychosocial wellbeing. An over-reliance on a formal diagnosis (for example, by determining treatment on diagnosis alone) can be as inhibiting of progress as the lack of any diagnosis at all, because every person is far more individual and complex than a mere diagnosis would allow. Balancing the clinical with the non-clinical is the best way to achieve a client-centred approach, achieve buy-in from the client, and to plan and implement their treatment.

45 'Dual diagnosis' is a limiting term because almost all people with a diagnosis of addiction and mental illness have other areas of their life that require professional assistance. As indicated above, in my experience, our clients may appear to many to only have two significant issues (mental illness and problematic AOD use) but in fact, the client may first need assistance in relation to stable housing or addressing their level of social inclusion before they are able to meaningfully engage with mental illness and AOD treatment. Having said this, in my view, if more funding was directed to additional dual diagnosis places throughout the sector, this would make a meaningful impact in terms of treatment for people with mental health and problematic AOD issues.

Challenges for service organisations when supporting people with co-occurring mental illness and problematic AOD use

46 Many specialist mental health services will not provide support to consumers if they have AOD issues. In my view, a lot of specialist psychiatric services that could offer positive change through treatment will not see a person if they are drug affected or if there is an addiction component to their presentation. This is a significant problem because every systemic barrier to treatment in this cohort can result in sickness and death. Even some tertiary outreach programs to homeless people with a mental illness will not see that person if they are drug affected. The question to ask here is 'How many homeless people with a mental illness are *not* illicit drug users?' Not many.

47 The unhelpful separation of addiction and mental illness has led to the 'silo-isation' of funding streams. Practically, this has meant that organisations have come to identify themselves as 'mental health organisations' or 'AOD organisations.' Even in the almost unheard of instances where mental health, medical, addiction, legal and other teams exist onsite together, a core part of their work is unfunded: conversation and coordinated planning. A funding system that does not adequately fund interdisciplinary communication provides a disincentive to do exactly what teams need to do most: communicate in an open, timely and thorough fashion.

48 Successful interventions in this area require highly skilled clinical and non-clinical staff. It is harder, though more satisfying and edifying, to master one's own discipline *and* integrate it with others, than simply to focus on one's own area. A first-year graduate of a diploma of AOD is unlikely to contribute a great deal within a team doing this high level of work, yet the only way to learn this is to live it. Initial attempts by organisations other than First Step to do this kind of work may prove unsuccessful if they do not heed the advice offered by services like ours.

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

49 In my opinion, it would be almost impossible to achieve whole-of-life improvements with dual diagnosis clients if your onsite team did not have expertise covering each of the mental health, addiction and psychosocial domains. For mental health teams, ongoing drug use would be likely to either a) prevent any gains from being achieved in the moment, or b) later down the track derail what might have been a good start to treatment. Similarly, undiagnosed or untreated mental health issues will surely stymie any attempts to treat addiction. An understanding and appreciation of likely traumatic histories and a team-based approach across all relevant areas is in my view the only way to work with people with a dual diagnosis.

Potential reforms

50 The Royal Commission has already observed that the mental health system has catastrophically failed to meet community expectations. The Productivity Commission has estimated that mental illness costs Australia about $180 billion per annum. A huge amount of these expenses are incurred in the criminal justice system (particularly in prisons) and in the hospital system. First Step and any similar multi-disciplinary hubs that might exist in the future would have the greatest chance (see paragraphs 55 - 56) of averting these crisis expenses which can amount to well over $120,000 per annum per individual (based on average incarceration costs) or millions of dollars per annum for the most frequent users of hospitals. Urgent reform is needed, and the entrenched distinction between mental health services and AOD services, and between state and federally funded organisations need to be overcome for progress to occur.

51 The silos of mental health, AOD, state services and federal services described in paragraph 47 lead to the use of ideas like stepped care or streaming to over-simplify and steer away from the possibility that an individual might receive all the care they want and need. Although there is logic in those concepts, they are in and of themselves, limiting and seek only to improve the functioning of a fundamentally limited system. Human beings do not need to be streamed, and their care does not need to be stepped, unless these concepts apply across all areas of need (addiction, medicine, psychosocial wellbeing, housing, legal issues), and are done in careful coordination (I would suggest by a single team on a single site). It must be understood that a complete picture of a person must be unearthed and understood across multiple disciplines in order to have client-centred care. There is little value in gaining that kind of complete picture unless the treating professional has access to colleagues who can join that consumers team and address all areas. A comprehensive assessment is just that, an 'assessment' - comprehensive care is something entirely different and needs to be funded in the form of multi-disciplinary hubs.

52 I firmly believe that multi-disciplinary hubs, such as First Step, are the future of care for people with complex mental health issues (i.e. many areas of their life in which they need professional assistance). This 'cohort' often includes people who grew up in out-of-home care and victims of childhood sexual abuse. The only effective long-term strategy for recovery and improved well-being is the pursuit of 'incremental, whole-of-life improvement' (see paragraph 16).

Insights for designing a multi-disciplinary mental health hub

53 Earlier this year I presented to the Technical Advisory Group for the federally funded pilot adult mental health hubs, outlining the key factors in successfully designing a multi-disciplinary mental health hub. The recommendations I gave include:

54 Team culture recommendations:

(a) prioritise communication as a key task (in my view, communication is as essential as the qualifications of staff, client load and staff activity);

(b) recruit 'team players' from the top down who have clients' best interests at heart. This is especially important for GPs. This can be a challenging task, however, drafting the right job descriptions and interview questions and assessing applicants at interview and during their probation period can assist;

(c) have a less hierarchical work environment. In my experience, team players work effectively in a less hierarchical work environment. Every worker's knowledge and input must be sought and respected. The best insights into a client could come from anyone and anywhere; and

(d) train staff on team care (where a multi-disciplinary team plans and implements care together with constant communication) as part of induction and periodically. Develop, document and evaluate the model with your staff.

55 Structural recommendations:

(a) for very large organisations, build smaller multi-disciplinary teams of your most skilled staff to work with complex individuals (at minimum this would include a GP, a mental health nurse or psychologist, a psychosocial worker, a case coordinator and a lawyer);

(b) abolish the concept of 'internal referrals.' Talk about 'building a care team' for each individual and use and develop Client Management Systems that make this easy. Once involved, each staff member should stay involved in the ongoing care of an individual unless their role is clearly redundant. A 'point person' is a good concept (the person who knows the client best) and can be a worker in any profession;

(c) include an onsite 'community legal centre'. In my view, community legal centres become 'health workers' in a service like First Step;

(d) include a Work and Development Permit program worker;

(e) build incentives for case conferencing of all types such as KPIs, job descriptions and workflows. Pay billing workers to case conference (and remove disincentives). For example, pay a full-time GP to case conference beyond the Medicare maximum of 3 case conferences per day; and

(f) schedule 'all treating staff' or 'all team' meetings. Balance this with smaller group meetings (such as case conferences) and ad hoc/spontaneous one-on-one discussions.

56 Cultural recommendations:

(a) create a culture of pro-actively maximising accessibility for clients (no fees for anyone, no catchment, reception staff who are skilled at managing difficult clients, having the motto that any entry point is the right one, an attitude of unconditional positive regard and developing methods to work with serious violent offenders). Regard should be had to how a service can help a person, not merely whether the person qualifies for the service by meeting certain criteria;

(b) adopt a practice of determined and persistent follow-up of non-attending clients;

(c) view dual diagnosis as the norm. Treatment should be informed by each client's personal circumstances and history (trauma-informed care); and

(d) ensure a positive first engagement with clients and a 'no wrong door' approach (i.e. It does not matter which service a client came to access. Every entry point is the right entry point for the whole clinic).

Best practice community service responses

57 Best practice is providing all clinically relevant services that the consumer wants and needs, in the one place by one team. The only potential reason not to do this would be theoretical cost concerns. However, it is not expensive to support First Step's cohort of individuals. For example, First Step's multi-disciplinary work with our most complex clients costs approximately $13,000 a year per each client. This assumes that the person requires mental health nurses, care coordination, sees their GP and psychiatrist fortnightly, requires bimonthly psychiatry, receives brokerage funding for $2,500 to overcome issues around social inclusion and has many hours of support from FSL (all onsite). By comparison, National Disability Insurance Scheme packages can be about six times as expensive. In my view, it is not an expensive investment to deliver 'wrap around' services to some of the most complex and vulnerable members of our society. This is particularly so when you consider the potential savings for the community if we can avoid hospital admissions or incarcerations due to mental illness, addiction and other needs.

Community based investments or actions to improve crisis responses

58 I find the 'fence at the top of the cliff versus the ambulance at the bottom' metaphor useful when considering community based investments or actions to improve crisis responses. The best strategy is a prophylactic one which involves providing high quality supports (everything a person wants and needs in one place from one team) such that crisis is not reached. The second-best response is to address an incipient, unfolding crisis before it is a full-blown crisis (for example involving self-harm, harm to others, police, ambulance or hospital). The best way to ensure we 'see a crisis coming' is to be engaged closely and on multiple levels with consumers. Since crises can have emotional, legal, housing, safety

or other triggers, the more comprehensive a service's work with a person, the more likely a crisis will be assessed early and successfully addressed. This is part of First Step's daily work.

59 In the event of full-blown crises (as described above), I consider that if every geographical area had a multi-disciplinary space like First Step, it would be highly beneficial to the community and for consumers. For example, people living in the community would gravitate to such a service (as they do with us) knowing that they would be likely to receive the support they need onsite. These organisations would, like First Step, be well-known to local emergency services and could coordinate calmly during a crisis.

Addressing the discrimination and 'double stigma' of mental health and problematic AOD use

60 I consider that there is a need to ensure that the community does not judge people who are not engaging in the level of self-care that we tend to expect from our community members. There can be judgment directed to people who appear to not be investing any energy into their life and making improvements. The strategy I often employ is to have direct discussions with people which tends to challenge stigma. I often explain that many of the people that may be stigmatised are likely to have been neglected or abused when they were children. Our society does not tolerate the abuse or neglect of children and has a visceral reaction to this. However, the people who are most in need of the support of organisations like First Step are these abused children who are now 'grown up'. This approach personalises the experience of our clients. As such, I consider that community education is likely to be central in relation to this issue of 'double stigma'. However, it is important to be mindful in any community engagement or education around this issue of the need to be respectful and to not further traumatise people who may have suffered abuse.

61 It is crucial that people understand the conditions experienced by vulnerable children in out-of-home care and the poor state of this system. Even if it is accepted that adequate care by the State is unachievable (and I personally do not believe it is unachievable), in my view it is crucial that the community understands the out-of-home care system's limitations. If this occurred, I believe that the community would be much more understanding of the people who were raised in out-of-home care. I don't accept that it is unachievable for the state to provide adequate out-of-home care and I am shocked that children in out-of-home care can have between 20 to 30 families or group homes involved in their care by the age of 18. This is a very common history for our clients, and I strongly believe First Step would not need to exist if there was no need for out-of-home care. The same is theoretically true if the out-of-home care system was significantly improved.

62 Personally, when I am struggling to retain a non-judgmental attitude, when I wonder why people behave the way they do, I find it helpful to ask the question: what would be worse? The resulting insight can help people like me, middle-class white folks who had two loving parents, to imagine just how bad life can be. For example:

(a) The Royal Commission into Institutional Responses to Child Sexual Abuse taught many of us that one reason children often don't report abuse is because they believe they are in some way to blame; that they invited or at least did not refuse the advances. Most of us fortunate enough to have not experienced this form of abuse struggle to understand how a child could possibly consider themselves to blame and can't imagine why it is so common. Asking 'What would be worse?' results in the following question: 'What would be worse than a child assuming responsibility for being a victim of sexual abuse?' Answer: 'That same child believing or comprehending that they are entirely powerless to stop the abuse.' Understood in that way, the guilt complex can be seen as an essential, even life-saving adaptation.

(b) Many of our clients first injected drugs before they were even teenagers. This is almost universally seen as a catastrophic failure. I don't disagree with that assessment, but the real problem is not the drug-taking, but the fact that the child felt the need to take drugs. But, asking the question: 'What would be worse than pre-teen injecting drug use?' can yield insights. I would suggest that the obvious answer is that same child taking their own life because their situation is unbearable without some form of escape and analgesic.

A note on 'integration'

63 I tend not to use the terms 'integration' or 'collaboration' for two reasons. First, these terms mean such different things to different people that they are almost meaningless without further clarification. Second, they reinforce the unconscious assumption that the most consumers can hope for is that separate services work well together, when what is most needed is multi-disciplinary services (one team, one site, everything a person wants and needs). There must be access to mental health professionals, addiction professionals, psychosocial workers and care coordinators who can run, organise and document case conferences between professionals. As stated above, onsite housing workers would also be a benefit. Based on First Step's experience, this multi-disciplinary, coordinated, single-site approach is the only way to achieve 'incremental whole-of-life improvements' and achieve sustained change with complex clients.

Components, structures or processes needed to enable a consumer experience that they are being supported by one team (including from the perspective of governance, operations or funding)

64 Adequate funding and the simplification of funding applications for multi-disciplinary services is essential. It is very challenging to fund a multi-disciplinary service like First Step because our funding for general GP services, mental health services, AOD services and psychosocial supports all comes from different sources. There is a high level of work that has to be conducted by the service from a governance perspective. Standard practices around the funding models for these types of services would be beneficial.

65 Wider access to and use of linked data (information held by the state on which people are accessing which services, including hospital admissions, incarceration and use of other government funded services) would also be useful and would greatly assist with obtaining an overview of the service needs. In my view, this would contribute to the amount of funding and resourcing the sector may need. For example, First Step has no awareness at a data level (nor does DHHS is my understanding), of which services our clients are accessing in addition to our own. I am currently working to progress this issue with the DHHS and its Director of Mental Health and believe this is also a priority for the DHHS.

66 It is important to consider what the optimal team size would be for a multi-disciplinary hub. For example, if First Step received a large amount of funding, I would not grow the team by more than 50 per cent (presently we have 26 staff). Instead, I would build another First Step site in another location. This is because a multi-disciplinary site needs to have the ability for the staff to all know each other, understand their skill sets, build a rapport and communicate with each other on a daily basis. An optimal, modest pool of staff would avoid a situation similar to what occurs at some community health centres where the business is simply too big and different service providers are co-located but do not know each other or understand the nature of their respective service offerings. This means that readily available referrals are not made, which may negatively impact on a patient and the ease with which they access treatment.

The need for individualised care

67 Individualised care needs to be provided, no matter the severity or complexity of a client's needs. In my view, it comes back to what the client wants and what the client needs in each case. Individualised care is, by definition, multi-disciplinary, and the more sites or organisations involved, the less effective it will be. Trust will not be transferred, appointments will be missed, a complete picture of each client's situation will not be developed, workers will not learn from each other. In my view, the risk is that lives will be lost.

68 Client-centred care means learning enough about the individual, from the person themselves, to build up a deep understanding of their personal history, present stressors, and individual strengths, among other things, and then developing a multi-disciplinary approach to that person's treatment, addressing all the areas where they want or need support. That's what individualised care is, and it must be multi-disciplinary if the individual's needs are complex and varied.

Workforce capabilities

Features of the existing workforce that prevent multidisciplinary and consumer-focused practice

69 If a service has professionals from multiple disciplines working together in close proximity in one location, then it will almost inevitably be multi-disciplinary. The 'trick' is to recruit staff who enjoy teamwork and are confident enough in their own abilities, and give them multiple opportunities every day to talk to each other. In my experience, if an organisation sees itself as a) an AOD organisation or b) a mental health organisation, they are likely to be suspicious of the other. For example, staff employed at an AOD organisation may be potentially envious of the better pay and advancement opportunities in the field of mental health services, while staff employed at a mental health services organisation may be potentially disdainful of what they see as a less deserving AOD client cohort. This is unfortunate but has been commented upon by respected leaders who have attempted integration in the past.

70 We also consider it important to emphasise the roles of our GPs at First Step. GPs are bestowed with great amounts of trust by the community. A GP practice is designed to be the front door for 'everything' and GPs themselves usually work in relative isolation. Not every GP will desire or appreciate a multi-disciplinary service, but the GPs we have at First Step find it rewarding, edifying, supportive and extremely advantageous to their patients.

71 Relatively isolated mental health, AOD or similar staff may fear having too few tools in the toolbox and/or making a mistake with complex clients, and therefore may shy away from this kind of work. Well-supported staff in a multi-disciplinary setting are far more able to accept greater risk *as a team*, including working with serious violent offenders, people on the sex offender register, and otherwise complex clients. This means that the most complex and most vulnerable clients receive the support they need which benefits those individuals, their families and their communities. This approach ensures that everybody has every chance to turn their lives around.

Skills and expertise required in mental health and AOD services to support consumers with co-occurring needs

72 In addition to my recommendations regarding team culture at paragraph 54, for this kind of team work to function well (which I would refer to as 'dual diagnosis plus plus'), given the current workforce you need three things:

(a) highly skilled generalists with a comprehensive overview across addiction, mental health and more. GPs are the clearest example of this;

(b) junior staff that are well trained across both mental health and AOD disciplines (for example, through the dual diploma in AOD and Mental Health) and psychosocial areas; and

(c) specialist/physician-level staff in both mental health and AOD disciplines. For example, a Fellow of the Australian Chapter of Addiction Medicine (Royal Australasian College of Physicians), or a GP with that level of experience without the actual qualification, and a psychiatrist. In my experience, even the most experienced GPs defer to a good psychiatrist when necessary. In my view, this highlights the complexity of these fields individually, and the need for an expert team to address dual diagnosis (and other factors).

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