



WITNESS STATEMENT OF PROFESSOR DAN LUBMAN

I, Professor Daniel Ian Lubman PhD, FRANZCP, FChAM, Executive Clinical Director of Turning Point, Eastern Health and Professor of Addiction Studies and Services, Monash University, of 110 Church St, Richmond, say as follows:

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

BACKGROUND

Qualifications and experience

- 3 I hold the following qualifications:
 - (a) Bachelor of Science (BSc Hons);
 - (b) Bachelor of Medicine and Bachelor of Surgery (MB ChB);
 - (c) Doctor of Philosophy (PhD);
 - (d) Fellowship of the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**); and
 - (e) Fellowship of the Australasian Chapter of Addiction Medicine (AChAM).
- 4 I have worked across mental health and drug treatment settings in the UK and Australia. My current roles are:
 - (a) Executive Clinical Director, Turning Point, Eastern Health;
 - (b) Professor of Addiction Studies and Services, Eastern Health Clinical School, Monash University; and
 - (c) Director, Monash Addiction Research Centre, Monash University.
- 5 Prior to joining Turning Point in 2010, I held the following appointments:
 - (a) Associate Professor, Centre for Youth Mental Health, University of Melbourne and Consultant Psychiatrist, Orygen Youth Health (2008-2010);
 - (b) Nauma Licht Research Fellow and Senior Lecturer, Department of Psychiatry, University of Melbourne and Consultant Psychiatrist, Orygen Youth Health (2003-2008); and

- (c) Nauma Licht Research Fellow and Consultant Psychiatrist, Royal Melbourne Hospital and Melbourne Neuropsychiatry Centre (2002-2003).
- 6 My research is wide-ranging and includes investigating the harms associated with alcohol, drugs and gambling, the impact of alcohol and drug use on brain function, the relationship between substance use, gambling and mental disorder, as well as the development of targeted telephone, online and face-to-face intervention programs within school, primary care, mental health and drug treatment settings.
- 7 I have published over 500 reports, peer-reviewed scientific papers and book chapters, and was Chair of the RANZCP's Faculty of Addiction Psychiatry for over a decade. I regularly provide policy advice and community comment and sit on numerous government expert committees.
- 8 Amongst others, I have received the following awards:
- (a) *Research into Action* (Exploring Men's Risky Drinking), VicHealth Award (2019);
 - (b) *Outstanding Achievement Award*, International Society of Addiction Medicine (2018);
 - (c) *Senior Scientist Award*, Australasian Professional Society on Alcohol and Other Drugs (2017);
 - (d) *Excellence in Prevention and Education* (MAKINGtheLINK). National Alcohol and Drug Awards (2017); and
 - (e) *Senior Research Award*, Royal Australian and New Zealand College of Psychiatrists (2016).
- 9 Attached to this statement and marked 'DL-1' is a copy of my curriculum vitae.

Current role and responsibilities.

- 10 Turning Point is a national addiction treatment centre dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs and gambling, integrated with world-leading research and education.
- 11 In my role as Executive Clinical Director and Professor of Addiction Studies and Services, I provide strategic, clinical and academic leadership across Turning Point, Eastern Health and Monash University. This involves ensuring the delivery of high quality clinical services, developing research and teaching programs that build new knowledge and competencies in the addiction field, and providing policy and practice advice on addiction issues to government and relevant service sectors, as well as expert comment to the community.

QUESTIONS FOR THE PANEL

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

Preliminary issues

- 12 Before addressing the issue of best practice responses, it is important to consider two broader issues.
- 13 Firstly, 'problematic drug and alcohol use' is a non-specific term that requires definition. 'Problematic drug and alcohol use' could simply refer to single use of an illicit drug, which would capture approximately 15.6% of Australians aged 14+ over the past 12 months, or 42.6% over their lifetime, according to the Australian Institute of Health and Welfare (AIHW). It could also mean drinking above the National Health and Medical Research Council's (NHMRC) alcohol guidelines of no more than 4 standard drinks on any one occasion at least once a month, encompassing 25.5% of Australians aged 14+ (AIHW). The non-specific and undefined nature of this term is problematic in its own right, and could be misconstrued as a prejudicial view of someone else's alcohol or drug consumption. It is my view that the term 'substance use disorder', as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-V), should be used, reflecting that we are discussing a specific category of mental health disorder.
- 14 The term 'problematic drug and alcohol use' is reflective of how the current health system typically views and addresses substance use disorders — not as legitimate health conditions, or even mental disorders, but something that is self-inflicted and trivialised. It is akin to dismissing depression as a genuine health disorder by saying that people have 'problematic mood', a term that minimises the suffering experienced and insinuates a level of blame, weakness or poor self-control. The failure to address substance use disorders by their proper name enables them to be dismissed as a health issue by both the health system, including mental health providers, and the community. It is also reflective of evidence demonstrating that substance use disorders are one of the most highly stigmatised health conditions. Language and terminology is key, as evidenced by the enormous investment in changing community understanding and narratives around depression, suicide and youth mental health over the past decade. By failing to use the appropriate terminology, it perpetuates the belief that substance use disorders are not health (or even mental health) issues, allowing them to be dismissed from any discussions around health reform and receiving adequate attention and resourcing.

- 15 Secondly, it is wrong to conceptualise substance use disorders as separate from mental health. Substance use disorders are mental health disorders, and have been classified as such for decades. The World Health Organisation classification of mental health disorders in the International Statistical Classification of Diseases and Related Health Problems 10th edition (**ICD-10**) clearly defines substance use disorders as mental health disorders. Likewise the DSM-V, published by the American Psychiatric Association in 2013 and adopted widely across the world by health systems, clinicians and researchers, also defines substance use disorders as mental health disorders.
- 16 In contrast, when we consider service provision, substance use disorders are almost invariably considered outside the context of mental health. This has implications for how we approach the treatment of substance use disorders and equip the community to deal with them. For example, Australian national and state policy documents which discuss the burden of disease note the substantial burden of mental disorders. They highlight that the most common mental disorders are anxiety, depression and substance use disorders. Yet, when service delivery is conceptualised and commissioned, substance use disorders are not considered as mental health disorders and are segregated and siloed in terms of service and system responses.
- 17 There is an enormous evidence base available on the effective treatment of substance use disorders, both locally and internationally. However, the failure to recognise substance use disorders as legitimate health disorders results in funding of services and systems that are typically divorced from mainstream healthcare, and not adequately resourced to deliver gold standard evidence-based treatments and models of care.
- 18 Throughout this statement, my comments relate specifically to substance use disorders and their relationship with mental illness. However, it is important to note that most of the issues that I raise in terms of terminology, comorbidity, segregation of service systems, escalation pathways, governance and workforce competencies, are also applicable to developing integrated care responses for gambling disorders. This is an important area for the Commission's attention, especially as up to three quarters of people seeking treatment for gambling disorders have comorbid mental health disorders. Similarly, in a recent large study we conducted on behalf of the Victorian Responsible Gambling Foundation, consumers attending Victorian mental health services were found to be eight times more likely to meet criteria for a gambling disorder than the general population. Mental health clinicians were found to have low levels of confidence in responding to gambling disorder, with less than 15% having received relevant training.¹

¹ Lubman DI, Manning V, Dowling N, Rodda S, Lee S, Garde E, Merkouris S & Volberg R (2017). Problem gambling in people seeking treatment for mental illness. Victorian Responsible Gambling Foundation, Melbourne.

Best practice

- 19 Best practice for the treatment of substance use disorders starts with the recognition that they are legitimate mental health disorders. Like other mental health disorders, they commonly co-occur with other mental health conditions, such as depression, anxiety, psychosis and personality disorders. Co-occurrence of mental health disorders is the norm within treatment settings and the population more broadly, and needs to be recognised as such. Indeed, local and international research clearly demonstrates that the majority of people presenting to alcohol and other drug (**AOD**) treatment services have additional co-occurring mental health disorders, and vice versa.
- 20 When we consider the evidence for what treatment should be offered as best practice, the default should clearly be evidence-based, holistic, person-centred care, delivered by a workforce with relevant competencies. People should expect to receive treatment that reflects their needs, rather than conceptualising them as an assortment of conditions that need to be compartmentalised and referred off to multiple providers for treatment.
- 21 As substance use disorders will commonly co-occur with other mental health disorders, people within the mental health system require appropriate training, support and supervision to treat them in accordance with best practice. Like other mental health disorders, the treatment of substance use disorders requires appropriate resourcing. To ensure that holistic care is provided across service settings, it is critical that the commissioning of health services takes an integrated approach in terms of policy, funding and oversight. The segregation of policy and commissioning for mental health and substance use disorders within the Victorian Department of Health and Human Services (**DHHS**) exacerbates challenges experienced at the service and consumer level in terms of integration. A downstream effect of the segregation and siloing at the policy and commissioning level is the experience of consumers and families in being 'bounced' between services and sectors, as well as limited oversight of client and family outcomes, critical incidents and quality and safety indicators for Victorians presenting to AOD services. For this reason, it is my belief that there should be a single government department with oversight of both the mental health and AOD service systems, as well as their performance, safety and quality.
- 22 However, it is important to state that the two sectors should remain separate at a sector and service level, given differences in treatment philosophies, workforce practices and service offerings. Ideally, each sector should report to a separate division within a single DHHS department, with oversight from a Director responsible for the performance of both sectors, as well as the delivery of integrated care. The opportunity to share knowledge and skills, without either sector overwhelming and consuming the other, should be a guiding principle for structural design. Experiences in amalgamating sectors into one service system interstate has identified that the much larger mental health system tends

to subsume the AOD sector. This includes diversion of funding or key positions, as well as implementing processes, philosophies and systems that are specifically tailored to the management of severe mental illness as opposed to best practice for the management of substance use disorders. New South Wales and Queensland are good recent examples of the challenges experienced and lessons learnt in bringing together the mental health and AOD sectors under one government department.

23 At Turning Point, we operate a broad range of clinical services across the Eastern Health catchment as well as specialist services based in Richmond. A small number of psychiatric and medical registrars, as well as hospital medical officers (**HMOs**), rotate through our clinical program, which is not the norm for the AOD sector more broadly, as medical specialists are not a funded stream of activity in the Victorian AOD service system. Our experience is that many of the trainee doctors and nurses who start working with us are apprehensive about interacting with patients with substance use disorders, which is consistent with community perceptions that people with substance use disorders are dangerous, untrustworthy and unpredictable. It also reflects the limited exposure to addiction curricula and clinical placements that medical and nursing graduates receive as part of their training.

24 It is important to note that by the end of their rotation, the attitudes and skills of these doctors and nurses' in dealing with substance use disorders have dramatically shifted, with many trainees expressing that they found it one of their most fulfilling and exciting rotations. In my opinion, it is a tragedy that most of the healthcare sector, including the majority of doctors and nurses, have not had the opportunity to undertake any formal training within addiction settings and services and this partly explains the poor knowledge, skills and attitudes that the majority of the health workforce hold in relation to people with substance use disorders.

The need for training and structural reform

25 I trained in the United Kingdom as a psychiatrist and addiction specialist, but when I arrived in Victoria in 1999, I was informed that substance use disorders were not treated as part of the mental health system. As such, I was unable to obtain employment in an addiction training post anywhere in Victoria, including within AOD services, as these positions did not exist. Victoria, at that time, did not offer a formal training program for addiction medicine or psychiatry, or fund addiction specialists within a tertiary clinical stream.

26 Even today, addiction medicine and psychiatry are still not a formal part of the health care system in Victoria. This absence of a clinical tertiary addiction stream across the Victorian hospital and health care system has its origins in the period post-deinstitutionalisation. In the asylum era, all mental health disorders were treated within large psychiatric hospitals,

with addiction services a core component of the treatment available. This integration of mental health and addiction services meant that all health practitioners in training (doctors, nurses and allied health staff) would have the opportunity to work within addiction settings as part of their rotation through psychiatric institutions. After deinstitutionalisation, mental health was separated into tertiary clinical services delivered through hospitals, with rehabilitation and recovery services delivered by non-governmental organisations. This structure still allowed health practitioners in training to have real world experiences of working within mental health across hospital and community settings and to receive relevant training. In contrast, after deinstitutionalisation only community-based addiction detox and rehabilitation, counselling and recovery services delivered by non-governmental organisations were funded, with the clinical tertiary arm of addiction services abandoned. This means that for over two decades, medical, nursing and allied health professionals have not had the opportunity to work within addiction settings, and as such, have not gained the requisite knowledge, skills and experience of working with people with substance use disorders, including confidence in the delivery of opiate substitution treatment. This explains the significant stigma and discrimination that is palpable across Victorian health settings towards this population, and the limited number of health professionals, including GPs and mental health practitioners, who offer services to this population. This failure to train an entire generation of health professionals is a significant travesty for Victorians who now present to health care settings with substance use disorders, including those with co-occurring mental illness, and this situation is only going to worsen as the remaining cohort of those who trained in the asylum era retire.

- 27 This structural flaw in the design of the mental health and AOD service system post-deinstitutionalisation has resulted in significant system gaps in relation to clinical tertiary addiction service provision. Tertiary addiction services, supported by addiction medical specialists, have not been provided or funded within the acute care system in Victoria in any systematic way since deinstitutionalisation. This contrasts with service delivery models in other jurisdictions such as New South Wales, which has over 40 funded addiction medical specialist positions within its tertiary addiction stream across the public health system. Since the 1990s across Victoria, there has been a generation of medical, nursing and allied health practitioners who have not had the opportunity to train in addiction settings or interact with Victorians in recovery, and as such, do not have the skills or knowledge to provide evidence-based care to this population, irrespective of setting. This gap in knowledge and experience has led to health practitioners having little confidence in AOD interventions or the treatment system and being pessimistic, even nihilistic, in their views around treatment and recovery. Today, there are limited opportunities across Victoria that allow medical, nursing and allied health practitioners to rotate through addiction services, and to have the opportunity to hear from those with lived experience of what works and what doesn't — even for GPs and mental health

practitioners — despite frequent requests to training bodies for training placements. As a result, there is a fundamental failure in translating evidence around the treatment of substance use disorders into practice across the Victorian health system, contributing to the poor health outcomes that we see for this population, and the limited number of medical practitioners willing to offer evidence-based interventions, including opiate substitution treatment.

- 28 When addressing deficits in skills and knowledge in relation to the treatment of substance use disorders, especially in the context of other co-occurring mental disorders, the Victorian approach has largely consisted of offering large scale brief didactic training workshops. We know from our research, as well as our experience as one of the leading providers of workforce training in addiction, that this approach does not lead to lasting skill development or practice change.² It is also at odds with how competency training is delivered across other health areas, where opportunities to practice and implement what has been taught under accredited supervision is the gold standard. By design, available training is largely geared towards providing screening and brief intervention, which leaves an enormous skill and knowledge gap in how to support people with more severe substance use disorders, including the delivery of evidence-based pharmacotherapies. Given that many of the same aetiological factors (such as trauma and loss) underpin the development of distinct mental health disorders, including substance use disorders, there is a need to build clinical skills in evidence-based interventions and models of care that address these conditions in an integrated manner.
- 29 This will require resourcing of a specialist tertiary addiction stream across both the public mental health and AOD sectors, to ensure an escalation pathway of primary and secondary consultation, accredited placements and supervision. A tertiary addiction stream would also be able to in-reach into Victorian hospitals to provide addiction consultation liaison services that support emergency departments and the acute hospital system. This is critically important given evidence by Professor Diana Egerton-Warburton and others, that up to a third of emergency department patients have alcohol-related presentations, while the majority of Victorians undergoing alcohol and drug withdrawal do so in acute hospital beds.³ These gaps in health knowledge and service delivery explain the high (and growing) rates of morbidity and mortality among people with substance use disorders, including rising opioid deaths and suicide, and the limited availability of opiate substitution treatment programs across Victorian health care settings. In fact, despite

² Hall K, Staiger PK, Simpson A, Best D & Lubman DI (2016). After 30 years of dissemination, have we achieved sustained practice change in motivational interviewing? *Addiction*; 111: 1144–1150

³ Egerton-Warburton D, Gosbell A, Wadsworth A, Fatovich DM & Richardson DB (2014). Survey of alcohol-related presentations to Australasian emergency departments. *Medical Journal of Australia*; 201: 584-587.

being one of the highest risk groups of people to die by suicide, suicide prevention policies and strategies typically fail to deliver and fund interventions to people who present with substance use disorders, with limited mental health and suicide prevention capacity within Victorian AOD services.

Question 2. A significant number of stakeholders have called for greater ‘integrated care’ for people with co-occurring mental illness and problematic alcohol and other drug use:

a. how do you define ‘integrated care’?

30 Integrated care refers to an inclusive, person-centred approach that addresses an individual’s needs in a holistic manner for the entirety of their treatment journey. It requires services to be collaborative and needs-led, and not constrained by administrative or organisational practices. At its most basic, integrated care means that a person’s mental illness and substance use disorder are treated simultaneously.

31 Unfortunately, the current scenario in Victoria is typically one of serial (one disorder treated at a time) or parallel (at the same time by different services) care. It is predicated on the notion that the two disorders can be treated separately as distinct disorders, despite clear evidence that they are inter-related. It is akin to treating depression in one service and asking the individual to go and seek treatment elsewhere for their anxiety. This situation reflects the impact of continued siloing of the mental health and AOD sectors, as well as the training and skill gaps of the respective workforces. Unfortunately, a tragic consequence of this approach is that many consumers with co-occurring disorders are bounced between services or excluded from them, and are unable to access appropriate addiction psychiatry support.

32 The poor outcomes associated with this population can lead to the perception that treatment is ineffective or that consumers are responsible (they ‘failed treatment’), when in reality they received disparate and disjointed care that failed to adequately address their individual needs. Such practices persist despite clear evidence that serial and parallel approaches typically result in poor health and social outcomes, while the best outcomes are achieved when co-occurring disorders are treated simultaneously by a skilled and capable workforce.

b. what are the ways this can be achieved?

33 In its simplest form, integrated care can be achieved through AOD and mental health services working together in partnership, with clear shared treatment goals and practices,

such as information sharing, joint care planning and supervision.⁴ Ideally, integrated care should be provided in a single service setting to minimise any additional barriers to care, as this population typically find it challenging to present to multiple services, and are more likely to drop out of treatment or present in crisis.

- 34 This could be achieved through co-location of services, or the embedding of addiction clinicians within a mental health service or vice versa, to ensure that a person receives the highest quality care wherever they present — a ‘no wrong door’. In terms of the latter model, this could be delivered through inter-agency agreements and partnerships, or by directly employing dual trained clinicians to work within a particular service. While directly employing a dual trained clinician may seem a relatively straightforward approach, there needs to be clear models of care, supervision structures and supports in place to make sure that the identified clinician is not isolated, overwhelmed, deskilled or absorbed into the general workforce. There also needs to be a mechanism to ensure appropriate escalation pathways with ready access to tertiary addiction specialist support.
- 35 It is important to note that while policies related to providing integrated care are typically targeted at services or clinicians, our research around delivering effective integrated care highlights the need for interconnected strategies that span commissioning, organisational priorities, service delivery models and clinical practices. This includes ensuring that integrated care is incorporated within service specifications of commissioning bodies and is adequately funded, organisations have a shared sense of purpose and priorities and that there are sustained coaching activities within services focussed on implementation of integrated care and capacity building.
- 36 We also need to put peers at the heart of this reform, to show us what integrated care looks like, what we are aiming for and what can be achieved. This includes hearing more of the success stories, particularly within training programs and across services, to build a culture of hope and expectation. Indeed, work that we conducted as part of Patient Pathways, one of Australia’s largest treatment outcome studies, demonstrated the critical importance of peer support in enhancing treatment effectiveness among people with substance use disorders.⁵ As such, the inclusion of peer support as a key component of integrated care ensures examples of success are readily available to consumers and families, resulting in increased engagement and participation in treatment, as well as improved connection to recovery supports within the community.

⁴ Savic M, Best D, Manning V & Lubman DI (2017). Strategies to facilitate integrated care for people with alcohol and drug problems: a systematic review. *Substance Abuse Treatment, Prevention & Policy*, 12: 19.

⁵ Manning V, Garfield JB, Best D, Berends L, Room R, Mugavin J, Larner A, Lam T, Buykx P, Allsop S & Lubman DI (2017). Substance use outcomes following treatment: findings from the Australian Patient Pathways Study. *Australian & New Zealand Journal of Psychiatry*, 51: 177-189.

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 alcohol and other drug use from the consumer perspective?

- 37 The experience from a consumer perspective would be one of seamless, holistic treatment with a single team of clinicians providing wraparound care, including early access to peer support. However, the components, structures and processes would need to be informed by the level of severity of the distinct disorders.
- 38 A critical component of a new redesigned system is the creation of a clinical tertiary addiction service stream that has been absent since deinstitutionalisation, comprising senior dual trained mental health professionals (including nurses and allied health), addiction medical specialists, addiction psychiatrists and experienced peer navigators. I anticipate that an investment of \$30 million per annum to create a tertiary addiction service stream could deliver the necessary structural transformation that would be a key impetus for providing high quality integrated care across Victoria. With a tertiary addiction stream in place, Victoria would be in a prime position to provide specialist in-reach into both the existing mental health and AOD systems, offering escalation pathways for primary and secondary consultation, opiate substitution treatment, specialist interventions, supervision, training, policy development and clinical placements. It would also support GPs' confidence and skills in managing substance use disorders, through a specialist consultation model that is similar to how other medical fields operate, including general medicine and psychiatry. The creation of a tertiary specialist stream would facilitate rapid access to key knowledge and skills across the health system, and address key gaps in current service delivery. For example, AOD agencies are frequently unable to access mental health/psychiatry assessment from local mental health providers due to demand pressures or the requirement that treatment can only be offered when the substance use disorder has resolved, while mental health services are unable to access addiction specialist assessments, support or supervision.
- 39 With support of a tertiary addiction service stream, the AOD system could manage most consumers with mild-moderate and stable severe mental illness with co-occurring severe substance use disorders. This would ensure that the majority of these consumers could be effectively treated outside the public mental health system, with clear escalation pathways also available. The fact that private addiction and psychiatry clinics are limited in their ability to manage this cohort, due to consumers' limited ability to pay private fees, highlights the importance of providing adequate mental health capacity within the AOD system.
- 40 In terms of the mental health system, most clinicians should be able to manage mild-severe substance use disorders with appropriate training, supervision and support

from a tertiary addiction service stream. However, there is an urgent need to create a new service model for consumers with complex needs (typically involving co-occurring severe substance use disorders), as neither system is currently capable of offering effective treatment to this group within existing resources and models of care. Ideally, this integrated service model would incorporate tertiary specialist expertise from both the addiction and mental health sectors working within one team and one philosophy, spanning both outpatient and inpatient care, with access to community housing, employment support, peer support and integrated long-stay residential rehabilitation. An assertive community treatment (**ACT**) model should be considered given its strong evidence base for this population.

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 alcohol and other drug use, including from the perspective of governance, operations or funding?

- 41 At Turning Point, we have developed and tested models of integrated care for consumers with complex needs, and share these insights with colleagues across the mental health sector. However, we are currently not funded for this activity and are often dissuaded by structural impediments in pursuing this work. It should be easier, not harder, to provide integrated care for a person in need.
- 42 Implementing effective integrated care necessitates system investment, inter-departmental collaboration and clear service specifications. If DHHS is to maintain separate departments to oversee the mental health and AOD systems, then it is critical there are clear processes in place to ensure joint planning, funding and performance monitoring. However, given that substance use disorders are indeed mental disorders and there are high rates of comorbidity across sectors, it is important that the Royal Commission consider incorporating oversight of both service systems within one department, to ensure integration at the highest level. This is likely to dramatically improve system planning, performance and improvement activities related to integrated care, as well as workforce planning and capacity building. A joint department would also address a major risk for the Victorian government related to the AOD system in terms of consumer safety and quality, with no current oversight or departmental review processes in place for sentinel events, emerging safety issues, clinical excellence or health care improvement.
- 43 A lack of oversight of critical incidents and safety and quality issues across the AOD system is a serious concern in relation to protecting the Victorian community, particularly as substance use disorders are major contributors to deaths, sentinel events and occupational health incidents. In fact, alcohol alone is the sixth highest risk factor for burden of disease in Australia, contributing to more than 70,000 hospital presentations each year, while opioid-related deaths have almost doubled over the past decade. This

lack of system oversight is in stark contrast to the significant work conducted by the Chief Psychiatrist's office within the mental health branch of DHHS, as well as that of Safer Care Victoria for health more broadly. It is my opinion that there is an urgent need to establish clinical governance oversight of the AOD system within DHHS, to ensure that integrated care is delivered according to best practice, and without unintended harm, with robust mechanisms in place to improve the overall quality and safety of the system. This should include review of deaths, critical incidents, complaints and patient outcomes, with a focus on quality of life and the effectiveness of treatment. It should also include oversight of community prescribing practices related to complex pharmaceutical opioid and other drug dependence, given the increasing number of drug-related deaths and suicides associated with these medications in Victoria. This is an area of critical need, especially given Victoria's recent roll-out of its real time prescription monitoring system, SafeScript.

- 44 Effective treatment of substance use disorders is underpinned by a robust quality framework. Turning Point was commissioned to deliver a draft national quality framework for the federal government, and there are opportunities to build on this work so that Victoria can be leaders in delivering high quality integrated services. Without a clear set of national standards, anyone can open an AOD service in Victoria without specialised qualifications or evidence-based models of care. This puts consumers and families at risk of exploitation. Victoria needs to ensure that there is a robust quality framework for AOD services, supported by a highly skilled and capable workforce, with services appropriately resourced to deliver quality, planning and innovation activities.
- 45 Currently, the minimum qualification for delivering AOD treatment in Victoria is a Certificate IV in Alcohol and Other Drugs, meaning that clinicians have limited experience or expertise in managing co-occurring mental illness. A lack of skills and experience necessary to appropriately assess and manage co-occurring mental illness within the AOD sector has been identified as a key barrier to effective service provision, and building workforce capabilities has been identified as a priority for the Victorian Government. Funding to boost the capacity of the AOD workforce to respond to mental illness and providing suicide prevention initiatives within these services must be key priorities in ensuring the delivery of integrated care, reducing the risk of suicide among this population of Victorians, as well as easing the demand on public mental health services.

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?

- 46 It is critical that the health system is able to tailor service response to client need, akin to a stepped care model. For other health conditions, such as diabetes, heart disease and cancer, there has been considerable work undertaken to develop clear models of care

that provide consensus in terms of service responses and escalation pathways depending on the severity and complexity of the presentation. They also provide clarity in terms of who is responsible for delivering each aspect of care, from primary care through to tertiary services. Such models ensure that Australians can be confident that wherever they live, they will receive a consistent treatment response.

- 47 In 2017, Turning Point was commissioned by DHHS to conduct a review of AOD service planning across the state.⁶ As part of the review, the Victorian treatment-seeking population was segmented into tiers, in order to create a population planning tool that matched consumers with differing levels of addiction severity and complexity to 'packages' of care. Within each tier, the presence of complexity factors, which included comorbid mental illness, was critical in determining the level of care a consumer needed to receive. Tiered models can be invaluable for system planning, and also provide the opportunity to conduct cost benefit analyses. They allow the system to be able to plan for the level of intervention and workforce competency needed, based on the severity and complexity of presentations, thereby informing prevention, primary care, mental health and AOD service activities.
- 48 To deliver a system of effective streaming based on consumer need, a clear model of integrated care must be developed for each tier based on:
- (a) the level of severity and complexity of presentation;
 - (b) what the evidence supports as effective treatment;
 - (c) workforce competencies related to the intervention to be offered;
 - (d) criteria for stepping care 'up' or 'down'; and
 - (e) clear escalation pathways if treatment is not working for that individual.

Other service models

- 49 A fundamental challenge in ensuring the delivery of an appropriate integrated care service response is the nature by which services are currently commissioned. Unlike other areas of health, there has been limited investment within the AOD system in terms of demand modelling, quality frameworks, clinical model development, escalation pathways and workforce competencies, despite consumers presenting with significant mental health comorbidities. This is in part due to the segregation of the AOD sector from mainstream health care, a prevailing belief that addiction is not treatable, and the absence of a strong lived experience platform for consumers and carers. Without an agreed model of integrated care and associated workforce capability and resourcing, there is a lack of

⁶ Lubman DI, Manning V & Cheetham A (2017). Informing alcohol and drug service planning in Victoria. Fitzroy: Turning Point.

clarity in terms of what is offered to consumers, and when to escalate treatment to a higher level of care or service.

- 50 A key issue with the current AOD system is the absence of escalation pathways, and the lack of a tertiary addiction specialist stream, as in other states. For example, New South Wales has a dedicated and large tertiary addiction specialist stream within hospital networks that in-reaches into the emergency department, hospital, primary care, mental health and AOD systems. New South Wales also has a clear model of how the AOD sector operates as a system. In Victoria, the AOD system is not currently configured to work as a system (unlike the mental health service sector), with care largely provided within single agencies or consortia in a flat, unidimensional structure. This means that for most consumers who do not respond to standard care, there is limited capacity or systems in place to escalate (or stream) treatment to a higher tier of evidence-based interventions or service responses.

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

- 51 To be able to support consumers with holistic, person-centred support, a critical first step is the development of clear models of care and workforce competencies that articulate what is expected to be delivered when and by whom. This includes the specific evidence-based interventions to be offered and related workforce competencies at every stage, with clear escalation pathways describing the next stage of intervention and related competencies. Workforce training must also include peer role models who can speak to the benefit of the care they received. Currently, there are no clear models of integrated care within the Victorian health system, and as such, limited guidance on the knowledge, skills and attitudes needed in a complexity capable workforce.
- 52 Basic competencies should be framed around essential knowledge and core practice skills. This should include an understanding of the nature of comorbidity, its aetiology, interactions and impact, and models of intervention and recovery, as well as the ability to engage and respond in a non-judgmental and compassionate manner with interventions that can be matched to the person's level of need. Higher level competencies build on these elements and are targeted to more highly skilled workforces that are able to support the broader workforce, offering referral pathways for those individuals who require escalation in their level of intervention and support. This must include upskilling of the medical workforce to be able to provide evidence-based pharmacotherapies, including the delivery of opiate substitution treatment within mental health settings.
- 53 These competencies should be underpinned by a set of shared principles and values, including respect, responsiveness, recovery, collaboration, inclusion and excellence, as articulated by previous work in this area.

- 54 There has been significant work conducted in terms of workforce competencies, including a capability checklist developed in Victoria in 2009 by Gary Croton, as well as other excellent frameworks developed in Tasmania, New South Wales and New Zealand.⁷
- 55 The evidence is clear however, that knowledge, skills and attitudes alone do not lead to a change in work practice without clear organisational and workforce support. Our work and others has shown that integrated practices are only sustainable when there are clear pathways for primary and secondary consultation, supervision and joint care planning, as well as common organisational goals and positive inter-agency relationships.

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

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

- 56 The Sax Institute, on behalf of the New South Wales Mental Health and Drug and Alcohol Office, published a report in 2014 that explored existing models of care, their efficacy and key considerations and recommendations in the design of best practice models.⁸ I would like to draw the Commission's attention to this report as I feel it provides an important review of the evidence that can inform the development of a Victorian framework of integrated care.
- 57 The most successful and effective examples of truly integrated care, both here and overseas, have clearly articulated models of care with dedicated staffing with defined skills and competencies. However, these services have generally not been replicated across the service system, due to the segregation and siloing of the mental health and AOD sectors, and the inherent bureaucratic challenges in commissioning integrated service models.

⁷ Croton G. (2009) Dual Diagnosis Capability Checklist: Alcohol, Tobacco and Other Drug Workers North East Health, Wangaratta. Available online at: http://www.dualdiagnosis.org.au/home/index.php?option=com_docman&task=cat_view&gid=39&Itemid=27

Croton G. (2009) Dual Diagnosis Capability Checklist: Agency or Service Level (Non-Victorian) North East Health, Wangaratta. Available online at: http://www.dualdiagnosis.org.au/home/index.php?option=com_docman&task=cat_view&gid=39&Itemid=27

NZ Ministry of Health (2008). Let's Get Real: Real Skills for People Working in Mental Health and Addiction. Ministry of Health: Wellington, NZ.

⁸ Deady M, Barrett EL, Mills KL, Kay-Lambkin F, Haber P, Shand F, Baker A, Baillie A, Christensen H, Manns L, Teesson M. Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Mental Health and Drug and Alcohol Office.

b. *How do you implement joint training approaches at scale?*

58 Implementation of the training required to ensure the delivery of integrated care is achievable with sufficient resourcing and a phased plan of activity. The Royal Commission should look to the delivery of new training and programs delivered through the Victorian family violence reforms to gain greater insight into what has and has not worked in terms of large-scale implementation.

59 The first step in developing appropriate training is to identify the key competencies that are required of particular workforces to be able to deliver a comprehensive model of evidence-based integrated care for Victoria. This would inform the development of a training framework that is able to deliver and ensure key competencies are obtained. Developing key competencies will undoubtedly require accredited training rotations and placements that allow for hands on experience in delivering key aspects of integrated care under appropriate supervision.

60 To ensure these competencies remain achievable over the long term, assessment and treatment of substance use disorders needs to be embedded as a core competency in undergraduate and postgraduate teaching at all levels of health practitioner training, with opportunities for hands-on training placements within AOD settings. However, this is harder than it sounds, as there are few clinical academics with expertise in addiction that can provide the teaching and training necessary within Victorian universities. This is a consequence of a lack of investment in tertiary addiction services in Victoria since deinstitutionalisation, as well as limited funding of clinical addiction academic positions. Sadly, I am the only full professor of addiction in Victoria with a medical background, and one of the only professors of addiction psychiatry in the whole of Australia. In contrast, New South Wales has more than five clinical professors of addiction medicine, while most other medical specialities in Victoria, such as oncology, gastroenterology, haematology and psychiatry, have many more. Unfortunately, the dearth of addiction academic positions is also true for nursing, psychology and social work.

61 This deficit in clinical addiction academic positions across health disciplines means that there is limited addiction input into university health curricula and limited capacity to educate the next generation of health professionals. While AOD education was implemented across medical schools in Australia in the 1990s with funding from the Commonwealth, after this funding ceased universities did not have the resources to continue offering this material in depth. This helps explain why the Victorian health workforce has such limited capacity to respond to substance use disorders in an evidence-based manner. This critical gap in clinical addiction academic funding is underpinned by the failure to recognise addiction medicine and psychiatry as core medical specialties within the Victorian public health system and to adequately fund addiction medical training and consultant positions.

- 62 Given the prevalence of alcohol and drug-related presentations within ambulance, primary and acute care, as well as across the mental health system, it is critical that addiction training is considered a core competency within medical, nursing and allied health undergraduate and postgraduate training. In an attempt to address this skills deficit in postgraduate training, Turning Point has developed a Graduate Certificate and Masters program in Addictive Behaviours in collaboration with Monash University, which includes core units on addiction assessment and treatment, as well as specific units on co-occurring disorders and recovery principles. Importantly, DHHS offers a small number of scholarships to complete the Graduate Certificate, but Turning Point is typically inundated with applications, highlighting the enormous thirst for knowledge in this area among health professionals.
- 63 Turning Point is regularly contacted by GP trainees and general practitioners from across Victoria, who recognise that they need to develop their competencies in managing substance use disorders, as they received limited training in addiction during their undergraduate and postgraduate training. They report that this has limited their ability to manage substance use disorders within primary care, despite its high prevalence. Unfortunately, there is no dedicated funding available to offer addiction training placements to GP trainees in Victoria, outside of MBS rebates, which further limits the ability of primary care to deliver integrated care in an ongoing fashion, in direct contrast to other chronic health disorders. Funding should be established to ensure Victorian GPs are able to gain the requisite skills they need to deliver best practice care, through supported placements in accredited AOD settings. Limited funding for addiction medical specialist positions within the Victorian public health system further exacerbates these skill gaps, as GPs are also unable to receive the necessary specialist advice and support they need to care for their patients, exacerbating the poor treatment outcomes for this population.

Question 8. What new roles, training and development are needed for mental health and alcohol and other drug workforces to enable integrated practice?

- 64 Given the common co-occurrence of mental health and substance use disorders, integrated practice should be considered standard practice, and should be a basic competency for all clinicians working across the mental health and AOD sectors.
- 65 This will require the development of a core competency course that draws on the expertise of existing training organisations within the Victorian mental health and AOD sectors, including the voice of consumers and families. Peer involvement is core to this training, offering visible reminders that treatment can work. Indeed, unlike most other health conditions, the stigma around substance use disorders means that health practitioners rarely hear common stories of success.

- 66 A comprehensive curriculum will need to be developed, and clinicians will need to receive ongoing coaching, mentoring and clinical supervision from accredited trainers to ensure implementation of skills and knowledge into the workplace. Clinical rotations to accredited training posts across agencies are also likely to be of benefit.
- 67 Activities that have been found to be valuable in supporting clinicians to deliver new models of practice include the opportunity for specialist consultation, supervision and case reviews, facilitating inter-agency partnerships and ensuring organisational support to assist with the adoption of new processes and policies. Indeed, the effectiveness of delivering these activities is highly influenced by the prevailing organisational culture. Workforce development approaches should therefore have a 'systems focus' that targets organisational and structural factors in addition to addressing the education and training of individual workers.
- 68 There will also need to be greater support of postgraduate addiction training opportunities for psychiatry, psychology, social work and mental health nursing within the AOD sector. Effective capacity building will also require the recruitment of clinicians experienced in managing co-occurring disorders, who can assist in training and service development. There will also be opportunities to draw on existing higher education courses that have an addiction focus.

TURNING POINT

- 69 Turning Point is Australia's leading national addiction treatment, research and training centre. Turning Point is part of Eastern Health and is affiliated with Monash University. Turning Point provides clinical care across the eastern metropolitan region as part of the Eastern Consortium of Alcohol and Drug Services, specialist addiction services in Richmond, and over 20 telephone and online helpline services across multiple jurisdictions as well as nationally. Turning Point conducts research on behalf of the state and federal government, as well as local and national funding bodies. Turning Point offers accredited training courses, workforce development and leadership programs, as well as a Masters program in partnership with Monash University.

a. *The Eastern Consortium of Alcohol and Drug Services*

- 70 Turning Point is the lead agency for the two consortia of alcohol and drug service providers across the Eastern metropolitan region of Melbourne, who have formed a partnership under the banner of the Eastern Consortium of Alcohol and Drug Services (**ECADS**). ECADS delivers services in the Inner East of Melbourne, which includes the Local Government Areas of Boroondara, Manningham, Whitehorse and Monash, as well as Eastern Melbourne, which includes the Local Government Areas of Knox, Maroondah and Yarra Ranges.

b. *Services provided*

71 Turning Point is responsible for coordinating the services provided by the consortium, and provides intake, assessment, counselling, care and recovery, and withdrawal services. Turning Point also offers a specialist pharmacotherapy service that provides opiate substitution treatment to patients with complex needs, addiction psychiatry specialist assessments, as well as an addiction consultation liaison service to Eastern Health hospital sites. Turning Point operates the Addiction Medicine Unit at Box Hill Hospital and Wellington House, which offers a subacute withdrawal and stabilisation service. Turning Point employs a full suite of health professionals, including addiction medical specialists and trainees, as well as a peer workforce.

c. *Access to services*

72 A consumer can access services at ECADS by ringing the central intake number and making an appointment, or through referral by their GP. Turning Point also offers a 'walk in' service at Box Hill. No appointment is needed.

d. *Limitations*

73 The limitations of ECADS are a result of how the broader AOD system is configured and resourced. Essentially, the AOD system is only funded to provide brief episodes of treatment rather than continuing care, with no identified pathways for escalation, meaning that the sector is inadequately prepared to meet the complex needs of many Victorians who present for treatment. For example, AOD services are only funded to treat people with substance use disorders for up to twelve sessions, which is an appropriate model for those with mild to moderate illness. However, due to extended delays in help-seeking, we typically do not see people until they have developed a severe illness with multiple complications. There are limited resources available to treat individuals at the severe end of the spectrum and a lack of escalation pathways to more specialist support.

74 The enormous stigma and discrimination which exists in relation to substance use disorders results in substantial delays in help-seeking. Research consistently identifies that on average, a person will wait 18 years from when they develop a substance use disorder until they seek professional help. This is an absolute tragedy, especially given the enormous investment seen in other areas of health in terms of promoting early intervention. By the time the person presents for treatment, they will generally have developed a range of complications, including poor physical and mental health, collateral trauma, social disruption, family breakdown, housing instability and potentially criminal justice involvement.

75 The AOD sector is only funded to treat the substance use disorder in isolation, the polar opposite of integrated care, and not any associated physical or mental health disorders,

or related social problems, including the impact on families. This is at odds with the treatment for other chronic health conditions. It is akin to only providing treatment related to glycaemic control in diabetes, and neglecting the associated cardiac, kidney, skin and vascular disease. This is particularly problematic given the discrimination frequently experienced by Victorians with substance use disorders within primary care, acute care and mental health services, when they seek assistance for their physical or mental health conditions. They are also likely to be told by mental health services that they need to be in full recovery from their substance use disorder before they can obtain treatment for any comorbid mental health disorders. This is not evidence-based clinical practice, but service delivery through the lens of a siloed system, where health practitioners do not feel appropriately skilled or obligated to manage presentations where substance use disorders are comorbid. It is a travesty that cannot continue.

- 76 Indeed, there are many primary care settings across Victoria that refuse to treat consumers with alcohol and drug use disorders, even if they present with mental illness, as they see this group as too difficult or complex to manage. The exclusion of Victorians with genuine health conditions from our primary care system is unconscionable, and needs to be addressed at the highest level, to ensure that discrimination of Victorians with mental health disorders is prohibited and optimal care is promoted.
- 77 At Turning Point, we are inundated with referrals from AOD services, GPs and mental health providers to deliver specialist addiction psychiatry assessment and treatment of Victorians with comorbid mental illness and substance use disorders. We are only funded to provide a small service and cannot meet the overwhelming demand for integrated medical and psychosocial care. This is due to skill deficits in the current psychiatry and mental health workforce, as well as primary care. AOD services themselves are not able to access public mental health or private psychiatry or psychology support for their client group, due to limited addiction psychiatry expertise in these settings, meaning that many vulnerable Victorians miss out and their recovery is delayed. Funding for a tertiary addiction service stream across Victoria is key, as this would provide capacity to provide addiction psychiatry in-reach into AOD and mental health services, as well as building GP confidence and competency.
- 78 I would also like to highlight the significant gap in funding that the sector experiences in terms of supporting families and offering peer support. Unlike the mental health sector, there is virtually no funding to deliver evidence-based family interventions with appropriately trained staff, despite their efficacy. Similarly, the sector is unable to embed peer support and lived experience within our treatment model, despite recognition of its prime importance in supporting recovery. This is in contrast to the mental health sector, where funded peer support roles are identified as best practice and are deemed core to the recovery model.

CO-OCCURRING SUBSTANCE USE DISORDERS AND OTHER MENTAL ILLNESS

The relationship and interplay between mental health and substance use disorders

a. *The impact of substance use disorders on mental health problems*

79 Early-onset, or regular substance use during adolescence, increases the risk of developing mental health disorders during late adolescence and early adulthood, as well as a range of other adverse outcomes that may increase the risk of mental ill-health, including educational underachievement, health problems as a result of accidents and injuries, and social difficulties.

80 People of all ages use substances to alter their brain chemistry and mental state. It is therefore not surprising that long-term use of most psychoactive drugs, including alcohol, is associated with the development of mental health symptoms and disorders. For example, long-term alcohol use can lead to depression, anxiety and even psychosis, while even short-term methamphetamine use can trigger depression, anxiety and psychosis.

81 It is important to note that some mental health syndromes are a consequence of altered brain chemistry induced by drug use, and may resolve when the person stops using drugs, whereas for others, the disorders persist even when the substance use stops. For example, psychosis induced by methamphetamine or cannabis may resolve when the drug use stops, however for some people, the drugs may have triggered an underlying psychosis that persists. This highlights the challenges in assessing and treating Victorians with comorbid disorders, and the importance of a workforce who are skilled and are able to match the treatment response to the person's needs. This means not excluding those who present to mental health services with co-occurring mental illness and substance use disorders, and ensuring that any underlying substance use disorder is appropriately treated.

82 In relation to a person who has developed a co-occurring substance use disorder, generally the more comorbidities a person has, the poorer outcomes they will experience overall. Co-occurring substance use disorders have a significant impact on:

- (a) treatment outcomes for other mental health disorders;
- (b) rates of suicide;
- (c) physical health;
- (d) family functioning;
- (e) relapse rates;
- (f) rates of acute service use;

- (g) the likelihood that a person will be non-adherent to their treatment or medication regimen;
- (h) the likelihood that a person will disengage from treatment;
- (i) the likelihood that a person will be homeless and on welfare; and
- (j) the likelihood that a person will be engaged with the criminal justice system.

83 Importantly, Victorian and international evidence demonstrates that co-occurring substance use disorders are one of the biggest predictors of re-admission to inpatient mental health units among people with mental illness, as well as a major driver of morbidity and mortality in the mental health system. For example, research we conducted examining clinical incidents within Eastern Health's mental health program across multiple years, identified that over half of the clinical incidents with an incident severity rating (ISR) of 1 or 2 involved consumers with co-occurring substance use disorders.

84 The risk of suicidal behaviour is also elevated in those diagnosed with substance use disorders. Globally, alcohol and drug use disorders were responsible for almost one-fifth of suicide-related disability-adjusted life years in 2010, with 13.3% of this burden attributable to alcohol use disorders alone, second only to depression. Although research consistently estimates that between one-quarter to one-third of suicide decedents meet diagnostic criteria for alcohol use disorder,⁹ specific suicide prevention strategies targeting individuals with such disorders remain notably absent, with this population infrequently identified as an important 'at risk' group within Victorian suicide prevention strategies and initiatives.

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

85 The consumption of alcohol and other drugs can affect the effectiveness of a range of pharmaceutical drugs in the treatment of both physical and mental health disorders. In terms of mental health, heavy and regular use of alcohol and drugs as a reflection of an underlying substance use disorder, have been found to affect both medication adherence and effectiveness.

86 However, there is considerable evidence that doctors do not readily identify or treat substance use disorders due to gaps in their knowledge and skills, with many patients also reluctant to discuss their alcohol or drug use due to fears of discrimination. As a result, polypharmacy is common in patients with co-occurring mental illness and substance use disorders, as doctors attempt to address poor treatment responses with

⁹ Witt K & Lubman DI (2018). Effective suicide prevention: Where is the discussion on alcohol? *Australian & New Zealand Journal of Psychiatry*; 52: 507-508.

greater doses or classes of pharmaceutical medications, despite limited evidence to support this approach.

- 87 Indeed, if an individual with co-occurring mental illness and substance use disorders does not respond to medication, it is likely that the mental health condition has been exacerbated by the underlying alcohol and drug use, and alternate evidence-based treatment approaches are indicated. For example, international studies consistently report that many people with alcohol use disorders are treated with antidepressants due to the depressive syndrome they present with. For many people, the alcohol use disorder is not identified nor appropriately managed. Systematic reviews also indicate that it is not possible to determine whether the depression is related to the drinking or independent of this, and have found that the best outcomes occur when antidepressants are commenced following a period of detox, if symptoms persist. This highlights the importance of integrating withdrawal services within a model of best practice mental health care, however currently this is not possible in Victoria due to the siloing of sectors and the limited addiction psychiatry support available within the AOD sector.
- 88 It is also important to note that nearly all of the international published clinical trials of psychiatric medications exclude people with comorbid substance use disorders from participation in their studies. This means that our current evidence base for pharmaceutical drugs is based on mental health populations without one of the most common comorbidities that we see in mental health services. This further discrimination of this population means that we have limited evidence to guide our clinical decision making in terms of pharmacotherapy, and a skill deficit in terms of alternate psychological approaches to managing co-occurring mental illness and substance use disorders within the mental health and AOD sectors.

i. Impact on consumers with severe co-occurring substance use disorders

- 89 The impact is greatest for those with co-occurring severe substance use disorders, as they are typically blamed for their lack of treatment progress, despite the ineffectiveness of current models of care, and are frequently excluded from receiving treatment within mental health settings due to the mistaken belief that their issues can be better managed within AOD services. However, when this population presents to AOD services, the sector is not adequately resourced to provide suitable evidence-based interventions, and have limited access to addiction psychiatry expertise due to the absence of a tertiary clinical addiction stream and limited funded specialist positions across Victoria.

c. *Self-medication by consumers with alcohol and other drugs to manage their mental illness and or the side effects of medication*

- 90 Alcohol and drugs are commonly used by Australians to help cope with stress, anxiety, pain and insomnia. They are also powerful emotional analgesics, and for Victorians who are victims of trauma, are a common way to help them deal with the significant accompanying mental distress. Research exploring self-medication among people with mental illness have identified dysphoria, anxiety and boredom as major drivers of continued alcohol and drug use, as well as helping to cope with emotional and psychosocial problems associated with their illness — for example, family conflict, trauma, financial problems, lack of vocational opportunities and social isolation. Such findings highlight the need for a multifaceted treatment approach in supporting Victorians with co-occurring mental illness and substance use disorders, as many of these underlying drivers will need to be addressed for treatment to be successful.
- 91 The impact is most significant for consumers with severe mental illness, limited financial and social supports, and few other coping skills. Experiences of trauma, family conflict, poverty, homelessness and other social difficulties impact on hope, meaning, identity, empowerment and connectedness, which are at the core of poor recovery outcomes. Given many of these consumers are bounced between services and sectors in the absence of a clearly articulated treatment framework, it is not surprising that they have poor health and social outcomes.

Challenges for people with co-occurring mental illness and substance use disorders

- 92 As discussed earlier, people with co-occurring mental illness and substance use disorder often fall through the gaps in service provision, or are bounced between services and sectors. This is due to a significant gap in workforce competency and capability, the absence of a tertiary addiction specialist stream, and existing models of care that do not include evidence-based approaches to integrated care. As a result, the consumer is typically blamed for 'failing treatment' as the available treatment response is not designed or suited to this population. In turn, this leads to repeated presentations to acute health and emergency services, including ambulances, emergency departments and police, with a revolving door of crisis presentations and short-term care, and a feeling of frustration and nihilism among consumers, families, police and health professionals. Ultimately this population are at high risk of misadventure, including suicide, as evident in the multiple deaths and major incidents investigated by the Victorian Chief Psychiatrist's Office and the Coroners Court of Victoria.

a. *The challenges for mental health services in supporting people with different types of substance use disorders*

93 A major challenge for Victorian mental health services overall is the level of demand on the service system and the available resourcing. The system is overwhelmed, and understandably services are trying to make very difficult decisions about who can be offered support. Given these constraints, the mental health system is focussed on supporting consumers with mental illness who are at serious risk of harm to themselves or others, and as a result need to exclude other consumers who are not deemed to meet these criteria. With limited training in managing substance use disorders available throughout undergraduate and postgraduate training, most mental health staff do not have the necessary competencies to deal with this population and hold similar stigmatising views towards this population as the general public. Without a tertiary specialist addiction stream in Victoria to provide clinical input, supervision, training and support, these skills gaps and discriminatory attitudes remain unchallenged, with limited impetus to change practice given other priorities and demands on the system.

b. *The challenges for alcohol and other drug services in supporting people with different types of mental health problems or illness*

94 A major challenge for AOD services is that many Victorians with co-occurring substance use disorders and mental illness are not eligible to receive psychiatric and case management support from mental health services. This may be because the service views their mental illness as being a result of their substance use and therefore best managed within AOD settings, or their mental illness is not deemed severe enough or risky enough to meet the threshold for receiving mental health service support. The issue here is that this patient group are not catered for by private psychiatry services, due to an inability to afford private fees.

95 At the same time, the mental health system is not aware that the AOD sector does not have the workforce or capacity to manage these patients without specialist mental health input, as they are not funded to offer this level of care, and there is a missing layer of tertiary addiction psychiatry support across Victoria. As a result, the AOD sector needs to support a significant number of Victorians with high levels of psychiatric disability and risk, without the necessary governance, quality framework, workforce competencies, escalation pathways and support systems in place.

96 Further to this, residential AOD services, including both withdrawal and rehabilitation programs, are not able to provide a quality and safe environment for many Victorians with co-occurring severe mental illness or suicide risk, due to infrastructure that is non-compliant with mental health sector standards, such as availability of individual rooms and non-ligature points, intervention programs that require a high level of social

skills and behavioural control, as well as a workforce that is not trained, skilled or resourced to manage their mental health needs.

- 97 Another key challenge for the Victorian AOD sector is that medical specialists are not a component of funded service delivery, meaning that there is limited medical support to undertake mental health and risk assessments, physical health checks and investigations, medication review and prescribing of effective pharmacotherapy. With limited GP access for this population due to skill gaps in primary care, this absence of a tertiary addiction specialist stream means that many patients receive substandard care, with limited access to medical and psychiatric reviews and evidence-based pharmacological and psychosocial interventions.

UNDERSTANDING THE AOD SYSTEM

The treatment approaches of the AOD and mental health sectors

a. *Engagement philosophies*

- 98 There are significant differences in treatment philosophies across the mental health and AOD sectors. A core tenet of the AOD system is that of a harm reduction approach. A key aspect of substance use disorders is ambivalence around change, driven by poor self-efficacy, competing health and social priorities, few alternate coping strategies and unresolved trauma or psychological issues. This means recognising where consumers are in terms of their stage of change, and the appropriate intervention needed to support them at that time. Clinicians within the AOD sector are skilled in working alongside consumers, with a focus on engagement using a motivational framework, and without the constraints of an involuntary paradigm and related system architecture.

- 99 In contrast, the public mental health system is heavily structured to manage risk in the context of an involuntary *Mental Health Act*. The resourcing of this system is firmly focussed at the pointy end of acute mental illness, with a particular focus on crisis management in the context of risk to consumers or the community. The system predominantly provides episodic care, with limited opportunity for long-term treatment or evidence-based therapies designed to address sustained remission and recovery. As such, the system is not designed to manage ambivalence and to work within an engagement framework, but to ensure consumers, families and the Victorian community remain safe.

b. *Potential lessons*

- 100 There are many components of the mental health system that would be invaluable for the AOD sector to learn from. These include well established quality and safety structures and processes, robust clinical governance, a distinct quality framework and related

standards, an articulated workforce structure with key competencies identified, and established mechanisms for supervision and clinical review.

- 101 The public mental health sector also works as a system, with coordination of activity, and clear oversight of its performance and quality, including a specific government office that is focussed on safety, quality and clinical guidance. In contrast, the AOD sector is largely governed as a collection of distinct services, with limited system oversight or coordination, or a focus on system performance and improvement.
- 102 In terms of the mental health system, I feel that there is much to learn from the treatment philosophy of the AOD sector, including its collaborative models, holistic focus, and orientation to remission and recovery as opposed to crisis and risk management.
- 103 The mental health system could enormously benefit from access to addiction psychiatrists, who are experts in understanding the relationship between drugs, addiction, mental illness and physical health, as well as related evidence-based pharmacological and psychological approaches. Addiction psychiatrists also understand the potential iatrogenic harms caused by many psychoactive medications, including benzodiazepines, amphetamines, antipsychotics and sleep medications, which are consistently associated with issues of diversion and misuse, as well as the increasing number of Victorian drug-related deaths. Addiction psychiatrists are an essential component of an integrated care system that supports mental health professionals with specialist advice and training in the safe prescribing of these medications, as well as ensuring consumers with mental illness receive ready access to opiate substitution pharmacotherapy and other evidence-based interventions.
- 104 While both sectors acknowledge the enormous importance of consumers and carers with lived experience, unfortunately it is only the mental health system that has dedicated funding for employment of a peer workforce across its system. This is a service gap that must be addressed.

Major gains in AOD sector service reform outside Victoria

- 105 Across Australia and internationally, there is consensus that comorbidity is the norm, and the lack of integration between mental health and AOD sectors disadvantages consumers, and results in poor outcomes and growing societal costs. As such, there have been multiple reviews and initiatives focussed on addressing this issue.¹⁰

¹⁰ Karapareddy V. A review of integrated care for concurrent disorders: Cost effectiveness and clinical outcomes (2019). *Journal of Dual Diagnosis*;15: 56-66.

Deady M, Barrett EL, Mills KL, Kay-Lambkin F, Haber P, Shand F, Baker A, Baillie A, Christensen H, Manns L, Teesson M. Effective models of care for comorbid mental illness and illicit substance

- 106 There are many lessons learnt from these multiple initiatives and I would like to draw the Commission's attention to the report published by the Sax Institute, as well as the models developed in Canada, US, New South Wales and Queensland.¹¹

YOUTH

Youth-specific risk factors

- 107 Early use of alcohol or drugs is associated with more frequent use during late adolescence, increased risk for later substance use disorders, as well as other health problems in early adulthood, such as injuries and the development of mental illness. Accessibility and availability of alcohol and drugs in the community, as well as prevailing cultural norms, are key drivers of substance use behaviours among young people. Peers also have a central role in the initiation and progression of alcohol and drug use, by influencing behaviour directly through providing opportunities to use, as well as indirectly by strengthening pro-substance use norms or modelling substance use behaviours. Other risk factors linked to harmful substance use during adolescence include genetic vulnerability, social disadvantage, child abuse and neglect, family breakdown, early school failure and favourable parental attitudes to alcohol or drug use.

Relationship between mental health and substance use disorders in young people

a. Differences with adults

- 108 In general, adolescents tend to recognise problems less readily than adults, present for treatment more frequently for drug use disorders than alcohol, report more binge and opportunistic substance use, and have higher rates of mental health problems. External pressures from family, school or legal settings are more likely to be a part of the reason for referral to treatment. Difference in choice of substances used between adults and young people is related to the varying finances, availability, access and social norms in those groups. For example, drinking heavily as a young person is more normalised than for a person in their late 30s with children and a career.

Barriers to help seeking and service access for young people

- 109 Seeking help early is widely recognised as a key protective factor, and promoting early and prompt treatment is critical for reducing the adverse impacts of mental health and

use: An Evidence Check review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Mental Health and Drug and Alcohol Office.

¹¹ <https://www.thenationalcouncil.org/integrated-health-coe/about-us/>.

Deady M, Barrett EL, Mills KL, Kay-Lambkin F, Haber P, Shand F, Baker A, Baillie A, Christensen H, Manns L, Teesson M. Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Mental Health and Drug and Alcohol Office.

substance use disorders. However, fewer than one in four Australian 16–24 year-olds with a current disorder access health services, with those experiencing a substance use disorder being the least likely to seek professional help. Rather than seeking professional help, research indicates that young people are keeping their problems to themselves or turning to their peers or key adults in their lives for help. This is despite evidence that many parents and peers have poor mental health literacy, as well as attitudes that do not promote recognition and appropriate help-seeking.

- 110 In addition, adolescents have knowledge, attitudes and beliefs about help-seeking and substance use that act as barriers to seeking professional help, and these are likely to have been established before the age of 13. Barriers identified include stigma, fears about lack of confidentiality, limited trust, lack of problem recognition, reliance on oneself, and concerns about helper characteristics. These help-seeking beliefs and preferences highlight the importance of building the mental health literacy of adolescents, including ensuring that they know when and how to assist their peers to access support.
- 111 Over the past decade, we have developed a school-based help-seeking intervention, MAKINGtheLINK, that teaches adolescents practical skills to help them support peers experiencing mental health or substance use issues.¹² This program addresses a number of critical gaps in existing school-based early intervention and health promotion activities, by focussing on exploring barriers to seeking help, teaching students the skills to overcome these barriers, and encouraging professional help-seeking. The program is novel in its emphasis on teaching practical steps for peers to become effective gatekeepers. However, while the focus on the program is primarily about supporting peers, improving students' mental health literacy and help-seeking skills is also a potentially effective means of increasing participants' help-seeking for their own problems. Indeed, a recent large NHMRC-funded trial we conducted in 21 Victorian schools found that students who received the program were more likely to subsequently seek professional help for their own mental health issues rather than informal support.¹³ This is a key finding, as it highlights the opportunity to help young people access evidence-based treatment earlier. MAKINGtheLINK is the only school-based intervention that has demonstrated that it is possible to change young people's help-seeking choices

¹² Lubman DI, Berridge BJ, Blee F, Jorm AF, Wilson CJ, Allen NB, McKay-Brown L, Priomos J, Cheetham A & Wolfe R (2016). A school-based health promotion programme to increase help-seeking for substance use and mental health problems: study protocol for a randomised controlled trial. *Trials*; 17: 393.

¹³ Lubman DI, Cheetham A, Sandral E, Wolfe R, Martin C, Blee F, Berridge BJ, Jorm AF, Wilson C, Allen NB, McKay-Brown L & Priomos J (2020). Twelve-month outcomes of MAKINGtheLINK: a cluster randomized controlled trial of a school-based program to facilitate help-seeking for substance use and mental health problems. *EClinicalMedicine*; 18: 100225.

and actual behaviours, and there is an opportunity to roll this evidence-based program out to Victorian schools as part of an integrated mental health strategy.

- 112 Research consistently shows that the stigma associated with substance use disorders leads to substantial delays in help-seeking – up to two decades.¹⁴ While there has been enormous investment in reducing stigma and service access for young people with mental health problems, with substantial growth in youth mental health services and funding for advocacy organisations, messaging around alcohol and drugs remains ambiguous. There are no public health campaigns promoting early help-seeking for alcohol use disorders, while national drug campaigns send the message that people who use drugs are aggressive and dangerous, and should be referred to police rather than health services. This situation is further exacerbated by extensive, and largely unregulated alcohol industry advertising, including aggressive social marketing campaigns to young people, that promote the idea that heavy alcohol consumption is the norm and core to socialising, relaxing and having fun. These mixed messages, coupled with prevailing social norms around the central role of alcohol in Australian life, result in many young people feeling at fault for developing an alcohol use disorder, and fearful of being judged.
- 113 If a young person is suicidal or depressed, there is clear public messaging and funding for promotion and advertising related to normalising early help-seeking and promoting the multiple options for seeking help, including helplines such as beyondblue, lifeline or eheadspace. This contrasts enormously with what is available in the AOD space, where there has been no public funding to promote or advertise help-seeking as a key health strategy, nor clear messaging about the options for getting help. For example, there has been no investment in advertising Directline, Victoria’s AOD helpline, as a first port of call for help, either through traditional channels or social media platforms that are heavily patronised by young people, despite significant investment in other Victorian mental health, family violence, cancer and quitline helpline services. This perpetuates the community belief, reinforced by negative media portrayals of addiction, that people with substance use disorders are the derelict drunk or the unconscious heroin junkie, and that treatment is ineffective and only for those who hit rock bottom. It is therefore unsurprising that most Victorians would not know that help is available for substance use disorders or where to easily seek support, with less than 10% of young Australians with substance use disorders currently seeking help.¹⁵ For those that do, what they receive is a lottery,

¹⁴ Chapman C. Delay to first treatment contact for alcohol use disorder (2015). *Drug and Alcohol Dependence*; 147: 116-121.

Wang PS. Delay and failure in treatment seeking after first onset of mental disorders in WHO’s World Mental Health Survey Initiative (2007). *World Psychiatry*; 6: 177-185.

¹⁵ Reavley NJ, Cvetkovski S, Jorm AF, Lubman DI (2010). Helpseeking for substance use, anxiety and affective disorders among young people: results from the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry*; 44; 729-735.

dependent on the competency of the school welfare, helpline, GP or youth mental health service they contact. Integrated care is a rarity, and most helplines and health services do not have the capacity or competencies required to address youth substance use disorders.

Tailoring substance use disorder interventions and programs to young people

- 114 There is an established evidence base for the treatment of substance use disorders in young people. Services that can provide a range of treatment modalities and evidence-based interventions will be best placed to respond differentially, depending on the specific needs of the young person and their family. Family interventions are essential, particularly for younger adolescents, with the balance of individual to family interventions increasing as the young person develops and becomes more independent. Group psychological treatment should also be offered, while access to opiate substitution treatment and medical support for detoxification should be available, and if not possible within a youth service, links with addiction specialist services developed so that clinicians can support young people at the interface. Tailored smoking cessation services should also be available to young people who have initiated smoking and want to quit, in order to prevent long-term morbidity and mortality.
- 115 Treatment planning should be tailored for each young person, taking into account co-occurring disorders, developmental issues and the family and social environment. Often the opportunity to address substance use disorders arises while these other issues are being addressed, thus integrating substance use treatment into the overall system of care is recommended, especially if the young person is not actually seeking help for their substance use or their use is exacerbating other problems. Management of risk and co-occurring mental health disorders is essential and is often required before the substance use can be addressed meaningfully. Effective digital interventions, either standalone or in conjunction with face to face therapies, will be increasingly available to complement more established therapies in future years.

Other models for young people with substance use disorders

- 116 Services are best set up separately and specifically for young people, rather than integrated with adult services, to ensure a developmental and engagement-focussed approach. They need to be flexible and accessible as even small barriers to entry can discourage those most in need. Nimble and responsive systems are required. Waiting lists or periods between assessment and entry into service should be avoided. Comprehensive assessment that identifies not only substance-related issues but also other co-occurring problems remains the foundation of effective substance use treatment, however a focus on treatment engagement, with an emphasis on relationship building in

the early stages of entry into services is equally important, as there is little to be gained from assessing young people who do not then turn up for treatment.

A service to provide compulsory treatment to young people with substance use disorders

a. Merits and risks

117 The concept of a compulsory treatment option for young people with severe substance use disorders that do not respond to less intrusive and restrictive interventions has merit, but would need to balance the incursion of civil liberties and human rights with a strong evidence base for the effectiveness of the proposed approach. It would also need to have a clear governance framework to ensure the rights and autonomy of young people were protected.

118 There is currently limited evidence to support compulsory treatment for young people with substance use disorders as being any more effective than offering voluntary treatment. When compulsory treatment is provided, it is frequently much better resourced in terms of staffing, infrastructure and other supports, than traditional treatment settings. Before we consider providing compulsory treatment, we must make sure that the current treatment available is of the highest quality, underpinned by a robust evidence base and a highly skilled workforce. Compulsory treatment should not be a substitute for high quality AOD care, and must be supported by clear evidence of effectiveness.

b. Are those considerations different if the consumers also have comorbid mental health challenges?

119 Only if there are considerations related to criteria relevant to the Mental Health Act.

sign here ►



print name DANIEL IAN LUBMAN

date 28 May 2020



**Royal Commission into
Victoria's Mental Health System**

ATTACHMENT DL-1

This is the attachment marked 'DL-1' referred to in the witness statement of Professor Dan Lubman dated 28 May 2020.

CURRICULUM VITAE

Name: Daniel Ian Lubman

Present Work Address: Turning Point,
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Academic Qualifications: *Physiology BSc (Hons)* 1989 (Manchester University, Class 2(I))
MB ChB 1992 (Manchester University)
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FRANZCP 2001
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Current appointment

- Executive Clinical Director, Turning Point, Eastern Health
- Professor of Addiction Studies and Services, Eastern Health Clinical School, Monash University
- Director, Monash Addiction Research Centre, Monash University

Career summary

Prof Lubman trained as a Psychiatrist and Addiction Medicine Specialist. He has published a substantial body of original work (>500 publications) that has helped to shape the field and led to policy and practice change. As Director of Turning Point, Prof Lubman heads Australia's leading national addiction treatment, research and training centre, providing policy advice, national research and training programs, and direct clinical care to patients and families across Australia. He is also the inaugural Director of the Monash Addiction Research Centre, a cross-faculty Monash University initiative, bringing together >150 inter-disciplinary researchers to deliver novel solutions to address addiction and its impacts.

Research support

Since 2004, Prof Lubman has obtained >\$40 million in research funding, including 25 major national competitive grants (18 NHMRC; 9 ARC) and >\$25 million in clinical treatment and training grants.

Contribution to the field

Prof Lubman has been at the forefront of human imaging work identifying key brain structures that are critically involved in the development and maintenance of addictive behaviour. This includes seminal work in the area of attentional bias, anhedonia, adolescent development and the impact of long-term cannabis use on brain structure and function. Prof Lubman has also led multiple clinical trials examining the effectiveness of pharmacological and psychological approaches for substance use and mental disorders (including smoking), as well as implementation studies related to their adoption within clinical settings, with the resulting products being embedded within many treatment services across Australia. He has led health services research related to addiction for the Victorian Government, including work in the areas of demand modelling, service planning, outcome monitoring, and the development of clinical tools and guidelines. Prof Lubman led the establishment of an internationally unique national surveillance system for alcohol, drug, mental health, self-harm and suicide in partnership with ambulance services across Australia, and has conducted multiple large cohort studies, including Patient Pathways, the largest Australian study of people accessing

alcohol and drug treatment services. He co-led the development of international mental health first aid guidelines for Problem Drinking and Problem Drug Use, as well as the award-winning school-based help-seeking program for substance use and mental health problems, MAKINGtheLINK, which is freely available, and has been adopted by many schools across Australia. His prevention work focusing on improving parenting strategies to reduce the risk of adolescent alcohol misuse has led to the development of freely available practical guidelines and an international first, tailored web-based intervention that supplements the 2009 NHMRC alcohol use guidelines. In recognition of his work, Prof Lubman has received multiple awards, including the *Senior Research Award* from the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the *Senior Scientist Award* from the Australasian Professional Society on Alcohol and Other Drugs (APSAD) and an *Outstanding Achievement Award* from the International Society of Addiction Medicine (ISAM).

Community engagement and participation

Prof Lubman has contributed to the development of multiple national drug strategies, and is regularly contacted for policy advice and community comment. He has made numerous submissions to Government consultation processes related to alcohol, drugs and gambling, including giving evidence at the *Senate Select Committee on Mental Health* and *Joint Select Committee on Gambling Reform*. He sits on numerous State and Commonwealth Expert Reference Committees, including the Mental Health Ministerial Advisory Committee.

Professional involvement

As Chair of the RANZCP Faculty of Addiction Psychiatry from 2006-2017, Prof Lubman led the College's education, policy and media responses to addiction issues, and successfully redeveloped addiction postgraduate training for psychiatric trainees and fellows across Australia and New Zealand. He also established and co-convened the first four *International Medicine in Addiction* conferences, the largest addiction medical conference in the region.

International standing

Prof Lubman is an internationally renowned addiction treatment expert. His work has been highly cited (>15,000 times, *Google Scholar*), and is at the forefront of understanding pathways into and out of addiction, so as to inform the development of effective prevention, treatment and policy responses. He is regularly invited to present at national and international meetings.

Supervision and mentoring

Prof Lubman has supervised research students (Honours, Masters and PhD) from a number of Universities, as well as overseas fellows (>40 research projects supervised since 2003).

Peer review involvement

Prof Lubman has provided external review for NHMRC Project Grants since 1999, and has previously been a Member of the NHMRC Project Grants Review Panel. He provides external review for the ARC, Netherlands Organisation for Health Research and Development Project Grants as well as the UK Medical Research Council. He also provides peer-review for high-impact addiction, mental health and neuroscience journals, including *Addiction*, *JAMA Psychiatry*, *Journal of Neuroscience* and *Neuroscience & Biobehavioral Reviews*.

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