ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Thursday, 18 June 2020 at 10am

Before: Ms Penny Armytage AM (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Mr Stephen O'Meara QC
Ms Georgina Coghlan
Ms Fiona Batten

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1 THE CHAIR: Welcome to the Commission's panel discussion on
2 how to support people living with mental illness and
3 problematic alcohol and drug use.
4
5 I'm Penny Armytage, the Chair of the Royal Commission
6 into Victoria's Mental Health System. I'm joined by my
7 fellow Commissioners: Professor Allan Fels, Dr Alex Cockram
8 and Professor Bernadette McSherry.
9
10 On behalf of the Commission, I acknowledge the
11 traditional owners of the lands on which we meet, and I pay
12 my respects to their Elders past, present and emerging.
13
14 Before we commence, I would like to thank Dr John
15 Reilly, Professor Dan Lubman and Dr Stefan Gruenert for
16 taking the time to participate in today’s panel. I know
17 that each of you has already contributed significantly to
18 the Commission's work in the development of your witness
19 statements, and in preparation for today’s panel
20 discussion.
21
22 We are conscious that this contribution has occurred
23 during the challenging time of the current pandemic and we
24 appreciate that you will have had other pressing work
25 related to the pandemic response. The pandemic, and its
26 mental health impacts, have emphasised to the Commission
27 how critical a stronger mental health system for Victoria
28 is now, and into the future.
29
30 The purpose of these hearing panels is to explore and
31 contest ideas through a shared discussion. While the forum
32 for our hearings has evolved in the current environment, we
33 know that the most powerful insights for our work occur
34 when we engage in discussion with experts and with those
35 with lived experience. The Commission has continued to
36 engage widely across the community, utilising online forums
37 such as this to continue its engagement work.
38
39 This panel is focussed on how to support Victorians
40 who have a mental illness and co-occurring alcohol and drug
41 issues. It will focus on how the future mental health
42 system can better support adults and young people, how the
43 mental health and alcohol and drug sectors are currently
44 responding to people with co-occurring needs and what
45 lessons can be learned from other jurisdictions.
46
47 In our community and expert consultations, we

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1 frequently heard about the complex and unique challenges
2 for consumers with co-occurring mental health and substance
3 use issues. This panel has been convened because the
4 opportunities to reform extend beyond the mental health
5 system, and into other service systems.
6
7 We know that currently many people with co-occurring
8 mental health and substance use issues are not receiving
9 integrated care. Some consumers are falling through the
10 gaps between mental health and AOD services or are
11 experiencing lengthy delays to access either. The
12 Commission has received submissions that highlight how
13 consumers are bounced between mental health and AOD
14 services; deemed too unwell for AOD treatment or ineligible
15 for mental health services because of their substance use.
16 These experiences can seriously undermine the health of
17 consumers as they wait for access or attempt to navigate
18 complex and siloed services. For those that do seek help,
19 we have been told about experiences of double
20 discrimination and stigma associated with mental illness
21 and substance use. For example, a participant in our
22 consumer focus group explained that:
23
24 *You be honest and say you use drugs. They*
25 *give you lectures about how bad drugs are*
26 *for your mental health but for me, it's the*
27 *only thing that makes me feel better.*
28
29 We also heard about the impact of these issues on
30 consumers and families during our community consultations.
31 For example, one family told us that:
32
33 *There is no integration for people with*
34 *mental health issues and AOD issues. There*
35 *are no facilities, there's no referral*
36 *points and the constant refrain I got from*
37 *her mental health team was that until she*
38 *recognises she has a problem with alcohol,*
39 *there is nothing we can do.*
40
41 This situation is concerning considering the insights
42 from experts across many sectors that the co-occurrence of
43 mental illness and substance use should be understood as
44 "the expectation rather than the exception."
45
46 The Commission understands that estimates of the
47 prevalence of co-occurring substance use with mental

1 illness nationally range from 25 per cent to 68 per cent of
2 people with mental illness.
3
4 The Commission has also heard of the work of many
5 dedicated and compassionate professionals across the mental
6 health and AOD sectors, including those who are working to
7 bridge these gaps. During our community consultations we
8 heard about how even a short intervention at a critical
9 point for a consumer can place them on a path to recovery.
10 According to one participant:
11
12 *When my son was going to discharge himself*
13 *following an alcohol-induced admission to*
14 *hospital they had one psychiatric nurse go*
15 *and see him. They spoke with him for 20*
16 *minutes and he agreed to become a voluntary*
17 *patient in [an inpatient unit]. This*
18 *changed his life.*
19
20 Recently, we have met with primary care and community
21 health services that are providing integrated care for
22 consumers with co-occurring mental health and substance use
23 issues. We have heard from consumers and carers who access
24 these services about how a welcoming, non-judgemental and
25 holistic response from empathetic and skilled professionals
26 has changed their lives.
27
28 We have read with keen interest your respective
29 witness statements, and it is evident that you bring a
30 wealth of expertise and experience to this topic, along
31 with thoughtful and progressive reform ideas.
32
33 There are areas of broad agreement across your
34 statements, including the need to improve consumer
35 experience and address service silos, and an
36 acknowledgement that both services have much to learn from
37 each another and that there are opportunities to increase
38 the capability of both workforces, the benefits of
39 integrated responses for consumers and the need to engage
40 young people through youth-appropriate and holistic
41 services.
42
43 The statements were in agreement on the importance of
44 integrated care, treatment and support, particularly for
45 people with more complex support needs. There was also
46 agreement on the important role that peer support can play
47 and the history of peer support particularly in the alcohol

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1 and other drugs sector.
2
3 There are also key differences, including different
4 perspectives on how integration should be pursued and at
5 what level. Your witness statements also contained a
6 breadth of research and local and international examples of
7 how to address these complex issues for which we thank you
8 all.
9
10 The purpose of this panel is to address both the areas
11 of agreement and to understand more deeply divergent views.
12 We are also keen to learn more about what reforms you would
13 each see as vital for the future mental health system here
14 in Victoria.
15
16 Today's discussions will be facilitated by Counsel
17 Assisting, Fiona Batten, and I and my fellow Commissioners
18 have largely a listening role.
19
20 Before handing over to Fiona to outline the logistics
21 and parameters for today's panel's discussion I would like
22 to once again thank you for your time in assisting the
23 Commission with our deliberations. We look forward to
24 hearing your insights and perspectives on these complex and
25 challenging issues. Thank you, Fiona.
26
27 MS BATTEN: Thank you, Chair. I would first like to
28 introduce our first three panel members and then I will
29 outline the main areas to be discussed. The introduction
30 is necessarily very brief and it doesn't do justice to
31 their experience and contribution, to which I'd refer
32 everyone to their witness statements.
33
34 In no particular order, Professor Dan Lubman trained
35 as a psychiatrist and addiction medicine specialist. As
36 the Executive Clinical Director of Turning Point and
37 Professor of Addiction Studies and Services at Monash
38 Health, Professor Lubman provides strategic, clinical and
39 academic leadership.
40
41 Professor Lubman is also the inaugural Director at the
42 Monash Addiction Research Centre at Monash University.
43 Professor Lubman has published a substantial body of work
44 and his contribution to the field has been recognised
45 through a number of awards.
46
47 Dr John Reilly is the Chief Mental Health Alcohol and

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1 Other Drugs Officer in Queensland. The latter title
2 reflects the integration of mental health and alcohol and
3 other drugs services in Queensland.
4
5 Dr Reilly has worked in clinical or Medical Director
6 roles for mental health services or components in both
7 Victoria and Queensland for over 20 years. He has clinical
8 expertise in addiction and has particular interest in
9 quality improvement, service development and governance.
10
11 Finally, Dr Stefan Gruenert is a registered
12 psychologist and the Chief Executive Officer of Odyssey
13 House. Dr Gruenert has worked in the alcohol and other
14 drug sector for 20 years as a clinician and manager,
15 supporting people with alcohol and other drug problems and
16 their associated mental health issues.
17
18 Dr Gruenert is responsible for managing the range of
19 residential and community-based services Odyssey House
20 delivers. He is a former President of the Victorian
21 Alcohol and Drug Association and a current Director of the
22 Victorian Council of Social Services.
23
24 As the Chair mentioned, each panel member has provided
25 the Royal Commission with a written statement which will be
26 published on the Commission's website. Thank you to each
27 of you for your energy and dedication you've put both into
28 your statements and to this panel process.
29
30 In this panel hearing, to assist the Commission
31 consider how people with mental illness and substance use
32 issues can be best supported, the panel discussion will
33 focus on five areas.
34
35 First, the strengths of the approaches of the alcohol
36 and other drugs sector; second, addressing the needs of
37 people with mental illness and substance use issues; third,
38 integration at a governance and policy level; fourth,
39 increasing workforce capability; and finally, the
40 priorities for the allocation of resources.
41
42 I will start by asking questions until approximately
43 11.30 and then give everyone a break for 10 minutes, and
44 we'll continue asking questions and then I'll hand over to
45 the Chair at approximately 12.20/12.30 for the
46 Commissioners to ask the witnesses questions directly.
47

1 So, our first topic is the treatment philosophy and
2 approach. The Commission understands that a strength of
3 the alcohol and other drugs sector is that it adopts a
4 holistic approach to treating consumers. In your
5 experience, what are the strengths of the treatment
6 approaches of the alcohol and other drugs sector?
7
8 Dr Gruenert, can I ask you to respond to this first.
9
10 DR GRUENERT: Thank you, Fiona, and Commissioners. I
11 think two points I should make around the context of
12 response to this question, and the first is that, whilst
13 there is some overlap of clients across mental health and
14 alcohol and other drug sector currently, they work with
15 very different cohorts by and large, which means that the
16 strengths and weaknesses of one sector can't necessarily be
17 compared with the strengths and weaknesses of the other,
18 and I think in most cases the alcohol and other drugs
19 sector is working with moderate-to-severe alcohol and other
20 drug problems, and mild-to-moderate mental health issues.
21 Those issues are things like anxiety, mood disorders, PTSD,
22 personality disorders, and the effects of trauma.
23
24 Mental health services in contrast are dealing mostly
25 with moderate-to-severe and low prevalence mental health
26 issues, and often very mild-to-moderate drug and alcohol
27 issues.
28
29 So, in terms of the actual strengths, I think some
30 comments made by the Chair about consumer input are really
31 important. I think the safety and the welcoming
32 environment that's non-judgmental and that gives consumer
33 choice is clear, sort of, markers of a strong drug and
34 alcohol sector.
35
36 I think the integration of peer support is a key
37 strength of the alcohol and other drug sector, and that
38 it's generally experienced by consumers as an egalitarian
39 partnership where they feel really part of the decisions
40 and part of the involvement in that work, and I think that
41 occurs both at the community-based service level all the
42 way through to residential programs, and it's also part of
43 the system for mild, moderate and severe issues around drug
44 and alcohol, and I think it really brings much more
45 effective outcomes as we've seen in research for
46 participants in sustainable recovery when there's strong
47 peer involvement.

1
2 Finally, at this point I'd probably just add also,
3 another strength is the capacity for the drug and alcohol
4 sector to integrate the care and support from a range of
5 different disciplines, again in quite a partnership and
6 egalitarian way, and that includes medicine, psychiatry,
7 psychology, social work, nursing and the lived experience,
8 without a strong divide between clinical and psychosocial
9 services that often exist and are referred to quite
10 frequently within the mental health system.
11
12 I think that assures that all of the associated
13 health, behavioural and social issues are addressed within
14 drug and alcohol services, including forensic and issues of
15 criminality, legal issues, vocational and housing needs.
16
17 MS BATTEN: Thank you, Dr Gruenert. Professor Lubman, can
18 I turn to you next in terms of the strengths of the AOD
19 sector.
20
21 PROFESSOR LUBMAN: Thank you, Fiona, and thank you to the
22 Commissioners for this opportunity. So, I fully endorse
23 the comments made by Stefan. I suppose there's just a
24 couple of things I'd like to raise in thinking about this
25 point.
26
27 Nearly everyone that we see in the alcohol and drugs
28 space are using drugs to solve a problem, to help with
29 dysphoria or distress or issues in their lives, so they're
30 presenting to us with a solution to the problem they have
31 that's not working for them, you know. So, the alcohol and
32 drugs are emotional analgesics that are helping them deal
33 with underlying mental health, stress, life, a whole range
34 of life complexity.
35
36 And so, when we see people in the alcohol and drugs
37 space our core focus is understanding that the drug use is
38 the solution to their problem and we need to work out what
39 the actual problem is, and so, we need to think
40 holistically with them to help them try and understand what
41 is underlying that, because for many people that we see
42 they're not really aware why they use drugs, they've just
43 used drugs for such a long time to address an underlying
44 issue that over time the addiction itself has been the
45 primary issue, and the actual reason they started
46 using underlines that, which might be related to trauma,
47 untreated mental health, a whole range of other life

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circumstance might be lost.

So, a big goal for us is around how we engage and work with people to try and understand where they're coming from and try to address the answers, not only just for how we treat the alcohol and drug issues, but how we treat the issues that actually led them down that path in the first place.

I think it's fair to say that the recovery models in both the mental health and alcohol and drug system are pretty similar theoretically in terms of policy documents, but I think it's really important to consider that the way in which the systems are designed actually influence how those principles are actually rolled out in practice.

I think it's fair to say that the focus within the mental health system on risk on the Mental Health Act, so an involuntary system, has a major colouring in terms of how the system sees and interacts and works with people, because there's a whole issue around the level of risk that needs to be managed and concerns around when people are not able to make informed decisions and the system has to step in, and I think that colours a lot of the decision making and lot of the way in which people are approached and dealt with within the system.

In contrast in the alcohol and drug system, we manage people who are incredibly risky, but we don't have that involuntary frame, we don't have that risk frame. So, for us in the alcohol and drug system, the only thing that we have to be able to work with people is a willingness to engage, a willingness to be non-judgmental, to be empathic, to hear where they're coming from, so our tools and our approaches and our models of care have to be about how we actually walk alongside people, how we encourage them to be part of the system, how we hear what their issues are, and how we develop interventions that actually work for them.

Having worked in the mental health system where the focus is much more on risk and just the nature of the demand on the mental health system, often when you work in that system you don't have the luxury of waiting to work out and understand people's problems and be able to have the time to actually understand where people are coming from; it's much more that risk-based system.

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1 Because of that, because of the system, and I think as
2 we said throughout our submissions, because there's been
3 the whole issue and a generation of health providers not
4 being able to be upskilled in the area of addiction, the
5 mental health system doesn't understand that drug and
6 alcohol use is a solution to a problem.
7
8 So generally, what happens is, when you come into the
9 mental health system, the mental health system says, well,
10 drugs and alcohol make your mental health symptoms worse so
11 you should stop using them. So, often the involvement that
12 I have in the mental health system is often working with
13 mental health providers to help them understand why people
14 choose to use alcohol and drugs, and it's not because
15 they're being difficult and because they're sabotaging
16 their treatment, it is because that is, as Penny's
17 highlighted, you know, the key solution to how they deal
18 with trauma and distress in their lives.
19
20 And so, the focus of our treatment is, well, how do we
21 find an alternative solution that actually is just as
22 effective, because I cannot tell somebody to stop using
23 drugs if I'm not giving them something that is effective
24 for them to use, they're not going to stop that if they've
25 been doing that for years without an alternative that is
26 just as effective.
27
28 So, for me, I wanted to raise those issues really
29 which is around issues of differences in the philosophy and
30 approaches of the systems based on the fact of risk and the
31 Mental Health Act which I think colours the mental health
32 system. The need for us to engage and so, our models of
33 care are very much about that and that the peer experience
34 is critical, in that, making people feel as though they're
35 the physical champions.
36
37 The other issue I wanted to raise is the stigma issue.
38 The stigma issue is enormous. You know, addiction has been
39 repeatedly identified as one of the most stigmatised health
40 conditions in the world. And so, the media, what we hear
41 within health professionals and even the mental health
42 system is that, you shouldn't use drugs, they're bad. And
43 so, because of that for many of the people we see, they
44 don't want to go to services, they don't want help because
45 every - you know, whether it's in the media, in the family
46 and friends or service systems, are constantly telling them
47 that they're making wrong choices. If it was just a matter

1 of choice, you know, people would be able to just stop
2 using, but the issue is, this is a solution for a whole
3 range of other problems and this is an actual mental health
4 condition as I sort of reiterate in my statement.
5
6 And so, we also need to acknowledge that stigma is so
7 prevailing that the alcohol and drug system's philosophy
8 recognises how stigmatising these conditions are, so it's
9 really critical that we have settings and services that are
10 welcoming to people and see them where they're at and don't
11 judge them, so we have to create an environment that
12 recognises that profound stigma, and unfortunately the
13 mental health system still has a very - because of issues
14 of lack of understanding around the issue of addiction
15 because of years of a failure to train, you know, that
16 professional group, stigma is still very strong around the
17 alcohol and drug issue and that becomes a very unwelcoming
18 environment for people presenting to those services. So,
19 I've probably said enough.
20
21 MS BATTEN: Thank you, Professor. I'll give you more
22 opportunities don't worry. Dr Reilly, can I turn to you
23 for the strengths of the alcohol and drug sector.
24
25 DR REILLY: Yes, thank you, Fiona, and thank you,
26 Commissioners. I'm just trying to think of what to
27 emphasise following the other discussions. I think what
28 I've tried to highlight is that I do think that there
29 sometimes is this notion of the AOD sector and the mental
30 health sector and this question does include that, and I
31 think we just have to recognise some of the underlying,
32 perhaps, thinking around that because that still seems to
33 imply some of those things that Dan and Stefan touched on,
34 which are, I think that it can be an unfair comparison
35 because we're talking about the AOD sector as being
36 separate, not having a - as has been highlighted - a
37 philosophy of perhaps more coercive treatments under the
38 Mental Health Act and not being risk focused.
39
40 But I do think that if you look - I don't think there
41 is any great difference in the AOD sector as opposed to a
42 broad mental health sector, I think that the comparison
43 we're talking about sometimes is between a broader AOD
44 sector with regard to multiple different types of services,
45 with a narrowly clinical mental health sector which is
46 focused on the treatment of the most severely mentally ill,
47 and so, in a sense I don't think it's a fair or reasonable

1 comparison.
2
3 So I think, with that proviso, I don't disagree with
4 some of the other things that Dan and Stefan were saying,
5 but I think it's important to put that context in. Because
6 I think that good mental health treatment follows all of
7 the same principles that we've just been discussing with
8 regard to consumer choice and involvement and engagement
9 and motivation to change, but clearly if we're looking at a
10 severe end of the mental health disorder spectrum with
11 consumers and patients that perhaps have lost capacity and
12 are posing risk, then there is an expectation on the mental
13 health services that they manage that risk.
14
15 Whereas, as Dan said, people with severe alcohol and
16 other drug problems may also pose risk, but in a sense the
17 AOD sector doesn't take on the management of that risk,
18 that risk is left with the patient and then really with
19 wider community risk management processes, whether that's
20 police or other things, as well as potentially mental
21 health services at times of crisis for people with severe
22 or significant substance use disorders.
23
24 So, otherwise I would agree with the strengths, I
25 think those are the provisos that I would add in.
26
27 MS BATTEN: Thank you. I know you've got a lot to say but
28 I'll keep you moving along with the questions, so we get
29 through the main content.
30
31 The second topic is addressing the needs of people
32 with mental illness and substance use issues. The first
33 question seeks to explore what integrated care should look
34 like in three contexts. So, I'll outline the question in
35 full and then, Dr Reilly, I'll ask you to respond first.
36
37 To best meet the needs of people with mental illness
38 and substance use issues, what should integrated care look
39 like for people, first, who present to a crisis setting;
40 second, who may benefit from assistance in a bed-based
41 setting; and third, who may benefit from treatment in a
42 community or primary care setting?
43
44 DR REILLY: Sure. So, what we're focused on here is
45 people with mental illness and substance use issues. So, I
46 guess what I would highlight there is, well, really though
47 we're talking about people at a particular level of

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1 severity most likely of mental illness and a substance use
2 disorder. And, if that's what we're talking about, we're
3 talking about co-occurring substance use and their other
4 mental health disorder which is causing them to seek
5 treatment in some way, in this first instance to a crisis
6 service, but obviously to health services more generally
7 with any of these.
8
9 So I guess, and along the lines of the four-quadrant
10 model that I attached, I'm really thinking about that
11 severe substance use disorder and severe mental illness
12 group, and as I've outlined what we're really talking about
13 in that case at least, crisis, is people who are probably
14 presenting to a mental health service specifically, they're
15 probably presenting, for instance, to an Emergency
16 Department or some form of an acute crisis setting, and
17 they're really presenting, although they've got a severe
18 substance use disorder, they're presenting with some kind
19 of a crisis that could be called a mental health crisis -
20 you know, suicidality or homelessness that is causing them
21 distress, something of that sort.
22
23 In that situation, if they also then have a severe
24 substance use disorder, really the issue is trying to
25 assist that person to recognise, a little along the lines
26 that Dan was just saying, what's the actual problem right
27 now and how might we then be assisting that person to
28 manage that, and that might be around suicidality, it might
29 also then be around alcohol use or other substance use, and
30 then other psychosocial stressors at present and what's
31 going to be a solution for that person.
32
33 Really then, that comes back to, looking at integrated
34 care, ensuring that the person, the clinician or other
35 staff working within that crisis service actually has a
36 good understanding of how to engage that consumer or
37 patient or client in a process of assessment, working out
38 with them collaboratively what's going to be the most
39 appropriate strategy to assist them at this point, and
40 really having the knowledge and the skills to be able to
41 work with that person, you know, to do that effectively and
42 to be able to go across a range of different clinical needs
43 and for that to be in that sense a one-stop-shop where
44 they're able to manage those, at least the health-related
45 issues, effectively and then that they've got links then
46 with other social situations.
47

And really therefore, in my mind again, that needs to come back to having those mental health clinicians feeling capable, confident of managing mental health issues broadly and that should include substance use and they're also then able to connect up with appropriate psychosocial supports, as I've said.

That therefore comes back to staff, it comes back to training, it comes back to attitudes, so we can touch on those later.

I think with regard to a bed-based setting I'd simply be saying the same thing. We've already touched on high prevalence, Commissioner Armytage started with that, we have to recognise that they are the norm and that therefore all of our clinical services, all of our staff need to recognise the importance of the managing co-occurring substance use disorders.

I think with regard then, I would simply say, well, that actually requires us to acknowledge that's just the norm and we need to have service systems which treat it as the norm, which again brings me back to the same issue, right, so that they're not compartmentalised, so that's about simply having that the mental health service system has to see this as its core business and then develop knowledge, skills and structures which support that.

I think the final one's much the same: if you're talking about community specialist services it's the same for community mental health services currently, that that's what they should be doing for the consumers that are presenting and receiving treatment within those community mental health services.

If you're thinking then, it says "primary care setting", then really that's about having whatever the specialist service is that's been involved in that case in transition to primary care, ensuring that all appropriate health-related disorders that that service should be looking at have been addressed, that the needs have been identified and treatment recommendations have been made that supports the general practitioner or other primary care provider in continuing that care if it's now appropriate for it to be devolved to that level. So, thanks.

1 MS BATTEN: Thank you. Professor Lubman, can I turn to
2 you next. Do you need me to repeat the question?
3
4 PROFESSOR LUBMAN: No, it's okay. I have a couple of
5 comments to start with. I think substance use is one of
6 the main precipitating and predisposing factors to mental
7 illness. It's also consistently shown to be one of the
8 strongest predictors of poor outcomes in terms of relapse
9 and re-admission, so it's central to the treatment of
10 mental illness: if you don't treat the substance use,
11 essentially you can't treat the mental illness.
12
13 So, for me, treatment of the substance use is
14 indistinguishable across those three settings: if you don't
15 treat it, you know, you're not doing anything for the
16 person's mental health and so it has to be a core part of
17 that treatment.
18
19 I suppose the nuance is, is the level of intervention
20 at those particular settings. So, for me, if somebody
21 presents with a heart attack and they have underlying
22 diabetes, to say that we would not in any way recognise
23 that diabetes or think about stabilising that diabetes in
24 terms of priority, you know, treating the heart attack, you
25 know, would be negligence in terms of a medical situation.
26
27 So, for me, it doesn't mean you have to have a
28 specialist in diabetes in the cardiology ward helping
29 people deal with a heart attack, but it needs to be
30 recognised as something that needs to be stabilised in the
31 short term, and that there needs to be specialist review in
32 terms of its treatment if it's a major factor in terms of a
33 cause for that heart attack.
34
35 So, for me, it's a cruel component. Work that
36 we've done and other people have done have shown that it's
37 the biggest predictor of relapse following an inpatient
38 admission. So, if it's the biggest predictor of relapse in
39 terms of inpatient re-admission within the next two to four
40 weeks, it beggars belief that it isn't a priority in terms
41 of a management plan, in terms of ensuring that person
42 stays well and remains well out in the community.
43
44 So, for me, I think everyone would agree that having a
45 capable workforce that has minimum knowledge and
46 understanding of how to manage these issues, so we would
47 expect doctors managing heart attacks to sort of understand

1 diabetes and be able to manage diabetes at the basic level.
2 You know, same here, we would expect that our workforce in
3 the mental health space would have a basic understanding
4 and capabilities in managing substance use, and then in the
5 particular - depending on the setting and the models we
6 want to put in place which we'll come to later, it's about
7 how do we bring in that specialist expertise to provide
8 additional support depending on where people are at.
9
10 So, in terms of an acute response, obviously we need
11 to prioritise the main presenting complaint, but we need to
12 be acknowledging and working with that underlying substance
13 use; as the person comes into the recovery phase, we need
14 to ramp up that support around substance use to make sure
15 that the recovery pathway is optimised and that we minimise
16 any risk of relapse and we ensure their wellbeing. So,
17 probably that's enough from me.
18
19 MS BATTEN: Okay, thank you. Dr Gruenert.
20
21 DR GRUENERT: Endorsing what Dan has said and much of what
22 John has said, just a couple of additional points I'd like
23 to raise. I think it's important for us to remember that
24 much of the drug and alcohol use in Australia is neither
25 problematic or does not necessarily relate to a diagnosis
26 of substance use disorder, and the mere presence of
27 someone's use of drug or alcohol needs to be considered but
28 not necessarily treated or managed whenever they're
29 presenting in any setting.
30
31 And so, I think the response that we take really needs
32 to consider the level of severity or what we're actually
33 talking about, and so, for me the kind of critical things
34 regardless of the setting are the capacity of the
35 environment, the workforce, the staff to be able to
36 identify what's going on, to be able to assess and
37 understand the level of severity or the impact that's
38 having and then to be able to have the skills to manage and
39 respond in an appropriate way.
40
41 So, from my perspective, I don't believe integrated
42 care equates to integrated service systems, and I think
43 integrated care can be done in a single setting within both
44 sectors, and that's the ideal way to provide integrated
45 care. I think an appropriately resourced drug and alcohol
46 system and a mental health system can respond to both a
47 person presenting with mental health or drug and alcohol

1 issues for all but probably the most complex cases with the
2 right trained staff and support.
3
4 If we're looking at the different settings, I think
5 it's fair to say that in any crisis, whether that's being
6 presented in ED or to the mental health service or to drug
7 and alcohol, that helping people to feel safe and welcome
8 so that you're at least getting a de-escalation of
9 behaviours and a sense that people are empathic and they
10 care and they're seeking to understand you is really
11 critical, and so the knowledge and skills of the staff to
12 be able to do that in a credible way are critical and again
13 we need those skills across both mental health and drug and
14 alcohol to be able to do that. So that, the language used,
15 the way people are approached when they're in crisis is
16 suitable, and I think I've referred to in my submission
17 that much of the crisis is presented in a hospital setting
18 where you're either getting a very sort of clinical medical
19 response or a security response around the crisis, and we
20 really need other responses that are much more behavioural,
21 that are understanding mental health and drug and alcohol
22 when people are presenting in that crisis.
23
24 In terms of the bed-based settings, I think it depends
25 what bed-based setting you're talking about. If we're
26 talking about inpatient acute mental health, then again,
27 the points Dan made are really critical about identifying,
28 you know, someone's drug use being problematic, dependent,
29 is it one-off episodic, is it just an intoxication that
30 brought them there, and what's really going on underneath,
31 the assessment around that, so that the better
32 understanding of the impacts on their mental health can be
33 understood.
34
35 If you're talking about a residential setting in drug
36 treatment, the key focus of that setting is really seeking
37 to develop the skills and the capacity to address all those
38 underlying problems that Dan talked about right at the
39 start that are really the reason why people are using drugs
40 and give them viable alternatives to that.
41
42 And so, the key need in that setting is to be able to
43 have the right people around as part of the team to be able
44 to manage and contain people's mental health symptoms until
45 they can get to a point where they've developed the
46 strategies and things to manage those on their own, and
47 that may be pharmacotherapy but it might also be a whole

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1 lot of psychosocial strategies.
2
3 Again, in a community setting, having staff and people
4 who are skilled up and knowledgeable about both mental
5 health and drug and alcohol is critical, so again, you can
6 do that, identify, assess and then manage or integrate
7 strategies into their care or treatment plan if that's even
8 needed, because the drug use may not have been an issue or
9 the alcohol use may not have been an issue in that setting.
10 And you don't want the mere presence to suddenly trigger,
11 oh, we can't work with you, you've got drug and alcohol
12 issues, you need to go over there.
13
14 So, for me, regardless of the setting, there's those
15 fundamental things that need to be in place to make sure
16 the response actually matches what's going on for someone
17 and at the right level.
18
19 MS BATTEN: Just before we move on to the next question,
20 you've all talked about a base level of knowledge of the
21 workforce but the potential need for more specialist
22 expertise in particular circumstances. What about the
23 scenario where someone has the most severe complex mental
24 illness and the most severe substance use issues, which I
25 presume would be a substance use disorder, what does the
26 integrated model of care look like in that circumstance?
27
28 Professor Lubman, perhaps I'll turn to you first.
29
30 PROFESSOR LUBMAN: So, I think when we're talking about
31 severe in both ends, so we're talking about a severe
32 substance use disorder and severe mental illness. I think
33 what's clear in all our submissions, and particularly the
34 work that we've done previously, is that there needs to be
35 a specific model of care for that patient group. There
36 isn't a model of care at the moment that exists.
37
38 At the moment we're asking our addiction services and
39 our mental health services to sort of make do with the
40 models they currently have, and I think what's been clear
41 through what we're hearing from consumers is, the current
42 response is inadequate and doesn't meet the needs of people
43 presenting with those issues.
44
45 So, there needs to be the development of a new model
46 of care that recognises the complexity of severe mental
47 illness and severe substance use disorders and actually

1 meets those needs.
2
3 I think in the submission we put in, and other people
4 have put in, there's really great evidence-based models of
5 what works in terms of models of care for that patient
6 group; they just don't currently exist in Victoria and we
7 don't have a system that is able to escalate.
8
9 I think that's one of the biggest issues, that when we
10 talk throughout the integration piece, is the need to
11 understand the ability for the system to escalate to be
12 able to identify what an issue is and whether that current
13 response in the system is able to meet that person's needs,
14 and if it is not meeting those needs there's the ability of
15 the system to escalate to another model of care that isn't
16 just giving more of the same stuff by more of the same
17 staff, it's a very nuanced and different model of care that
18 has been shown to be effective and has been shown and
19 resourced to actually meet the needs of that population
20 group.
21
22 MS BATTEN: Dr Reilly, you've already touched on this
23 fourth-quadrant group, is there anything that you wanted to
24 add about the model of care?
25
26 DR REILLY: No, simply to say, I agree with what Dan is
27 saying and I'm not suggesting at the moment that I think
28 anyone's routinely in these services doing that well, but
29 it is clear that it does need to be integrated, and
30 therefore, in general it needs to be sitting with the
31 mental health system with that responsibility and at the
32 moment we're not taking up that particular challenge.
33
34 MS BATTEN: Okay, thank you. Dr Gruenert, is there
35 anything else you wanted to add to that layer of model of
36 care?
37
38 DR GRUENERT: By and large I agree with the comments that
39 Dan made and John made terms of the need for a model like
40 that. I think there are some examples where it is an
41 escalation point from drug and alcohol and they're just
42 starting to be trialled in Victoria with sort of an
43 enhanced residential setting. I don't think they've quite
44 got the capacity around mental health that are required to
45 really deal with the severe end there.
46
47 I think you've got two challenges in that

1 fourth-quadrant in the most complex group. One of them is
2 dealing with any initial and immediate needs around
3 withdrawal and, you know, where someone's drug and alcohol
4 use is so out of control that it's physically dangerous and
5 harmful for them and it needs to be carefully managed in a
6 way. Likewise, in mental health when someone's really
7 unwell, you know, the management of those systems and
8 containment for the person's safety is really critical.
9
10 But then we move into a different stage where, if
11 we've got a severe drug and alcohol issue and clearly this
12 has been problematic for them for a very long time and
13 merely going through withdrawal might have alleviated the
14 initial concerns and symptoms and safety for that person,
15 and you can do a whole lot of work with them, but unless
16 all those underlying issues are dealt with in a very
17 intensive way you're not going to get resolution, so I
18 think we do need to develop a much more nuanced response
19 there that really has equal input from across drug and
20 alcohol and mental health and is an escalation point for
21 the sector, because I think they'll be willing to take on a
22 lot more in their own sectors to do the best they can if
23 there is that back-up of an escalation point.
24
25 MS BATTEN: Thank you. Professor Lubman has suggested in
26 his witness statement that ideally integrated care should
27 be provided in a single service setting to minimise any
28 additional barriers to care.
29
30 So, the question is, is a single treatment setting
31 required in all mental health settings?
32
33 Professor Lubman, can I invite you to respond first.
34
35 PROFESSOR LUBMAN: Yeah, thank you. I suppose my comments
36 are largely related to an ideal state and really reflect
37 the issue that we shouldn't be segmenting and
38 compartmentalising people's issues into different - into a
39 whole range of different issues where they need to seek
40 treatment from multiple different treatment services and
41 providers in different environments.
42
43 The key thing is that we know that often, when people
44 present, they present with a whole host of issues and
45 they're looking for a solution from their treatment
46 provider and the challenge is that often we identify
47 multiple problems that we identify in that individual and

1 that we - because of the way in which our system is
2 designed, we tell the person they actually need to seek
3 help from multiple service providers rather than a single
4 service provider, so the issue is more about the system
5 response rather than what the individual's presenting with.
6
7 And so, I think the key principle that we all agree on
8 is that we should make, you know, seeking treatment as easy
9 as possible for the individual; that when an individual
10 presents, that their needs are ideally met in a single
11 setting. That might mean that we need to upskill the
12 workforce in those settings to be able to - at a base level
13 to be able to provide most of those persons' treatment
14 needs. It might need, in some situations we might need to
15 co-locate services and actually work together.
16
17 The important thing to say here though is that
18 co-location doesn't necessarily equate to integrated care,
19 because there's lots of examples where services co-locate
20 but actually still don't work together, so it's more about
21 how we commission services on the expectations of that
22 commissioning and how we monitor what services are
23 providing.
24
25 It's about, at an organisational level, the
26 inter-agency partnerships and treatment philosophies and
27 shared goals and it's about, at the service level, at the
28 staffing level, how we work together with our colleagues in
29 other fields to actually provide a much more seamless
30 treatment response.
31
32 So, for us the principle is really about ease of
33 access, treating the people where they're at, not making
34 the treatment more difficult by having them need to go to
35 multiple services to receive that need.
36
37 Obviously, we work in an environment where we can't
38 cover everyone's needs: there might be physical health
39 issues, mental health issues, substance use issues, housing
40 issues. It's going to be difficult to have all those
41 co-located or in one setting, but the principle that we
42 need to work towards is, we make it as easy as possible for
43 the consumer and we have those capacities in those services
44 to meet those persons' needs so that we can maximise their
45 engagement and ensure they have the best possible holistic
46 response.
47

1 MS BATTEN: Thank you. Dr Reilly, can I turn to you.
2
3 DR REILLY: Yes, look, I would agree and I think that
4 consumer choice can sometimes be the issue, and so, there
5 may well be circumstances where a consumer may prefer to
6 see two separate providers for what they are considering as
7 two separate issues, but that would be unlikely in most
8 instances if the consumer is thinking that the person who
9 they are seeing has the capacity to manage their problems
10 in an integrated way, you know, I would see that as not
11 being a likely scenario but of course it might happen on
12 occasion.
13
14 And I'd agree with what Dan's saying, I think that
15 there are inevitably some boundary points. We can think
16 that it would be good, for instance, for someone who's
17 got - say, who may also need treatment for Hepatitis C, for
18 chronic pain as well as for an opioid use disorder and has
19 a severe depressive disorder that they're seeking treatment
20 from. It's going to be very difficult for any one service
21 provider to make sure that they're addressing each of
22 those, and there are of course going to be some boundaries,
23 so it's really about trying to configure services in such a
24 way that they are most generalist whilst still providing
25 the appropriate levels of specialist care.
26
27 MS BATTEN: Thank you. Dr Gruenert.
28
29 DR GRUENERT: Yeah, when I was speaking to some young
30 people in preparation for this, some of them have said
31 things like, "My issues impact on lots of areas of my life,
32 my housing, my family, my relationships. There's drug and
33 alcohol issues, there's mental health issues, but I don't
34 see myself as complex. What's complex is the system and
35 the things, the hoops and hurdles I have to jump through to
36 try and get someone who can actually hold that picture of
37 me together."
38
39 I agree there's a tension between, you know, ensuring
40 all systems are generalist enough that they can hold that
41 picture, that they can do those assessments and identify
42 things and see a person as a whole person, whilst not
43 replicating every part of the system within, because
44 there's some real value in having some specialist systems
45 who are really key in what they do.
46
47 I think the issue of choice is important too, and

1 certainly we found that, whilst we have been able to
2 provide some vocational services for example to some of our
3 clients, they actually have a better experience when they
4 engage with a specialist vocational service who can be with
5 them for the long journey throughout their recovery and
6 help them find employment over multiple occasions rather
7 than feeling dependent on us who got them through the key
8 part of their journey. So, sometimes there is a value in
9 seeing a specialist, you know, a sexual assault counsellor
10 who really is at their peak of working on that particular
11 issue, but it needs to be based on a foundation of
12 generalist care where the case management and the treatment
13 planning and everything are put together in a way that
14 incorporates and considers and understands that whole
15 person and can sequence some of these things with them or
16 prioritise what you're going to work on and they don't feel
17 like they have to engage in so many different trusting
18 relationships.
19
20 So, as a general rule for most people single setting
21 is the ideal you're aiming for, but of course there's
22 exceptions and boundaries to cross at times.
23
24 PROFESSOR LUBMAN: Can I just make one (indistinct).
25
26 MS BATTEN: Yes.
27
28 PROFESSOR LUBMAN: I just wanted to give an example which
29 I think is really helpful.
30
31 We've been fortunate to be able to trial a whole range
32 of different integration models over the past 10, 15 years,
33 and the models that have the most success is when we're
34 able to embed workers in other people's services and create
35 models of care that actually work.
36
37 So for example, we had a pilot project where we were
38 able to put an alcohol and drug nurse in an inpatient
39 mental health unit for 12 months. So, that position was
40 supernumerary to the existing sort of mental health staff,
41 and they were there bringing addiction expertise. So they
42 were there to provide in-service training to the nurses,
43 they were there every day, so that they were there at
44 handover to be able to ask the question around substance
45 use, so became much more familiar in the assessments and
46 the management plan.
47

1 They were able to hand-hold people in the system in
2 terms of treatment of withdrawal within that setting, and
3 they were able to facilitate referrals out of the system to
4 the broader alcohol and drug system in which they work.
5
6 And that model worked really well. We saw a massive
7 increase in screening for substance use disorders, a
8 greater confidence in workforce in terms of managing people
9 with substance use disorders, we saw a greater number of
10 people who actually had good withdrawal plans while they
11 were in the inpatient setting and were actually linked to
12 services.
13
14 Then the funding ran out and within six months the
15 services returned back to what they were doing previously,
16 you know, in terms of not screening, not doing many
17 withdrawal plans, not linking the services.
18
19 So the issue is - and when we've had models where we
20 just fund a service, for example, to provide an addiction
21 nurse within the service setting, what inevitably happens
22 because of the budget constraints and issues within systems
23 is that, that position is only within that service and
24 isn't linked, we don't get that external linkage to the
25 other parts of the system. And then through budgetary
26 constraints what almost invariably happens is that person
27 gets absorbed into the general pool of nursing so that it
28 doesn't become a specialist position over time.
29
30 So for me there's really great examples of how we
31 integrate services by actually embedding workers within
32 each of the services.
33
34 We did another project where we had mental health
35 workers when I was working at Orygen in my team and we had
36 them embedded within YSAS and another youth alcohol and
37 drug service. Again, they were embedded, they actually
38 worked there, they were providing mental health treatment
39 to people who present at that service, so we trained up the
40 alcohol and drug workforce to do screening, to identify, to
41 build a capacity, and have a referral point for actual
42 treatment, and that worked, again, really well, increasing
43 people's confidence and capability in managing a whole
44 range of risk issues that they previously were not happy to
45 do and wanted to refer to the mental health system. So, we
46 were able to manage that within the system, increasing
47 people's capability and then the funding ran out and those

1 people left and we went right back to where we were.
2
3 So there's really great models of imbedding workforces
4 in our respective systems to actually create that
5 integration, to increase capability, to increase traffic
6 and trust and ability to refer across the system, so
7 there's really great models where we can do this, but it's
8 important that we work in partnership and we build on those
9 evidence-based principles.
10
11 MS BATTEN: Just quickly, other than funding, was there
12 anything else needed to sustain those kind of models?
13
14 PROFESSOR LUBMAN: I think, as I say in my
15 submission/witness statements, we've done a whole range of
16 work around what good integrated care looks like.
17 Integrated care is at four different levels: it's at the
18 commissioning level, it's at the organisational level, it's
19 at the service level, and it's on the ground with the
20 clinicians. So, funding is one component of that, but if
21 there isn't a commissioning framework that says this is a
22 priority for us and we're going to measure that, and if
23 there isn't an organisational priority that says we've
24 recognised that this is a really important way in which we
25 need to provide good care to our client group or to our
26 patient group, and we want to work in partnership with our
27 local providers, if there's not agreement at the service
28 level that we want to do this in terms of best practice and
29 we have models integrating that.
30
31 So, funding's obviously critical, but we have to have
32 all those other elements in because otherwise it becomes
33 just an ad hoc sort of individual response that's not in
34 any way systematised, so we have to think about, you know,
35 the entire system and all those different elements to make
36 sure it remains a success and is not dependent on
37 individual personalities.
38
39 MS BATTEN: Did anyone else want to comment on anything
40 that Professor Lubman's just said before I move on?
41
42 DR REILLY: No, perhaps later.
43
44 MS BATTEN: Thank you. We were talking before about
45 single setting care, so the next question is: are there
46 viable alternatives to fully integrated or single setting
47 care in certain mental health settings?

1
2 So, Dr Reilly, perhaps if I turn to you first, are
3 there viable alternatives.
4
5 DR REILLY: Yeah, look, of course there are viable
6 alternatives. I think along the lines - in a sense when
7 I'm talking integrated care, I guess what I'm saying is
8 that a team or a clinician is providing that care fully by
9 that clinician or within that team.
10
11 Now, then it comes down to, well, are you expecting
12 that clinician, therefore, to have all of those skills or
13 are you expecting that it might be something that works
14 across, say, perhaps a wider multidisciplinary team. And I
15 think, if you go with the latter, then certainly it's
16 possible for people to have portfolios of particular
17 interests, and I think that the examples that Dan just gave
18 are kind of examples of that, where you're perhaps
19 suggesting that in a team, whether it's a community team or
20 an inpatient-type service, that perhaps someone's got a
21 portfolio.
22
23 I think the challenge though then with that still
24 becomes that there's always the risk that, if it's not
25 fully integrated but there are people - that it's kind of
26 compartmentalised to some degree, there is the risk that
27 others still tend to see that as being someone else's
28 responsibility rather than assuming full responsibility,
29 and that means that in their individual clinical
30 interactions in other contexts perhaps that doesn't work.
31
32 So, I think that it is possible but I'm just not, you
33 know, I would see that you would have to be really clear
34 how it's going to work, what the requirements will be if
35 you're going to separate it out and not have that as an
36 expectation that all mental health clinicians should
37 actually be capable of managing in an integrated way.
38
39 MS BATTEN: Okay, thank you. Dr Gruenert, can I turn to
40 you next.
41
42 DR GRUENERT: If I pick up a point that Dan raised early
43 on, that one of the most powerful tools we have in the work
44 we do in the drug and alcohol sector, and I'd argue in many
45 parts of the mental health sector, particularly the
46 psychosocial end, is the capacity to engage with people and
47 be there as a sort of non-judgmental credible person.

1
2 This is often one of the biggest issues and one of the
3 biggest difficulties for many of the people seeking our
4 help, because they've had their trust damaged on so many
5 occasions and they've struggled with their relationship
6 skills.
7
8 We know in sustainable recovery from both drug and
9 alcohol and mental health issues, that positive, strong
10 relationships and relationship skills are one of the key
11 predictors of long-term success.
12
13 So, if we're trying to assist someone who often comes
14 with all sorts of issues, damaged relationships, difficulty
15 in trusting, the biggest challenge is establishing a
16 relationship with someone where they can build that trust
17 and build those skills, and this is also why so many peer
18 support programs work particularly well, because they can
19 share the ideas and thoughts and go on that journey
20 together with other people that have had similar
21 experiences, at least as part of their treatment.
22
23 So again, regardless of the model you're using,
24 whether it's co-location, whether it's embedded staff in
25 one service, whether it's a highly skilled generalist
26 that's got the multiple skills, I think the aim is really
27 trying to minimise the number of different people, or even
28 if it's a multidisciplinary team where there's multiple
29 different specialities, of course you're going to have
30 better specialists in a multidisciplinary team and each one
31 of them will be better at their particular thing than just
32 one generalist. But we always come back to this point of
33 trying to limit the number of people and different contact
34 points that someone has to engage and develop that
35 relationship with in order to receive their care, their
36 understanding, their assessment, at least initially.
37
38 So, I think all of us would agree that these are
39 issues people have been struggling with for ages, I don't
40 think there's a perfect solution just sitting there ready
41 for us to go - people have tried many different ways of
42 approaching this, but I think it is a fundamental that we
43 need to limit the number of people they're having access
44 to, or that are delivering that care, and the more we can
45 support that person or that team of people with help the
46 better, whatever the model looks like.
47

1 MS BATTEN: Okay, thank you. Professor Lubman, do you
2 think there are viable alternatives to fully integrated or
3 single setting care?
4
5 PROFESSOR LUBMAN: I mean, I think there's not much really
6 to add to what Stefan and John have said. I think the
7 principle is there, I think we're a long way from that, I
8 think there's steps along the path in terms of how we can
9 get there.
10
11 For me, it's not integrated care, for me it's just
12 good care. It's how do we provide good care, and the
13 integration is really around, what are the different
14 support systems around that that we can build in to create
15 a much more optimal experience?
16
17 So, in terms of providing good care, yeah, we should
18 definitely be providing good care in every setting. How do
19 we integrate some of the specialist services together to
20 actually create a much better treatment experience?
21 There's certainly lots of models out there that we can draw
22 on and I think there's a lot of literature out there of
23 what does work.
24
25 And I suppose it's around - I think one of my biggest
26 frustrations in the system is that - is we don't recognise
27 when we're not doing a good job. So, when people are
28 struggling in the system, we don't really have good
29 mechanisms of escalation, I think it comes back to this
30 again. So, when something's not working, the system - it's
31 very difficult for the system to step back and ask what is
32 wrong with the system. You know, very much it's about the
33 individual, so, the individual isn't motivated, the
34 individual isn't responding to treatment, the treatment's
35 not working, the medication isn't working yet.
36
37 But sometimes it's about the system not actually being
38 the right system for that individual, and we don't really
39 have mechanisms to step back and ask, you know, how can we
40 nuance the system, or what different system approaches can
41 we take to actually meet the needs of that individual and,
42 you know, we're often left having a very generic service
43 model that we just plant everywhere.
44
45 So, for me one of the biggest things out of this is,
46 how do we think about recognising that different people
47 need different things, and we need to work out how we

1 provide the best quality response for the person, for them,
2 and we need to recognise when it's not working and we need
3 to work out how we escalate to different models that might
4 be better.
5
6 So for some people we might say, they might have
7 severe mental illness, but actually they're going to do
8 much better in some of the alcohol and drug spaces with the
9 right support, or they might be better in the mental health
10 system with a bit of alcohol and drug support.
11
12 I think we direct traffic based on what the services
13 thinks best, not what the individual thinks best, and I
14 think really that's a challenge I think for all of us to
15 think about how are we to design a system that actually
16 best meets the needs of individuals and best gives them
17 what they need to optimise their health.
18
19 MS BATTEN: As the Chair said, the Commission is speaking
20 directly with people with lived experience to understand
21 their perspective, but in your experience what are the
22 benefits of an integrated experience at the frontline for
23 consumers?
24
25 Dr Gruenert, can I ask you that question first.
26
27 DR GRUENERT: Look, I think we've touched on many of the
28 benefits already. I think for a consumer to have a single
29 touch point, to tell their story once, to have their - who
30 they are as a person and what they're struggling with
31 understood without having to compartmentalise, it is a much
32 more satisfying and rewarding experience, and it's also
33 rewarding for the staff when you can actually see people
34 achieve success and make steps in their journey when it's
35 done in that particular way, and I think the outcomes are
36 typically better.
37
38 I think Dan's point is really critical. We employ a
39 lot of staff with a lived experience in our services, and
40 one of the biggest things we have to do during that
41 orientation phase is to help them understand that, what
42 worked for them doesn't necessarily or isn't necessarily
43 going to work for everyone else who accesses the system.
44 So, for some people it's the pharmacotherapy that was the
45 thing; for some it was those peer support groups; for other
46 people it was the sort of psychological strategies or
47 repairing a relationship, and it's really important that we

1 do have the diversity and we encourage and nurture that
2 across our systems to allow that, both the choice of the
3 consumer and often they make a lot of choices. Sometimes
4 the system tries to feed them in one particular direction
5 but they often come with a clear idea of what they want or
6 what they think will work for them, and if we have a system
7 that does acknowledge that, then it's a much more
8 satisfying experience for the consumers.
9
10 MS BATTEN: Dr Reilly, is there anything that you have to
11 add to that?
12
13 DR REILLY: Perhaps just that, I think Stefan highlighted
14 before relationship, and if you've got integrated
15 experience, then you've got a greater capacity then to
16 focus on maybe building a relationship with a person who's
17 going to be actually taking a more comprehensive and
18 holistic perspective rather than separating out and telling
19 you to go off and see at least two different services, that
20 obviously enables you to engage.
21
22 I think it minimises - potentially at least, it
23 minimises duplication and allows you therefore to have a
24 more comprehensive whole perspective on that person from a
25 service point of view and I think consumers can feel that
26 if that's done well.
27
28 MS BATTEN: Thank you. Professor Lubman, is there
29 anything that you wanted to add to this question?
30
31 PROFESSOR LUBMAN: Yeah, I mean, I think we've covered a
32 lot of it here but I just wanted to emphasise what Stefan
33 raised around staff.
34
35 I mean, a lot of the time that we get involved in sort
36 of working with services to look at complex clients, which
37 as we've already heard is less about the complexity of the
38 individual but the complexity of the system. You know,
39 staff are often very frustrated because they don't know
40 what to do, they don't have the capability, the skills,
41 they're often left with somebody who's not getting well,
42 and staff can feel very frustrated because they don't know
43 what to do and then there is a tendency to blame the
44 individual for that lack of response.
45
46 So, for me, working in this integrated space and
47 having worked with a whole range of workforces in terms of

1 building their capability and providing that level of
2 support, I think one of the most remarkable things is to
3 see the level of optimism and hope return to the workforce,
4 and that then gets dissipated, you know, to clients and
5 families.
6
7 I think the most frustrating thing is, if the staff
8 and the service don't know what to do, that from a client
9 and family point of view when they're coming to that
10 service and they're getting a response which is
11 essentially, you know, the frustration of the service not
12 knowing what to do, you know, I think that's a terrible
13 experience for clients and families. And, families are
14 struggling, they don't know what to do often with the
15 substance use, they don't know how to respond, they're
16 looking for professional advice around what to do, and if
17 the service also doesn't know what to do, they don't know
18 how to properly support the families to actually provide
19 the best and optimal care to the individual.
20
21 So, an integrated response is, you know, critical at
22 so many levels, and it's critical really in terms of
23 re-energising the system in terms of building its - you
24 know, hope. Really, you know, hope is lost a lot in the
25 system because people don't know what to do and they feel
26 stuck, so we want to engender a system that actually
27 promotes hope. We've got to make sure that staff
28 themselves feel confident that they know what to do and
29 that they have options available to them.
30
31 MS BATTEN: Thank you. Finally, in terms of addressing
32 people's needs, the question is: is a different approach to
33 integrated care needed for young people?
34
35 Professor Lubman, I might stay with you. In your
36 view, is a different approach needed for young people?
37
38 PROFESSOR LUBMAN: I think at a broad level it would be
39 fair to say, no. I think good integrated care where we're
40 meeting the person where they're at and we have the right
41 level of supports for them I think is critical. Obviously
42 there's a number of youth relevant models because of, you
43 know, developmental stage, or age, or how we better
44 integrate families at that stage, I think, might be key.
45
46 But I think broadly, no; no, I don't think there is
47 differences. There's differences obviously in the type of

1 substances young people use, in how they might present, in
2 how they might engage; we need to bring in developmentally
3 relevant evidence-based strategy around that, but in terms
4 of the principle of integrated care and access, I don't
5 think there's much difference in terms of what we've been
6 saying.
7
8 MS BATTEN: Thank you. Dr Reilly, do you have a comment
9 on the models for young people?
10
11 DR REILLY: No, I'd emphasise - sorry, echo what Dan said,
12 and therefore the only comment would be that it's perhaps
13 recognising that young people then are sometimes dealing
14 with different service systems, sometimes related to how
15 health sets up or mental health sets up, and therefore if
16 we're talking about other aspects of culture and workforce
17 it's important to be as holistic as possible in our
18 thinking because it might be a different group to the ones
19 that we're proposing to think about.
20
21 MS BATTEN: And, Dr Gruenert?
22
23 DR GRUENERT: Echo those comments, no difference to the
24 approach or broad philosophies, the way they're implemented
25 can be completely different to make sure they work with
26 young people.
27
28 The point I'd add to all of what's been said is, for
29 young people it's critical to have - engagement's critical
30 - and you only get that with credible staff who can
31 understand and, I guess, feed back that experience to the
32 young people and because, without that engagement, you're
33 not going to get the effective partnership approach and the
34 motivation and compliance, or the working together around
35 the implementation of all the treatment goals and things
36 that you've got.
37
38 The second thing I think that's possibly in its
39 implementation is slightly more of a challenge or different
40 is the way we work with families alongside young people.
41 Obviously families are important for people anywhere across
42 the spectrum including with adults. You know, they're an
43 untapped resource and the service systems don't
44 particularly integrate the work with families particularly
45 well across the spectrum.
46
47 It's particularly critical for young people - so much

1 of the pathway that they're on can be alleviated or
2 diverted if we can get the relationship with families.
3 Now, that's a real challenge for many people working with
4 young people who are often a younger age, because that
5 engages well with young people, and therefore they often
6 don't have quite the experiences around parenting or
7 working with families, and they often have a lack of
8 confidence in doing that.
9
10 So, I think the family work is really critical with
11 young people, but broadly the approaches are the same, it's
12 just how they're implemented and nuanced in the youth
13 models.
14
15 PROFESSOR LUBMAN: Can I just add (indistinct)?
16
17 MS BATTEN: Of course.
18
19 PROFESSOR LUBMAN: I suppose one of the challenges we
20 often see in some parts of the sector is, you know,
21 obviously with young people, you know, and their strive for
22 independence at a critical age, that some experiences with
23 staff that we see in these services can misconstrue the
24 independence as independence from family and supports, and
25 there can be tensions in terms of, you know, how do we best
26 engage that family in providing that critical support
27 setting around them.
28
29 So, the young person might say they don't want to have
30 anything to do with their family, but we know from working
31 with people that getting their family to re-engage and
32 building those supports is critical for that person's
33 long-term recovery. But if you're - you know, as Stefan
34 says, one of the issues we'll come onto is around
35 capability in workforces, but if you're an inexperienced
36 worker who doesn't come and isn't trained in family-based
37 approaches, you know, they can inadvertently make the
38 situation worse by siding with the young person and
39 actually working against the family rather than with the
40 family, and I think that's really critical in terms of when
41 we think about our models of care and when we think about
42 the capability of the workforce; sometimes we underplay the
43 important role and skill set around family-based practices.
44
45 MS BATTEN: Dr Gruenert and Professor Lubman, you've both
46 mentioned different engagements, young people engage
47 differently, what does that mean in terms of providing

care, how do you better engage young people then?

Sorry, Professor Lubman, can I turn to you first.

PROFESSOR LUBMAN: So, I suppose often when we see people in the adult space, we're seeing people who have struggled with problems for a long time, and have had lots of reflections about what's going on with them, and in some ways more articulate around their needs and what they're looking for.

Often for a young person there's a lack - you know, there's obviously a lack of life experience, there's a lot of things going on for them that can be extremely bewildering and confusing, and it can often - you know, they can often - it can often be difficult for them to articulate what they really need.

So, the big difference I think in young people is around how you meet the person where they're at, you know, particularly for the young person, and find some common ground, and identify an issue that they want to work on. So, it's about identifying the issues that they want to work on and being able to work on that.

So for them that might be something around studying, or school, or work, or housing or Centrelink payments. The critical thing is, it might not be working on their alcohol and drug or mental health issues in the first instance because for them that is not the priority that they see. You know, it's that flexibility to be able to build that relationship by identifying what are the one or two issues that they think are the priority that they need to work on, and by demonstrating that you can actually be helpful in that space and actually do something for them, that builds that level of trust that actually you might be a useful worker to work alongside, and that then allows that broader conversation to develop around those other issues that you're trying to target.

So it's that flexibility to not just be focusing on the clinical response which is important, because for that person that might not be their priority and it might not be something they're ready to engage with; it's that ability to have that broader panacea to build that trust so that you can actually address the real issues that are underlying where that young person is struggling.

1
2 MS BATTEN: Thank you. Dr Gruenert, is there anything
3 that you wanted to add to that?
4
5 DR GRUENERT: Agree with Dan's comments, but I would add a
6 couple of things. This is a real classic example of where
7 there's a tension, and there's many parts of the system
8 where it's finding the balance of the tension that works
9 really well.
10
11 And the tension I'm talking about is that, we know
12 sort of supportive counselling or aligning yourself with
13 where someone's at is the best way to engage someone but it
14 doesn't necessarily bring about change. And we know the
15 psychoeducational things and setting boundaries and having
16 a sort of challenging dialogue can be really effective in
17 bringing change, but people lose engagement and they drop
18 out of treatment and that doesn't work either.
19
20 So, the best way this is done is where you have those
21 two things in tension with each other, and we've all heard
22 of examples of services where it's all about sport and
23 recreation, rock climbing and fun staff, Hip Hop, dance
24 classes, whatever, spray painting, and if that's all it is,
25 sure people will come along but there's nothing that's
26 actually taking them to the next level.
27
28 And vice versa, a service that's based on a whole lot
29 of evidence of the actual interventions and tools, you
30 know, if young people aren't getting there, then it's not
31 effective either, so it's walking that line.
32
33 The one point I would make that we've found most
34 effective, it's not just with young people, but it's
35 particularly there: the people most likely to engage
36 someone and take them to the next level are the people with
37 a lived experience who (indistinct - audio malfunction).
38 So, if we can take someone who has been there fairly
39 recently who can understand where someone's at but has
40 moved through it, they are the best person to identify
41 exactly what's going on for someone, use the right language
42 for them, and so, in some ways asking us or asking me as an
43 expert what's going to engage young people is probably not
44 the - I can share my observations, but we've got to ask
45 young people.
46
47 And I totally agree with Dan, we've got to start with

1 what they want, what's their priority and their goals and
2 their dreams to build that relationship, and over time we
3 need to then put the things in place that we know are going
4 to bring about change.
5
6 And at times when a young person is out of control,
7 you know, the voluntary system doesn't do that, and we see
8 people cycle around, they're given lots of opportunities to
9 engage, they simply don't, and I think there is some place
10 for a non-voluntary front-end to the system that, when
11 people come out the other end say, they can acknowledge I
12 was out of control, I needed someone to pull me up, and I
13 can see how I was going downhill in a particular direction
14 but at the time I couldn't see that. So, it is a tension.
15
16 MS BATTEN: Thank you. Dr Reilly, was there anything that
17 you wanted to add to engaging young people?
18
19 DR REILLY: Sorry, can you hear me still?
20
21 MS BATTEN: Yes, I can, thank you.
22
23 DR REILLY: Suddenly I muted everyone, it seems.
24
25 MS BATTEN: That's okay, I can hear you.
26
27 DR REILLY: So I think what I would say there is, in
28 response to what Stefan just said though, I agree it would
29 be great, it's just a bit difficult to see how you would
30 govern that issue of the involuntary treatment at the
31 front-end for those problems but fascinating to see.
32
33 MS BATTEN: The next topic is governance, and I'm just
34 noticing the time, so I might give you a break now rather
35 than break-up the governance topic. So, I'll give you a
36 break for 10 minutes and then we'll come back with the last
37 topics: governance, workforce capability and prioritising.
38 Thank you very much.
39
40 **SHORT ADJOURNMENT**
41
42 MS BATTEN: Thank you. The next topic is governance. The
43 first question is, how could Victoria integrate governance
44 and policy of mental health and Alcohol and Drug Services
45 at a departmental level?
46
47 Dr Reilly, can I ask you that question first, please.

1
2 DR REILLY: Sure. Look, I don't actually know how down
3 in Victoria because I'm not really familiar with how its
4 Department of Health works, but clearly it's all within a
5 Department of Health, the Departments of Health are
6 configured in various ways and of course they do at times
7 with regard to governance shift branches and divisions or
8 whatever within them.
9
10 So, I think it's really - the key issue is a clear
11 decision at the level of, you know, the Executive of the
12 Department and the Minister that that's a policy position
13 that the Government and then the Department wants to take
14 forward, and then it's considered what are the issues
15 associated with that and I think if that happens then it's
16 actually a comparatively straightforward matter.
17
18 The Queensland experience essentially was that, I
19 think it was more at a departmental level but obviously
20 with Government approval, and I think the challenge then of
21 course then becomes one issue particularly perhaps that
22 alcohol and drug services - or alcohol and drug policy
23 relates to perhaps more the prevention aspect and that
24 there are some larger issues that sit within Health but
25 outside more clinical service delivery policy, and so those
26 challenges need to be considered in such a decision. So,
27 that's all I would say at this point.
28
29 MS BATTEN: Sorry, just to keep you for a second. From
30 your perspective what would the best model of integration
31 look like in terms of governance and policy, maybe
32 reflecting on what Queensland's done and what's worked well
33 there?
34
35 DR REILLY: Sure, well, the Queensland decision was
36 essentially that the clinical aspects of AOD policy needed
37 to be linked with mental health policy and commissioning,
38 and so they were connected up, and so it is a mental health
39 and alcohol and other drugs branch and I'm in that Chief
40 Mental Health Alcohol and Drugs Officer role, but that's
41 comparatively new and that links to the Chief Psychiatrist
42 role.
43
44 So I think the issue is that there's overarching
45 governance across both mental health as well as alcohol and
46 other drugs sitting at a particular point, because that
47 creates the incentive then for integration at other levels,

1 in my mind at least, and a clear understanding that's the
2 case.
3
4 You can then have separateness further down, because
5 there are still a whole variety of things that will have to
6 be dealt with separately. Certainly, even if there was a
7 clear decision you wanted to integrate everything, you'd
8 still have to do a very graduated progress of changing
9 commissioning funding and the structures, and I'm not
10 suggesting that, just saying it would require that kind of
11 machinery change and that would be difficult.
12
13 So I think it's about how you just make sure that at
14 the policy inter-planning level that those things are
15 considered always together rather than being completely
16 separated out.
17
18 MS BATTEN: Okay, thank you. Professor Lubman, from your
19 perspective what would be the optimum model of integration
20 of governance and policy and at the departmental level?
21
22 PROFESSOR LUBMAN: I think as we've all been saying, you
23 cannot treat the mental health issue without treating the
24 alcohol and drug issues. For me that means a single
25 Department that overseas both the mental health and the
26 alcohol and drug sectors, and which oversees things like
27 performance, planning, quality, policy development.
28
29 Now, it's critical that there's a shared vision around
30 the mental health and wellbeing of Victorians and, you
31 know, as I say clearly in my submission, alcohol and drug
32 issues/addiction is a mental health issue so it needs to
33 sit within that framing of other single departments. So,
34 that's commissioning, oversight, performance and quality
35 issues.
36
37 I think the other point I want to make though, that
38 while that's at the commissioning and policy level, I'm
39 also very clear that the systems need to be separate. I
40 think as we've already discussed, that there's marked
41 differences in the populations that they serve, the
42 treatment philosophies, the approaches they take.
43
44 And so for me, while we have an oversight and a single
45 governance and a single Department, the systems themselves
46 need to be commissioned and oversighted separately but
47 within that overarching framework.

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Because I think, you know, as I say in my witness statement, the examples - obviously John can talk about Queensland - but certainly in other areas the mental health system is such a much bigger beast than the alcohol and drug system and, you know, obviously with a whole range of drivers around demand and around risk and around a whole range of other issues, the major risk is that the alcohol and drug system becomes subsumed within the broader mental health system and I think it's really important that we keep them distinct and keep them separate because of their separate workforces and approaches and interventions and philosophies.

The other thing to say about governance that I've said in my witness statement is around the role of quality and safety. The Chief Psychiatrist's office obviously plays a really important place in oversighting critical incidents and safety issues and really plays a critical role of building the effectiveness and the safety of the system. That is currently absent in the alcohol and drug space. We don't have a mechanism at a system level for oversighting critical incidents and reviewing safety issues, identifying innovation and documenting that and evaluating and sharing that across the system.

So there needs to be a mechanism, like there is in Safer Care Victoria for the broader health network and within mental health within the Chief Psychiatrist's office to actually look at system oversight, look at critical incidents, look at issues of quality and safety and ensure that we're continuing to improve and that there's a culture of quality improvement and there's key lessons there to learn around how we approach different issues.

I sit in on a number of committees on the Chief Psychiatrist's office around critical incidents, morbidity and mortality, complex cases, and, you know, 90 per cent of all of them involve alcohol and drug issues and yet I'm the sole representative from the whole system.

You know, what constantly comes up is issues in terms of system integration, issues to do with capability, issues to do with monitoring and quality indicators, so there's a really important opportunity to bring that quality and safety component within the governance structure so that we can ensure that we continue to build the effectiveness and

efficiency and safety of the system.

MS BATTEN: Thank you. And, Dr Gruenert, from your perspective, what would the optimal model of integration look like at the governance and policy level?

DR GRUENERT: I think this is a really interesting and difficult area and it's probably the one that we have had the most struggle even as a panel and probably areas of disagreement around.

I would agree with everything Dan has said around the potential for integration at the departmental level, and I think in theory that should work, but I'm less convinced, and I'm less convinced because history internationally and history from my colleagues in New South Wales and Queensland continually tell me of its failings, and that may be as much in the implementation as in the actual - you know, the intention.

So, I think in theory there should be the capacity for integration under a Minister, under an Executive at the Department, as John was discussing, that has responsibility for both those areas, and that they're integrated in a way that has a shared vision and where, particularly the quality, as Dan was saying, the quality mechanisms and processes that exist in mental health which don't in drug and alcohol could really enhance other services in the systems and the planning happens together.

The issue for me is, fortunately in Victoria we have a Department of Health and Human Services, and I think the Human Services part of the Department has a really important part to play in the treatment of people with both mental health and alcohol and other drug issues when you're looking across the whole spectrum of that.

And so, one of the criticisms about the way it's often done in the departments is that there's not a broad enough perspective; it can take a sort of pure medical or psychiatric role at the expense of the lived experience and psychology and other things.

Now, if you've got someone who can really practise it or does understand holistic medicine and the broad - you know, that ideal, then I think that definitely will improve the way the governance is done, but often that's not done

1 and it's tokenistic, and I think the points Dan made around
2 the size difference between the two Departments, or even if
3 they're distinct areas within a sort of an integrated -
4 even at the Department level, they can get swamped and that
5 again has been the experience of colleagues in other states
6 where the policy's often just developed in mental health
7 and it's AOD's consultation feels tokenistic or you're
8 always trying to fit a mental health policy into a drug and
9 alcohol setting.
10
11 And if I could use an analogy to describe what often
12 happens: I talk about clothing, so we could all agree that,
13 you know, tops and bottoms that we wear are important,
14 they're both clothes. Most people tend to try and
15 integrate their clothing between the top and the bottom,
16 sometimes the style, the colour, or for a particular
17 climate. My kids always insist on only having shorts on
18 the bottom so they can play sport and it's fit for purpose,
19 whilst they'll wear some pretty warm tops, and so, the
20 choice around what people want in those areas is different.
21
22 But, no matter what you do to a top, you can't stretch
23 it or cut it or squeeze it to suddenly become shorts or a
24 pair of pants. And it's even worse if the emphasis of the
25 top you're wearing is just a winter coat and a jacket, and
26 I'm thinking of the sort of clinical tertiary part of the
27 mental health system, trying to turn that into a pair of
28 shorts.
29
30 And so, we really need to make sure that the responses
31 are fit for purpose and that the thinking, even on policy
32 development, it isn't tokenistic and it has a broad
33 representation to make sure that, yes, we're dealing with
34 the quality of the clothes, you know, we want good shorts,
35 but we don't need ski pants for someone who just wants
36 shorts, they just need to be good quality shorts, and if
37 they tear or rip we want to make sure they're built with
38 the same quality of the fabric of the top and that we're
39 thinking about the design with similar processes and ways
40 but we're not trying to refit them.
41
42 That's in my experience what often happens in the
43 implementation. So, I agree in theory, I'm less convinced
44 as having seen it done well.
45
46 DR REILLY: Could I just comment?
47

1 MS BATTEN: Yes, of course.
2
3 DR REILLY: Because there's differences, this is probably
4 the area where we had most disagreement. I guess just to
5 highlight, I think there's always challenges with regard to
6 where you draw the line about how things are integrated, so
7 there's no question, there's no right way to do that, it's
8 about what's going to work most effectively in a particular
9 scenario and who's prepared to push that.
10
11 There's no question that AOD services are going to
12 feel they're the small brother if they are integrated
13 within a wider mental health system that's larger, but I
14 also think there's lots of benefits to be gained from that
15 as well, which I accept, do require though a good
16 implementation, effective implementation of that whilst
17 looking after those interests.
18
19 I think though, we all certainly think, is it really
20 such a unified mental health sector? There's marked
21 variation with regard to, for instance, the way in which
22 child and youth services or perinatal services or some
23 older person services or specialised eating disorder
24 services work within a Health Department and within a
25 Mental Health Department or branch, and I don't think that
26 seeing AOD as a kind of subspecialty area within such a
27 wider more integrated mental health and alcohol and drug
28 branch is necessarily all that different.
29
30 I think also Stefan highlights that there are still
31 issues with regards to what's perhaps more clinical
32 healthcare as opposed to non-Government-led healthcare, and
33 there's no question that Departments are doing funding out
34 to different types of services, and again, we've probably
35 brought those together and we haven't sort of come out
36 always with the specifics of that.
37
38 So, there's no question there's challenges and I don't
39 think there's any absolute way to do those things.
40
41 MS BATTEN: Dr Reilly, just to stay with you, in terms of
42 the potential adverse impacts for the alcohol and drug
43 sector being overwhelmed by the mental health sector, what
44 kinds of things has Queensland done to kind of guard
45 against them and maintain the position of the alcohol and
46 drugs sector?
47

1 DR REILLY: Sure. I think the issue is perhaps having
2 clear responsibility for that sitting with an Executive
3 who's got that responsibility where there's a recognition
4 that's really important; that is, that looking after the
5 integrated alcohol and other drug services is important,
6 and I wouldn't necessarily disagree in what Stefan's saying
7 that Queensland has done that extremely well, but I think
8 that's something that we're continuing to look at and, once
9 that's consolidated, that change, then I think that helps
10 to highlight that this is an ongoing need to be looking
11 after the AOD service system in the same way.
12
13 I think the only other thing I would say which I've
14 said previously is, in Queensland we've obviously got
15 fairly structured hospital and health services as our local
16 health networks. There's only 16 of those and they are,
17 you know, independent; that's where the funding goes out
18 to, and each of those has their responsibility for both
19 their mental health and alcohol and other drug services
20 being integrated under an Executive Director or equivalent.
21 Obviously there's a Chief Executive and a board, they also
22 have the responsibility for ensuring that AOD services are
23 being looked after within their HHS in the same way as
24 mental health services.
25
26 So I don't think it's just a departmental issue. But
27 that then raises the issue of linkages with PHNs and then
28 commissioning of NGOs, and there's no question that, in
29 that regard, because of the way in which AOD services are
30 structured, NGOs, there's not that sense of an area-based
31 approach to quite the same level that there is historically
32 in mental health services, at least in Queensland.
33
34 So, I think there's a lot of aspects of that question,
35 a lot of things that need to be considered and a
36 recognition, and I believe it might be more the case in
37 Victoria, that perhaps there's a misalignment and it's
38 difficult to get planning to cohere across LHNs, mental
39 health services, AOD services, both clinically as well as
40 with regard to non-Government organisations being
41 commissioned.
42
43 And, given that you've had a fairly different service
44 system over time than perhaps Queensland's, there's no
45 question that there's quite a challenge with trying to make
46 such changes, and my observation over time has been, that's
47 been quite a significant challenge purely from mental

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1 health services. If you're then also then going to try and
2 align AOD services up on that checkerboard, then obviously
3 it brings significant additional complexity.
4
5 MS BATTEN: Thank you.
6
7 PROFESSOR LUBMAN: May I offer one point?
8
9 MS BATTEN: Of course, Professor Lubman.
10
11 PROFESSOR LUBMAN: Sorry, quickly just echoing what other
12 people have said, I think one of the challenges that's come
13 up during COVID - I mean, I think COVID has been really a
14 great illustration of what works and what doesn't work.
15
16 So, what really happened during COVID was, what we saw
17 was the mental health system sitting within a part of the
18 Department that thinks of it as a system, was able to step
19 up and create a whole range of responses that recognise
20 what the system was and recognise the different components
21 of the system.
22
23 The alcohol and drug system at the moment sits within
24 the community portfolio of the Department of Health and
25 Human Services, alongside community health centres,
26 paediatrics, dentistry, opticians, all the other parts of,
27 I suppose, other industries that actually don't work as a
28 system, they're all independent - essentially independent
29 businesses that sort of provide services but don't work -
30 there's no sort of comprehension of that as a service
31 system and how the different parts of the service system
32 operate.
33
34 And I think that became really evident during COVID,
35 that while the sector wanted to mobilise and think more
36 from a sector perspective, the structures in place because
37 of where it sat within a Department was not able to move as
38 it could have - as it did in other parts of the health
39 system.
40
41 And I think for us, you know, the issue in terms of
42 commissioning and where the benefits would lie sitting more
43 in that mental health space is thinking about service
44 models. So, at the moment the way the service is
45 commissioned in the alcohol and drug space are as widgets
46 that are agnostic to service models.
47

1 A good example of that is an area that we're working
2 on together around the issue, for example, of residential
3 services. So, we have detox services across Victoria that
4 are funded, but there's no - but each of those services
5 operate in very different ways, and there's strengths in
6 that, but that is not through a process of being planned,
7 that we have these planned different services with
8 different staffing profiles, different models of care,
9 different entry criteria, that's not planned from a system
10 point of view, that's just how they evolve, and yet we
11 expect people to try and navigate that system and
12 understand what that system is without any sort of system
13 design and planning.
14
15 So for us, particularly in the alcohol and drug space,
16 we would really welcome sending in a Department that had a
17 broader thinking around service and system design to think
18 about what the multiple needs of different client groups
19 and families actually are and how we actually configure the
20 system to build on the strengths within the system rather
21 than it being an ad hoc system where it's, you know,
22 essentially a coin toss around what the response is going
23 to be where you present.
24
25 DR REILLY: Could I just make an additional comment,
26 sorry?
27
28 MS BATTEN: Yes.
29
30 DR REILLY: And I guess just to follow on from Dan's
31 point, so perhaps to highlight that, is that, because in
32 Queensland we've been trying to plan using the National
33 Mental Health Service's Planning Framework for mental
34 health services and have seen the benefits of being able to
35 do that so that we get greater consistency across the
36 state, I think that because we've got a combined branch,
37 integrated branch, what the - so, the same people are
38 responsible for planning of AOD services as for mental
39 health services, and they have been taking the lead in
40 trying to set the DASPM up, the Drug and Alcohol Services
41 Planning Model, in a sense to catch that up so that it's
42 going to work in a similar kind of way to the National
43 Mental Health Service Planning Framework in Queensland.
44
45 So I think that that's an example of the benefit of
46 the integration of recognising that this is something that
47 mental health's doing that actually drug and alcohol

1 services would benefit from, and where I think that will
2 also add the capacity then to start having those two
3 aspects talking together.
4
5 Just with regard to Dan's specific example, because
6 we're an integrated branch, because we've got clinical
7 services within our HHSs, AOD clinical services, we
8 essentially were able to address alcohol and other drug
9 issues, at least for the HHSs, in exactly the same meeting
10 structure as we were doing - it was mental health alcohol
11 and drugs, it was completely integrated, we were
12 considering opioid-related issues at the same time as we
13 were considering aspects of clozapine, for instance.
14
15 We did have some separate meetings with regard to AOD,
16 just to sort of hone in on those more specifically, but
17 there were certainly lots of advantages for us in being
18 able to do that.
19
20 MS BATTEN: Thank you. Just in terms of this integration
21 of governance and policy and, Professor Lubman, your
22 comment that the AOD sector is much smaller and can be
23 swamped, what are some of the adverse impacts that
24 integration at that level could have on the AOD sector and
25 what could be done to address those adverse impacts?
26
27 So, Professor Lubman, I might ask that question to you
28 first.
29
30 PROFESSOR LUBMAN: I mean, I think what we've all touched
31 on is this issue around a, in some ways homogenisation of
32 processes and policies and pathways in clinical care. I
33 mean, that's the biggest risk, is that, having worked
34 within an alcohol and drug service within a mental health -
35 under a mental health director, you know, what became
36 really clearly evident is that our mental health colleagues
37 didn't really understand what we did or how we operate; and
38 because they're managing a large mental health program, you
39 know, they don't have the time or focus to be able to
40 understand those nuances in the system.
41
42 And so, what we saw time and time again was, you know,
43 a policy was developed in the mental health program, it was
44 then sent over and say, well, this is going to be
45 applicable across the whole mental health and alcohol and
46 drug system, and so, things that we were not funded for or
47 couldn't implement were endorsed as policy documents.

1
2 So, that relates to anything from - you know, and
3 obviously sometimes these are relevant or not - but relates
4 to issues around residential settings, around mental
5 health, and there's a very different focus around ligature
6 points and the way in which - you know, safety of those
7 settings, which are very different to some alcohol and drug
8 settings which are more recovery and community-focused.
9
10 Differences in terms of risk profiles, so for example
11 because mental health programs very much focus on risk and
12 suicidal risk and homicidal risk, there was mandating of
13 questions and approaches that we had to put in as some of
14 the first questions when we see people, which goes against
15 all of the things we talked about before in terms of
16 treatment philosophy.
17
18 So, rather than understanding that we have different
19 treatment models and treatment philosophies in a different
20 way, different population, different approaches, it was
21 this sort of in some ways bulldozer approach of, you know,
22 we're developing something in the larger mental health
23 program, you guys are essentially like a mental health
24 program, so we're just going to roll it out to you guys as
25 well, without understanding that that actually has negative
26 impacts for the treatment models and the approaches that we
27 take.
28
29 So that's a very concrete example of my experience of
30 that, and the challenges that - I had to spend most of my
31 time educating my mental health colleagues as to why this
32 wasn't a good idea and why we had to reverse it, rather
33 than spending time focusing on helping clients and
34 families.
35
36 And I think that's the big issue. The big issue is,
37 you know, while they are integrated they are different
38 models, and we need to be very careful that the evidence
39 base and what works in this system isn't steamrolled, you
40 know, to fit in with the larger machinery of the public
41 mental health apparatus.
42
43 MS BATTEN: Thank you. Dr Gruenert, can I ask you, what
44 do you think are some of the adverse impacts and what can
45 be done to ameliorate against those?
46
47 DR GRUENERT: Yeah, I agree 100 per cent with Dan there,

1 that we can all see the benefits of bringing those systems
2 approaches and the additional resources and benefits to the
3 drug and alcohol system, but I think one of the tensions
4 and the issues the Commissioners are going to be struggling
5 with here is the resources involved and required and
6 available and working within those resources. And I think
7 the biggest adverse impact would be to completely lose some
8 of the efficiencies that exist within the drug treatment
9 system by inadvertently putting quality and risk mechanisms
10 and compliance things that just increase the overheads and
11 the work required where it's actually not fit for purpose
12 and isn't required and it will just increase the cost of
13 services in some areas.
14
15 I think, as Dan said, there's so many examples where a
16 policy or a thing has been developed, you know, the
17 residential facility guidelines have come from mental
18 health and they thought with a few tweaks this could be
19 made to fit drug and alcohol, but it's a completely
20 different model: we don't need nurse stations with
21 observations around people's bedrooms and things, you know.
22 Bedrooms, they spend so little time there that they need to
23 be on the floor participating with the program.
24
25 There was a recent example during COVID where, there's
26 a great Telstra initiative of giving out mobile phones and
27 SIM cards and computers so that people can engage in
28 telehealth, and they developed guidelines in mental health
29 and were just going to roll it out across drug and alcohol.
30 And we said, wait a minute, you want to give out all of
31 this stuff and you expect it all returned at the end?
32 Who's going to be responsible if it's not returned, if it's
33 sold off and hocked? Just things that hadn't been thought
34 about that really need to be - you know, frameworks and
35 things that need to be built from the ground up for drug
36 and alcohol, not just a tweak to mental health.
37
38 I think the last point from me, or the last two
39 points: the drug treatment sector has had a lot of
40 flexibility to innovate, and whilst the sort of lack of
41 governance and rigorous guidelines and things have often
42 been an issue and can be improved, they have allowed a very
43 nimble quick system to adapt to things.
44
45 So, when COVID came along, the services moved to
46 telehealth and phone-based support really quickly and they
47 were able to do some quick consultations to make sure there

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was new guidelines and resources from Turning Point and others in place to support that, rather than building incredibly onerous clinical governance systems that would have taken a lot longer to roll out.

The second issue that's unique to the drug and alcohol sector I think relates to issues of criminality and the sensitivity of some of the issues in drug and alcohol politically.

And, it's always been a really strong point that, to have people with strong advocacy, we've had to work really long and hard to get evidence-based programs funded in drug treatment rather than be at the whims of what individuals think will work in drug treatment, whether that's community members or Members of Parliament, and we need really strong advocates in the Department that can push those models and aren't concerned and nervous that there's an election coming up so we can't talk about whether it's, you know, decriminalisation or pill testing or harm reduction measures in prisons or a whole range of other things. We need a unit that has the strength and sufficient size, you know, not just be 5 per cent of a Department and does get steamrolled.

So, I think if there are mechanisms that can be put in place that ensure the processes really do build things from the ground up within drug and alcohol as much as they're commenting on mental health things, and that ensures some efficiency in the system and we're not putting unnecessary layers on top of services that are suitable for clinical and tertiary end of the spectrum but not for some of the psychosocial supports, then there's a chance this could work.

MS BATTEN: Thank you. Dr Reilly, I feel like I've already asked you this question in relation to Queensland, but is there anything else you wanted to say in response?

DR REILLY: Just a quick comment. Stefan, with regard to COVID and the mental health service creating massive governance models that will take a long time, I'm not aware what they were, but I certainly wasn't involved in such things that I know of.

Yeah, I think the only other comment that I would make is, some of the concerns - and I understand the concerns

1 completely, don't disagree - I think they also stem from a
2 very separate service system because they're all really
3 about saying, the mental health service system doesn't
4 understand us so we need to stay separate. I accept that,
5 that's the way to approach it.
6
7 I think the problem is though when we're talking about
8 all of those issues, they can change if the mental health
9 service system actually sees that AOD services are a core
10 part of mental health services. The problem at the moment
11 is, as Dan and as Stefan have highlighted, is that that's
12 not the way that people think.
13
14 And I agree that it's not possible to just change like
15 that. So, therefore there is the challenge with regard to,
16 and if you were to say let's integrate, how you would do
17 that, how you would protect that along the lines that I was
18 talking about before, so I think that's how any adverse
19 impacts would have to be addressed and what you'd have to
20 do is to have, you know, a good kind of ringfencing of AOD
21 and monitoring and a gradual development of knowledge and
22 skills that works across the wider service system were that
23 to be contemplated.
24
25 PROFESSOR LUBMAN: Can I just add, I know we ventilated it
26 somewhat, we can expand on it later when we talk about the
27 addiction medical specialists, but I think that is a big
28 huge gap.
29
30 The comment I made before when I sit on a lot of the
31 Chief Psychiatrist's committees around morbidity, mortality
32 and complex care is because unfortunately I sit on those
33 because there aren't many of me in Victoria.
34
35 And so, one of the issues is, if we're trying to
36 integrate alcohol and drug and mental health, the reality
37 is professional groups talk to professional groups, and so,
38 I get invited to so many - when we talk about alcohol and
39 drug I get invited all the time and that's because
40 unfortunately there's only very few of me available and
41 that's the tragedy in Victoria, that we don't have a - you
42 know, a breadth of addiction medical expertise that can
43 work with our colleagues in the mental health space to
44 actually advocate for what's needed, to actually help build
45 knowledge and clinical systems and expertise, and I think,
46 without that, you know, there's that whole missing gap in
47 terms of a workforce that can communicate and link and

1 build confidence in their colleagues.
2
3 MS BATTEN: I'm going to turn straight to workforce
4 capability and the addiction specialist issue, and stay
5 with you, Professor Lubman, are you able to articulate very
6 briefly why there is this gap of 20 years of lack of
7 addiction specialists in Victoria and then move swiftly
8 onto what's needed to increase the number of addiction
9 specialists.
10
11 PROFESSOR LUBMAN: So, thank you. So, I tried to
12 articulate in the witness statement sort of the, I suppose,
13 how we got here and how we got here was really --
14
15 MS BATTEN: Sorry, Professor, not the how, the why. Do you
16 know the why? I know that there's --
17
18 PROFESSOR LUBMAN: The how is the why. The how and the
19 why is integrated because, you know, why is because, you
20 know, an unintended consequence of de-institutionalisation
21 was the failure to recognise the need for a clinical
22 addiction stream as part of service delivery in Victoria,
23 and so, you know, there was a misunderstanding at that time
24 and that sort of failure and essentially unintended
25 consequence of a policy decision has meant for the last
26 20 years we haven't had a systematised clinical addiction
27 stream in Victoria.
28
29 A by-product of that has meant that there hasn't been
30 an opportunity for medical nursing and allied health
31 professionals to actually train within those settings,
32 within addiction settings, to actually get the clinical
33 expertise and capabilities. It happens essentially by
34 random and, you know, on an ad hoc basis rather than as
35 part of a thought out system.
36
37 So, we have a whole generation of health professionals
38 who know nothing about addiction, and in fact know as much
39 about addiction from The Herald Sun as they do from their
40 undergraduate curricular. And that explains why we have
41 such huge amount of stigma and discrimination that you
42 would have heard from consumers throughout the Royal
43 Commission process.
44
45 We have a whole generation of health professionals who
46 really don't know what to do, and that's not just within
47 the mental health space but includes in primary care, and

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1 that's a critical issue because we're seeing a whole
2 generation of GPs who trained in the old system who are
3 starting to retire and they are the backbone of opiate
4 prescribing in Victoria, and within the next five to
5 10 years we're going to hit a major catastrophe in terms of
6 prescribing around opiates if we don't do something to fill
7 that gap.
8
9 So that's how we got there from an unintended
10 consequence of a policy decision. Why we're in this
11 position is because we don't have career pathway funded
12 positions, and because we don't have - if we look at all
13 the senior positions in mental health, clinical - you know,
14 in mental health, a lot of those positions are also joint
15 academic positions which allows in-reach into the
16 university system to train undergraduates both in medicine,
17 nursing, allied health in terms of mental health.
18
19 Because we don't have that senior clinical addiction
20 stream, we don't have senior staff in those medical
21 nursing/allied health positions with academic positions, so
22 we have no presence on undergraduate/postgraduate
23 curricula, so there's a huge gap here that we need to fill
24 because otherwise, no matter what we do in this space, no
25 matter how much we talk about integration, if we don't have
26 a senior clinical addiction workforce in place, you know,
27 we're never going to address this issue of the poor
28 treatment of people with addiction and addiction with
29 comorbid mental health issues.
30
31 And it's always been a surprise to me that, you know,
32 how the Department - not this Department - how the thinking
33 has been that, you know, for a clearly - you know, a clear
34 health problem, that the Health Department can say that we
35 don't need medical specialists to oversee, you know,
36 treatment for those with most complex needs. It's akin to
37 saying in the hospital system and the mental health system
38 we should de-fund all psychiatrists and clinical
39 specialists and they should use MBS items if they need a
40 specialist opinion.
41
42 So, you know, there's a huge discrepancy between what
43 we see in health and mental health and that discrepancy, I
44 think, speaks to the discrimination and stigma that we see
45 for this population group.
46
47 MS BATTEN: In terms of rectifying the number of addiction

1 specialists, you've mentioned career pathways; what needs
2 to be done to increase the number of specialists and what
3 kinds of organisations need to be involved?
4
5 PROFESSOR LUBMAN: Yes, so I just wanted to flag for the
6 Commission that we've been working for a couple of years
7 now with the Department in terms of an addiction/medicine
8 training - a workforce program. So, we've been able to
9 secure positions within the College of Psychiatrists and
10 the College of Physicians to create a coordinated training
11 for addiction positions in Victoria. So, we've got a
12 training program and a couple of coordinators training,
13 which is fantastic.
14
15 We're also just about to release a report which we
16 commissioned from HMA, a consultancy firm that's working
17 with sales in the Department to look at the development of
18 an addiction medical specialist workforce model for
19 Victoria. So, they've been doing a lot of work looking at
20 existing models, of workforce models, consulting with
21 experts across other jurisdictions and internationally
22 around what's needed to happen, and their report is going
23 to be available within the next two months which I would
24 urge the Commission to look at, which estimates the number
25 of addiction specialist positions that are needed and
26 training positions. That figure's around 110 based on
27 modelling, based on another jurisdictions.
28
29 I can tell you that we are a long way from that figure
30 in Victoria and, despite having coordinated training, the
31 biggest issue we have is, we don't actually have many - a
32 clear strategy around funding, funding training positions.
33 So, there's an issue around funding of training positions.
34 There's an issue about accreditation of supervisors, so we
35 don't actually have many funded addiction specialists in
36 Victoria who can actually oversee trainees and provide that
37 specialist pathway.
38
39 And it's a very hard sell - I mean, John will be able
40 to talk about this because one of his key roles is around
41 oversighting training for addiction psychiatry across
42 Australia and New Zealand. But we have a lot of very
43 interested trainees but the problem is, is that there's no
44 job at the end of it. Why would anyone want to put their
45 hand up to do that job? So we need to actually have a
46 career pathway where we have training positions, accredited
47 placements and actually a job at the end of it, so we need

1 to have publically-funded addiction specialist positions
2 and a model that actually speaks to where they sit in the
3 system of care.
4
5 MS BATTEN: Thank you. Dr Reilly, do you have views on
6 what can be done to increase the number of addiction
7 specialists in Victoria?
8
9 DR REILLY: Well, I think, as - I generally support what
10 Dan said. Clearly there need to be positions for medical
11 addiction specialists. I think that that issue of training
12 is vital, and I think that coming back to it from the
13 co-occurring substance use and other mental health
14 disorders focus, then as I've highlighted in my submission,
15 I turned into sub-specialists and generalist specialists
16 along the lines of the UK paper. And I do think that we
17 have to train all psychiatrists as being generalist
18 specialists going across all of psychiatry which includes
19 addiction. That doesn't mean that they're at that level of
20 addiction sub-specialist, whether they're an addiction
21 psychiatrist or addiction medicine specialist, but I think
22 that's what we need to be thinking.
23
24 And so therefore what we have to be thinking is what
25 are the ways we create training positions; certainly within
26 sub-specialist addiction services, but also how do we
27 emphasise that, of course, we've got enormous prevalence of
28 comorbid substance use disorders within our training
29 services that all of our psychiatry trainees are going
30 through and we need to ensure that in fact we seize those
31 training opportunities which at the moment we don't because
32 people don't actually know what are good models of care,
33 they're not identifying them, they're not assessing them,
34 they're not treating the co-occurring substance use.
35
36 And if we did that we would certainly be building the
37 capacity, but to do that we would have to actually be able
38 so start that process off and, because we don't have that
39 core group of addiction sub-specialists and because we
40 don't have that mindset, at the moment we can't. So, I
41 could go into much more detail but that's probably the best
42 thing at the moment.
43
44 MS BATTEN: Dr Gruenert, do you have views on what can be
45 done to increase the number of addiction specialists?
46
47 DR GRUENERT: Yeah, look, John and Dan are the experts in

1 this particular area and I would defer to them on the
2 particular pathways, but I will add two things. One, we're
3 talking about a long-term, I guess, timeframe in order to
4 achieve this from where we are in Victoria and we clearly
5 need some things in the interim to get us there. And I
6 think, if we are to achieve the sort of capacity in the
7 mental health system, we definitely need some input from
8 addiction specialists there.
9
10 The key point I'd make is that we need to go beyond -
11 so, addiction medicine is a massive gap in the Victorian
12 AOD system and I think that's impacting on the integration
13 of care for people with mental health issues, but we've
14 certainly got a lack of pathways and pipelines for a senior
15 workforce across all sorts of disciplines in drug
16 treatment, and I think we also need to have a strategy
17 that - because, as Dan says, people do talk to their peers,
18 so we need it at all levels, from social work, nursing,
19 psychiatry, medicine, GPs and psychology all the way
20 through the system.
21
22 The second point I make really relates to workforce
23 development. We know that simply study, theoretical
24 programs, don't develop a capable workforce and what we
25 need is really a lot of on-the-job training, and there's
26 really good models and mechanisms in medicine and health
27 for - and, you know, in other disciplines, for placements
28 where people can learn on the job with proper supervision
29 and support, including staff from mental health coming and
30 doing rotations through drug and alcohol services at
31 various levels to help build that capacity which just
32 simply aren't there.
33
34 And, we know that that's the best way to breakdown
35 stigma. We have lots of graduates who, even if they've
36 done some mental health or some addiction, which is pretty
37 rare in any university degree, the minute they are
38 confronted with someone, particularly if they're
39 intoxicated or in a crisis, the stigma and all their
40 systems go into defence alert mode, so they need to be able
41 to have real relationships with consumers in a variety of
42 settings to build up that confidence and to understand
43 people in a way that breaks down those barriers.
44
45 So, the models of workforce development have to be
46 embedded in services and they have to lead to some funded
47 positions, as Dan said, out the other end. That applies

1 across all the disciplines, but I totally agree there's a
2 real gap in addiction medicine, but we're talking
3 multiple years to start filling that, but we can start the
4 rotations and the practices as soon as possible to make the
5 most of the people we do have in the system before they
6 retire.
7
8 MS BATTEN: Okay.
9
10 DR REILLY: And so I do have to jump in and say, it's not
11 just addiction medicine but it's also addiction psychiatry.
12
13 DR GRUENERT: And psychiatry.
14
15 DR REILLY: Because unfortunately that does separate out
16 and that's actually a problem in a lot of documents. I
17 understand Stefan's not meaning that, but that is part of
18 the problem so I just need to be clear about that.
19
20 DR GRUENERT: Agree.
21
22 MS BATTEN: I do want to ask about the increase in the
23 workforce generally. Dr Gruenert, I might go to the others
24 and then come back to you to see if there's anything
25 further you want to add.
26
27 Dr Reilly, perhaps I'll ask this directly to you
28 first: how do we increase the capacity of the workforce
29 generally? So we've talked about addiction specialists
30 acknowledging that there's addiction psychiatrists and
31 addiction medicine specialists, so the capacity of the
32 workforce beyond them to address co-occurring mental
33 illness and substance use issues?
34
35 DR REILLY: I think, as we discussed originally, Fiona,
36 the issue there is, I do think that - I maybe being
37 medically centric - but I think it's reasonable to start
38 with medical specialists because if they lack capacity,
39 then it's very difficult for anyone else to come in over
40 the top of them - I'm not saying impossible, but it makes
41 it much harder because they are often taking significant
42 clinical decisions. So, I think, if we've got that, then
43 what we have got is that people are in fact, as Stefan
44 said, learning on the job.
45
46 If we can train our psychiatrists in the mental health
47 service system to actually be competent and capable in

1 managing co-occurring substance use disorders, that helps
2 to pull other people along.
3
4 I think the other issue is then trying to get more
5 crossover, that people do have those training experiences
6 at all levels of training and, whilst we've got separate
7 service systems, that's much harder. I think that if the
8 service system is more integrated there's greater capacity
9 to start to make those links and connections, but clearly
10 that's still very difficult at this point.
11
12 MS BATTEN: Professor Lubman, do you have views on how we
13 can increase the capacity of the workforce to deal with
14 co-occurring issues?
15
16 PROFESSOR LUBMAN: I mean, I have a couple of things to
17 say. I mean, I think if we go back 10, 20 years, we had
18 the establishment of the Victorian Dual Diagnosis
19 Initiative which at the time I think was a brilliant
20 initiative because it was really increasing people's
21 awareness of the interrelationship between mental health
22 and alcohol and drug issues. And I think, for its time, it
23 was a great initiative and it was very successful in
24 increasing awareness.
25
26 The challenge with that initiative is that there
27 wasn't - the strategy for what it was trying to achieve
28 became outdated and there wasn't governance over what the
29 initiative was actually trying to achieve, and the backbone
30 of that initiative became didactic training which we know
31 in workforce models is not an effective way of changing
32 practice.
33
34 I think I speak for all of us when we say that, you
35 know, if we want to increase the capability of the
36 workforce we actually have to do competency-based training;
37 we have to actually - you know, the whole model of working
38 in the field of health and medicine is around, you know,
39 seeing something, doing something, teaching something. You
40 know, that does not - you know, if I want to teach somebody
41 how to deliver a baby, I do not do a half an hour workshop
42 on the theoretical ideas of delivering a baby and then send
43 people out delivering babies.
44
45 You know, because that's easy to do and because we can
46 do it at a mass level, you know, unfortunately that's been
47 sort of the way in which training has been delivered in

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1 this space: let's do a couple of one day workshops and then
2 we'll see change.
3
4 I think what John's referred to, is that, we've had a
5 number of examples where we've worked with different
6 professional groups to increase the capacity, but then they
7 go into a mental health service where the consultant
8 psychiatrist is not interested in substance use, doesn't
9 want to know about it, and so, there's no mechanism to
10 actually provide evidence-based alcohol and drug
11 intervention into that setting because the medical
12 leadership in that team does not feel capable or does not
13 see it as a priority, so there is something about
14 prioritising that medical workforce.
15
16 One of the initiatives that we were able to get funded
17 a couple of years ago was to identify - and, building on
18 what John said, there are a number of consultants across
19 Victoria who recognised that they need to increase their
20 skill mix in the treatment of addiction, and we were able
21 to get some funding from the Department to actually have
22 that person come and sit with us one day a week for
23 18 months to work in an opiate pharmacotherapy clinic, to
24 see a whole range of people with co-occurring disorders to
25 become skilled in that space, and they then were able to
26 return to their area mental health service and adopt the
27 lead role as a portfolio holder for addiction and
28 co-occurring substance abuse disorders in their mental
29 health program.
30
31 So, there are opportunities for looking at how we
32 create, not necessarily just addiction specialist
33 expertise, but how we build the capabilities of medical
34 leadership in the different area services so that we can
35 have people who are very skilled in this space, who want to
36 upskill their colleagues and want to create models of care
37 that actually work.
38
39 So, for me, it's very much about competent models,
40 opportunities to work under supervision and to actually
41 see what - you know, practice what's happening under that
42 supervision and to feel capable and being able to then
43 share that knowledge with their colleagues.
44
45 I just want to also add comment to what Stefan says
46 when we talk about the workforce. I mean, I think
47 unfortunately what we see very much strongly in the alcohol

1 and drug space, is that, a lot of the funding models mean
2 that, when we do get very highly-skilled, senior nursing
3 and allied health professionals, there's not a career
4 pathway for them in the alcohol and drug space because we
5 don't have this sort of tertiary clinical addiction stream.
6
7 What that means is, is then you know, we spend a lot
8 of time training up these really experienced nurses and
9 allied health staff, and they end up moving into mental
10 health because they pay better, and not necessarily into
11 roles that actually play to their strengths in terms of
12 knowledge and expertise in the alcohol and drug space.
13
14 So, when we're thinking about this area of a tertiary
15 clinical addiction stream, it is about not just a career
16 pathway for doctors and having clear specialists in the
17 space of the broader mental health system, but it's also
18 being able to retain specialists in nursing allied health
19 to be able to continue to provide their expertise both
20 within the sector and to be able to in-reach into other
21 sectors and to work with their colleagues.
22
23 MS BATTEN: Thank you. Dr Gruenert, was there anything
24 you wanted to add in terms of developing workforce
25 capability?
26
27 DR GRUENERT: I think the issues have been pretty well
28 covered. The only point I would add is that, for this to
29 work, if we're really serious about changing both the
30 culture within drug and alcohol and mental health and
31 delivering better care for people, we need a sustainable
32 strategy.
33
34 So, one-off little injections have never worked
35 because we always had turnover of our workforce and, if we
36 want our investment in the area to really have a lasting
37 and a real benefit, it does need some level of sustaining
38 over time. And that includes - I think is why I'm so keen
39 on some dedicated funded positions because I'm sympathetic
40 to the arguments that Dan's put forward around, you know,
41 sometimes when resources are tight, you know, money can get
42 lost in a pool and it'll get used in other ways.
43
44 So, in including some of those outreach of your staff
45 models so they keep some specialist connection to their
46 sector but are seen as a dedicated role to support people
47 in the other sector, and that's worked really well across

1 child and family supporting drug treatment and family
2 violence where you've got some specialist funded positions
3 that really do build the capacity.
4
5 We don't though just want people that are sort of in
6 training roles, they really need to be on the ground, you
7 know, with the capacity to work and do some clinical work
8 as well across those disciplines, but I think the rest of
9 the issues have been well covered.
10
11 MS BATTEN: Thank you. I'm going to turn to the final
12 question and then hand over to the Commissioners, which is
13 on the issue of prioritising and, Dr Gruenert, I might stay
14 with you and so ask you to respond first.
15
16 In the context of this Royal Commission into
17 Victoria's mental health system and considering the reality
18 of rationed resources, for Victorians with mental illness
19 and substance abuse issues, what are the priorities of
20 allocation of resources?
21
22 DR GRUENERT: So, the two priorities for me would be to,
23 firstly, have specialist funded positions within both
24 sectors that can ensure that, when someone seeks help and
25 support, they can get a response from that sector that
26 provides, you know, holistic care - whether you call it
27 integrated or not - that meets their needs and prevents the
28 need for them to be referred elsewhere in the most cases.
29 So, the majority of people can be supported within each
30 sector without having to swamp or overwhelm or be shunted
31 back and forth between sectors, so some dedicated
32 specialist positions.
33
34 And the second one is, I do agree there's a gap in the
35 specialist addiction psychiatry and medicine that will
36 support the decision-making and the governance and the
37 training across the board. I just have some anxiety that
38 that becomes the dominant framework if the focus is only
39 there and that we don't value, you know, peer workers,
40 people with lived experience, social work and psychology,
41 nursing, across the whole spectrum.
42
43 MS BATTEN: Thank you. Dr Reilly, can I turn to you and
44 ask what would be your priorities for the allocation of
45 resources?
46
47 DR REILLY: Sure. So, I think I'm not clear whether

1 Victoria's mental health service system along the lines
2 that what I was saying without our dual diagnosis toolkit
3 and the four quadrants, at least there's a clear statement
4 - I'm not saying necessarily followed in Queensland, but at
5 least a clear statement that in Quadrant 4 there is an
6 expectation of co-occurring substance use disorders being
7 looked after by the mental health service. I don't know if
8 that's the case in Victoria, there may be a document that
9 says that, but it's not clear to me.
10
11 So I think that that policy issue doesn't cost a cent,
12 it costs some thinking though and a decision that that
13 would be required, and obviously that might lead onto
14 issues about capacity, but I think that's the first step.
15
16 After that, then it's really about, well, if that's
17 required and if that's what the - you know, the Department
18 says, how is that being implemented? Because the message
19 seems to be, well, it's not being implemented at the moment
20 effectively and, if that's the case, then how would you do
21 that?
22
23 And I guess, as I've said in my submission, really
24 that then comes down to having a clear model around that
25 expectation that mental health services do provide
26 treatment for co-occurring substance use disorders. And,
27 to do that, my simplest approach would still be - and, this
28 is without fund - I agree completely, Dan has already
29 highlighted that we would need to develop that specialist
30 addiction capacity - but, if you didn't have any funds,
31 then I would still be saying that it should be possible to
32 get training for psychiatry trainees to all have a
33 mandatory experience in addiction. And, doing that, the
34 simplest way I can see at the moment is still the
35 consultation liaison term should be integrated, but there
36 should be a greater focus on that co-occurring substance
37 use disorder within all of their training.
38
39 That's absolutely cut back to nothing, just saying,
40 that's what I would start with.
41
42 MS BATTEN: Thank you, Mr Reilly. Professor Lubman, what
43 do you say as the priorities for the allocation of
44 resources?
45
46 PROFESSOR LUBMAN: Yeah, I think, as I said throughout my
47 witness statement, I mean, I think the big missing gap is

1 the clinical addiction stream that's been missing since
2 de-institutionalisation. For me, that's a stream that's
3 multidisciplinary, and that's not just addiction medical
4 specialists, but also nursing, allied health, senior peer
5 navigators, a multidisciplinary team.
6
7 That I would see a series of clinical hubs across
8 Victoria that are in-reach both into the mental health
9 system, into the general hospital system, into the alcohol
10 and drug system and providing support to primary care.
11
12 So I think that sort of clinical hub and spoke model
13 of a tertiary/clinical addiction stream of expertise would
14 provide, you know, a huge boost in terms of addressing the
15 many harms associated with addiction issues that we see
16 across our general hospital, primary care, alcohol and drug
17 and mental health settings, and I think that is a priority
18 in terms of, if we want to address the issues of
19 (indistinct) care.
20
21 MS BATTEN: Thank you very much. Sorry, Dr Gruenert, I'll
22 go back to you.
23
24 DR GRUENERT: Can I just add there: I mean, I think
25 that's a really important issue but I see it as a two-way
26 thing. The drug treatment sector also needs the support
27 around mental health to ensure that we don't - you know, we
28 can manage most of the people that seek help from us within
29 our - so, I see that model that Dan was talking about as a
30 two-way thing, so we're actually bringing in the mental
31 health expertise into drug and alcohol as much as we're
32 putting drug and alcohol expertise into mental health.
33
34 PROFESSOR LUBMAN: Can I just - on that, Stefan, I
35 completely agree. So, for example, as I would see in this
36 stream, we would have at addiction psychiatry stream. So,
37 we run an addiction psychiatry clinic at Turning Point, and
38 I can tell you that we have to stop our waiting list
39 because we have, you know, less than 0.5 EFT to offer that
40 clinic, and we are inundated by AOD providers and GPs and
41 the mental health system asking for advice around how to
42 manage the cases.
43
44 So, you know, you set one of these things up, there is
45 huge demand in the system, both providing the addiction
46 mental health piece; we know that this is a huge gap and we
47 know that there's huge demand, but we need - this is a huge

missing piece.

And my colleagues - unfortunately, my colleagues here work in private mental health, in the private system; again, there's very limited expertise in addiction. And, you know, we get referrals of, you know, many, many hundreds of people who just cannot access the right treatment in the private mental health system because they have a co-occurring substance use disorder and our private colleagues don't feel they have the expertise to actually manage that comorbidity.

MS BATTEN: I'm going to hand over to the Chair now, unless there's any final comments? Okay. Thank you, Chair, I'll hand over to you for the Commissioners' questions.

THE CHAIR: Thank you very much to the panel members and to you, Fiona, as well for leading that discussion, it was fabulously informative and has I think given us a lot of insight into what some of the opportunities as well as the challenges might be in terms of us building our future system that's more responsive to these issues.

I guess, one of the issues - and, just to go to your suggestion, Professor Lubman, about the series of clinical hubs that could in-reach: do you think that would make a difference to some of the volatility that we currently see?

I think we all talked about the stigma associated with mental illness and drug addiction. We've got real challenges right now in Victoria where we hear from consumers, we hear from service providers about the fact that too many people are getting very unwell, presenting; police picking them up, or ambulance, being taken to an ED, some being admitted to an inpatient unit in highly agitated volatile states; no-one feeling that well able to cope with it, having high incidences of occupational violence and associated issues.

And so we're, in addition to taking a long-term strategy about how we're going to improve our capability in this sector, facing some pretty immediate challenges about whether or not we're running services that have models of care that are providing for the safety and needs of all consumers.

1 So, is there models of care that are available that
2 can help with this? Are they existing in Queensland or
3 other jurisdictions? But can you just talk to us about how
4 you think we might address this issue, because it is an
5 exacerbating problem but also adding to the stigma around
6 these issues in the community and in service providers.
7
8 PROFESSOR LUBMAN: Yeah, I mean, I think it's a really
9 great point. I mean, I would say there's a couple of
10 things here: one is that there's a belief in the system
11 that treatment doesn't work; that there's a nihilism across
12 the health system, across the police system, across the
13 paramedic system, across the EDs, that if you have an
14 alcohol and drug disorder, you know, that basically there's
15 no way you're going to recover.
16
17 That's what we hear consistently in the media. We
18 don't have any visible champions out there telling us that
19 there's anything different. If nobody spoke up about
20 recovery from cancer, you know, what we saw 30 years ago
21 when we didn't see anyone who would actually recover from
22 cancer, there was a belief that cancer was a death sentence
23 and, because of that people - you know, when I trained as a
24 medical student I would see people presenting to cancer
25 clinics with end stage cancer because they were so
26 embarrassed that they had cancer, they feel nihilistic
27 around feeling that there's any treatment, that they didn't
28 actually seek treatment until they had all these
29 complications.
30
31 So, I think the issue for us is, you know, because of
32 this failure to have a clinical addiction stream, nowhere
33 in the undergraduate, or postgraduate training, or in the
34 everyday lives of people who work in the health system do
35 they come across people who actually are experts in this
36 who can tell stories around what works, who can actually
37 demonstrate what the interventions actually are, there's
38 none of that visibility.
39
40 So for me, you know, one of the biggest issues working
41 - I'm fortunate to be able to work in a large hospital
42 network and I'm able to go to medical ground rounds with my
43 colleagues from ED and psychiatry and general medicine, and
44 I'm able to work across those distant basis, and certainly
45 when I first started in this role all I heard consistently
46 was, you know, why do you see these people, they never get
47 better, nothing ever works, it's a waste of time, you know,

1 they should be treated in the criminal system. And it's
2 only by actually being there, being able to be part of the
3 system and demonstrating what is possible, that we're
4 actually able to change people's views and attitudes in
5 this space.
6
7 Because the evidence is pretty strong that we have
8 evidence-based treatments that actually work, we don't have
9 to go far to actually search high wire for them. There's
10 very good strong evidence of good treatment models for the
11 treatments and good outcomes for the patients that we see.
12
13 In fact, for people with schizophrenia, for example,
14 who don't have a substance abuse disorder have worse
15 outcomes long-term, in terms of their prognosis, than
16 people with a substance use disorder. So, substance use
17 disorder is a good predictor of good prognosis because, if
18 we address that, it's likely that their psychosis will
19 massively improve.
20
21 So, there's all these positives around, you know,
22 how/what we can do, but the issue is, is that, we are not
23 present in the health system, we're not with colleagues in
24 other areas of health who see what we're able to provide.
25 We're not working alongside paramedics or police or other
26 aspects of the system, and so, there's a general nihilism,
27 nihilism in the community; people don't come to treatment
28 until it's too late, people don't believe it works, people
29 don't think about referring us to actually have
30 evidence-based treatment.
31
32 So, for me, this is a critical gap in terms of
33 presence and visibility and our ability to influence, you
34 know, what can happen in the health system.
35
36 THE CHAIR: Thank you. And, can I go to you, Dr Reilly:
37 is that different in Queensland where you've got an
38 integrated model, or are you equally challenged by the
39 issue that we are facing here in Victoria at the moment?
40
41 DR REILLY: No, absolutely equally challenged. I think
42 that though - I understand what Dan's saying and I don't
43 disagree fully, but I do think that psychiatrists have been
44 dealing certainly with people presenting with
45 substance-related psychosis and acute psychotic episodes
46 not related to substance use with aggression for a very
47 long time, so I actually do think that they can manage and

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1 contain that.
2
3 I think that the challenge is though that, if it is in
4 fact say amphetamine related, then they don't have a
5 mindset that this is an ongoing issue that they might now
6 need to be involved in addressing and working with, they
7 don't feel confident, and instead what they want to do is
8 to say, oh well, it's amphetamine related, it's not my
9 problem, someone else should be coming in and taking
10 responsibility for that; rather than, in a sense, taking
11 over the ownership of that because we haven't set up that
12 sense, as Dan said, that this is something that they need
13 to do, we've instead allowed that to be externalised.
14
15 So I do think - now, they can manage the acute, but
16 they don't - you know, they will complain about that
17 because they don't see it as really something they should
18 be doing; along the lines that Dan was just saying he's
19 always had, it should instead be something else that
20 someone else should somehow deal with, whether that's the
21 criminal justice system or somehow some other magic
22 specialist who's going to come along to deal with this
23 issue. I think that's a fantasy, but nevertheless it
24 continues to exist in many mental health services and
25 clinicians.
26
27 THE CHAIR: Thank you. Dr Cockram, do you want to ask the
28 panel a question?
29
30 COMMISSIONER COCKRAM: Yeah, my question, I think I'm
31 going to ask Dr Gruenert this first but, if I could, with
32 this single question come back to Professor Lubman.
33
34 If we postulate, and the group has postulated the
35 potential opportunities of creating a more cohesive shared
36 vision at a Department level of both AOD and mental health,
37 and perhaps having a policy and planning setting that
38 supports that, but I also think that you have particularly
39 highlighted the importance of maintaining a commissioned
40 service system that is fit for purpose and separate where
41 needed. I'm interested in your thoughts where we bring
42 those systems back together again, perhaps in integrated
43 community environments, and people have talked about that.
44
45 How do we governance to support both models of care at
46 that more local integration as opposed to at the state
47 Department, and have you seen shared governance models or

1 collaborative models that you think might work; i.e. not
2 one or the other, but both, is what I'm asking?
3
4 DR GRUENERT: Thank you for the question. I think where
5 I've seen it work best has been in escalation models for
6 more complex people, and I've certainly raised this issue
7 with the Chair in terms of some services that Odyssey ran
8 in New Zealand where people in residential drug treatment
9 services, if they become particularly unwell around their
10 mental health issues, have meant they've been unable to
11 really participate in drug treatment, and the size and
12 scale of those programmes does not support the sort of
13 de-escalation of those symptoms and management of those,
14 and there's been a specialist dual diagnosis program that's
15 residential, small in numbers, and it has access to
16 psychiatry and addiction medicine and higher
17 staff-to-resident ratios, and it's been really effective in
18 stabilising, you know, suicidality and people who have
19 schizophrenia who may be able to manage it from time to
20 time but it escalates into psychosis at times, and that's
21 been well integrated and managed well.
22
23 I think equally, if you're talking at a local level in
24 some of the psychosocial services, there has been a greater
25 propensity, if you're talking about recovery, to integrate
26 some of the sort of higher prevalence but lower severity
27 issues across drug treatment in mental health. So, I
28 think - but again, it's usually been because you've got
29 some skilled clinicians who are experienced enough and know
30 where they can get support or access others to be able to
31 do that.
32
33 I haven't seen and I haven't read any evidence or seen
34 examples where there's been that full integration of
35 service provision at the local level between two systems
36 working well. All I've ever heard about is why it failed
37 and the tensions that existed and then people going their
38 separate ways again, and it's largely come back to
39 philosophies approach. And also some differences in the
40 cohorts: you know, your services are better supporting
41 these, and more of your services are oriented to better
42 service that, and your services are more oriented to
43 service that.
44
45 Now, to some extent that's an example of what is, you
46 know, rather than what could be. But I think a lot of the
47 things we're trying to grapple with here, including the

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1 chaos in the system and presenting to ED, are symptoms of
2 the system failing. And, you know, you're always going to
3 need some emphasis at that critical crisis, bottom of the
4 cliff end, but if we're getting the other parts right, and
5 that may just be properly resourcing both systems on what
6 they need to do, I think we're going to avoid a lot more
7 people presenting in crisis and really needing a full
8 integration even at a local service level.
9
10 COMMISSIONER COCKRAM: Thank you. Professor Lubman, can I
11 just sort of shift the question slightly. I guess, if
12 there's a shared vision, can there be a shared
13 accountability at a system level? And particularly, say,
14 in a community integrated clinic or any other environment,
15 is there something the Commission should be thinking about,
16 about saying that, rather than either/or, that we're
17 creating some opportunity to get collaborative and shared
18 accountability for a general success for a group of people
19 as opposed to one or the other?
20
21 PROFESSOR LUBMAN: That's a great question. I suppose the
22 thing that I suppose I would reflect on in that question is
23 this issue of differing populations.
24
25 So, there's clearly, I think - we've got a Venn
26 diagram, so we've got one sphere here that is clearly in
27 the remit of alcohol and drug services, that there will be
28 some part of that Venn diagram that overlaps with mental
29 health. And similarly, we've got the mental health system
30 that largely sits in the purview of the mental health
31 system with a small overlap in terms of the alcohol and
32 drug system, and then it's where there's overlapping
33 nature, that's I think where we need to target.
34
35 I think, I suppose, my experiences of that is that,
36 you know, that we can get shared governance arrangements
37 and agreement as long as - you know, there's a couple of
38 issues: one is around, how do we incentivise it, and what
39 are the relevant policy levers around that?
40
41 But I think we can all share - and Stefan might be
42 able to comment on this as well - I often find it's harder
43 to actually do something in a shared way with other
44 services than it is to do it by ourselves. The system
45 actually puts in perverse incentives to make it more
46 challenging, both in terms of our funding structures, in
47 terms of our reporting, in terms of our information

1 sharing, in terms of our expectation, so the system
2 actually creates incentives not to work together.
3
4 So, in terms of having that shared governance, it's
5 around making sure the system is incentivised to actually
6 work together, and so, identifying what those barriers are
7 to working together and actually looking to overcome them.
8
9 But my experience is, when you have organisations -
10 and I've been involved in multiple projects where we've
11 had, you know, the senior leadership team of one
12 organisation and another recognise that this is what we
13 want to do, we've got common sort of goals and a shared
14 perspective, and we want to work together to do that, we've
15 got some really great examples of where that's worked well
16 with the appropriate resourcing and the ability to direct
17 resources to do that.
18
19 So, I don't think that's too hard, but there's
20 challenges in information sharing and other sort of - you
21 know, other bureaucratic processes that sometimes inhibit
22 the ability to actually deliver that.
23
24 COMMISSIONER COCKRAM: Okay, thank you.
25
26 THE CHAIR: Thank you. Professor Fels.
27
28 COMMISSIONER FELS: Well, I was going to ask, kind of, a
29 conciliation type question and maybe you'll find yourself
30 just repeating what you have said, but I was going to ask
31 one of Dr Reilly and then Professor Lubman.
32
33 I mean, Dr Reilly, suppose contrary to what would be
34 your wishes I think, you received an edict from on high to
35 go back to a more separated system, what would you insist
36 should happen in that case?
37
38 Then I was going to ask Professor Lubman the opposite:
39 having heard a litany of reasons why the subject matters
40 are different and there should be a degree of separation;
41 but supposing, contrary to all of that, there were some
42 move to more substantial integration, what would your log
43 of demands be?
44
45 As I said, I think we've heard a fair bit already, but
46 I still would find it just useful to hear an answer to
47 those unthinkable propositions. Maybe, Dr Reilly.

1
2 DR REILLY: Sure, thank you, Professor Fels. I think that
3 absolutely would be unwanted of course but, if so, then at
4 a departmental level, fine, those things happen; and even
5 then, if there was a disaggregation at an HHS level
6 following on from that and teams were - yeah, teams were
7 separated out again, I guess I'd still say that I think
8 from a clinical point of view at the level of the consumer
9 what we should be looking to do nevertheless is to say
10 that, you can't split that, that that's not actually a kind
11 of Government decision but that's actually about
12 evidence-based care, that the evidence-based care is for an
13 integrated model.
14
15 And that, sure, we can split all of the systems, but
16 we nevertheless have to create structures which support and
17 encourage those integrated models of care, and that
18 includes at the very least training models which ensure
19 that people working in both separate areas actually have
20 experience and work closely together and ensure that those
21 training models cross over if it's been completely
22 de-integrated.
23
24 But, you know, it doesn't make sense, unfortunately,
25 to go that way but that's what I would be perhaps arguing
26 for most.
27
28 PROFESSOR LUBMAN: I suppose the point I would raise is
29 that, often what we're doing is we're trying to retrofit
30 systems. So, we have things that we wouldn't design in the
31 first place, and then we're asked to how we put them
32 together to somehow solve a problem that's very complex.
33
34 And so, in that context, I think for me the thing that
35 we would really need to do very carefully if we were to
36 integrate systems is, is we would have to take a step back
37 and be really clear about what it is that we're trying to
38 achieve.
39
40 So, for me, I think where we often fail to do the work
41 is, we don't do the work in terms of demand modelling:
42 understanding who are the populations in need, what are
43 their characteristics, what do they need, what is the most
44 appropriate way in which to sort of set up services to meet
45 the different population needs that we see.
46
47 We don't then think about, what is the evidence base

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in the care models that we have to create that are the most effective. So, looking at the population and breaking them down, and seeing how they look and seeing how we might need to step up and step down our models of care; we don't clearly define what those models of care are and what the competencies and workforce makeup of those models of care actually are; and, overarching that, then we don't think about the quality framework and the principles of care that underpin how those systems are designed.

So, for me, I think if we were to start from scratch, for example, and you were to throw everything up again and we were to redesign the whole system, for me, as long as we took a really clear evidence-based pragmatic approach where we looked at what works, and we design the system that actually meets the needs of individuals, and actually articulates what it is we're trying to achieve and what workforce we actually need to do that, I would feel very confident in that space.

My concerns are, is that we don't tend to think in that way strategically. We tend to say, we've got service X and service Y, you guys work together now, you know, and make it work, without any investment in models of care, the appropriate workforce, the clarity of the framework and the principles of work we want to achieve. So, for me, they're the things I think we need to think very carefully about.

COMMISSIONER FELS: Thank you.

THE CHAIR: Thank you. Professor McSherry.

COMMISSIONER McSHERRY: Yes, I have a question about legal frameworks for Professor Lubman, and I was interested, when you started off you mentioned how the Mental Health Act and risk approaches has really driven where we are now with the mental health system. We've also heard a lot throughout the course of this Commission about stigma in relation to both sectors, we've heard a lot about law and order agendas and so on.

So, I'm interested to get your perspective on the fact that we've long had legislation that enables compulsory treatment in the alcohol and other drugs sector, and at the moment we've got the Severe Substance Dependence Treatment Act, and yet that hasn't driven the AOD sector, and I'm just wondering whether you have any perspectives on why

1 that might be the case: whether it is just a matter of
2 people falling within the compulsory mental health system
3 instead or whether there's something else going on here?
4
5 PROFESSOR LUBMAN: Great question. Look, I've got to say,
6 the Severe Substance Dependence Treatment Act is not a very
7 workable Act. If you look at the number of people who have
8 used that - who have come under the remit of that Act, you
9 know, we're talking a very small percentage of the
10 population.
11
12 It's very difficult to navigate, there's a lot of
13 confusion around who's eligible. There's a lot of
14 confusion around - well, there's a lot of processes in
15 place in terms of how to make it work, and the duration of
16 the Act makes it a disincentive to use the Act because
17 you're only - it's only relevant for a certain amount of
18 time. So, by the time you've got somebody in and using
19 it - you know, obviously we're talking about issues that
20 are long-standing and complex, and using it for a very
21 distinct period of time, a short period of time, is really
22 not workable.
23
24 There's also - I mean, I think the biggest issue is,
25 you know, I think within the mental health space there's
26 greater clarity of, I suppose, when somebody is impaired in
27 the mental health space. I think, as Stefan has talked
28 about before, particularly in the alcohol and drug space,
29 it is an incredibly political issue, so anyone in some ways
30 who chooses to do something illegal is in some way impaired
31 in one context, and so, there is a whole political overlay
32 of what impairment means in the alcohol and drug space.
33
34 And I think, you know, certainly we see that every day
35 when we are dealing with family members who come to us
36 concerned about their loved ones and feeling, you know,
37 unable to do anything and wanting us in some ways to
38 forcibly, you know, apply treatment to people, you know.
39
40 And I think, you know, the challenge is, is for us, is
41 around having a system - you know, often when we - and I
42 say this in my submission, often when we create systems
43 that are underpinned by legislation we actually create
44 resources to enable that person to get good quality care.
45
46 The downside of our non-mandatory system is, we have
47 services that aren't adequately resourced to actually meet

the needs of the individual, and I think they're the tensions that we constantly struggle with.

COMMISSIONER McSHERRY: Thank you.

THE CHAIR: Thank you.

MS BATTEN: Dr Gruenert has got something further to say, just in case you missed it.

THE CHAIR: Thank you.

DR GRUENERT: Commissioners, I just want to add one thing to that comment. Very few people actually access the drug and alcohol system on a voluntary basis. Even though they might not be mandated under any Act to do that, they're all experiencing some pressure usually, and that may be pressure from Child Protection because they're going to lose their child; it might be some legal issues that are pending that are going to have significant impact on them if they don't choose to engage in treatment; it may be pressure from a family member or a friend, or to be kicked out of home, or a health issue that's pending, so there's lots of other levers that motivate someone into treatment which is, I think, also one reason why we wouldn't see the use of the Act as much as necessary.

And I guess, for me, it's critical, whichever decision or way the Commission chooses to go with these services and the system and how it's designed, for me a fundamental is, if we're continually assessing the voices of consumers and those experiencing the system and the outcomes it's achieving and evolving the system over time, then I'm always open to, you know, one model versus the other and trialling different things in sort of a real evidence base and evolution of the system.

THE CHAIR: Fantastic, thank you very much.

So, panel members and Ms Batten, thank you so much for the discussion we've had today, it's been incredibly informative. It was very helpful, as I said at the beginning, for the Commissioners to read your witness statements, even greater help for us to hear and have the opportunity to discuss some of these challenging issues with you and to reflect upon what you think is the desirable future system.

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And, it is definitely work-in-progress, you know, there's a level of flexibility required in our thinking about what direction we want to pursue and, given the Government has committed to implement the recommendations we put forward, we have a great sense of responsibility to do no harm in terms of ultimately what we recommend by these systems, and recognise both the strengths and opportunities for that, both service systems, and the strengths that the AOD sector has to bring to the table as well as the mental health system, and so, this has been a very, very helpful discussion for our deliberations, so thank you very much for your time.

And, particularly Dr Reilly from interstate, thank you for being so committed to helping us in terms of trying to design a future mental health system here in Victoria.

So, thank you all for your participation.

AT 1.00PM THE COMMISSION ADJOURNED

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