Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR JOHN REILLY

I, Dr John Reilly, Chief Psychiatrist, Queensland, of 15 Butterfield St., Herston, Queensland, say as follows:

Professional background

1 My position is Chief Mental Health Alcohol and Other Drugs Officer in the Mental Health Alcohol and Other Drugs (**MHAOD**) Branch in the Clinical Excellence Queensland division of Queensland Health. I hold the statutory role of Chief Psychiatrist under the *Mental Health Act 2016* (Qld) (the **Act**). I have held this role since July 2017. In my role, I am responsible for exercising the statutory responsibilities of the Chief Psychiatrist under the Act and for providing consultation and specialist advice regarding the clinical care and treatment of people with mental, behavioural and neurodevelopmental disorders, with a particular focus on those receiving services within Queensland Health's MHAOD services.

2 I hold a General and Specialist Registration with the Medical Board of Australia. I completed a Bachelor of Medicine, Bachelor of Surgery in 1984, a Diploma of Psychological Medicine in 1994, and a Graduate Diploma of Epidemiology and Biostatics in 1995 all from the University of Melbourne. I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**). I have had extensive involvement in undergraduate psychiatry and postgraduate training within mental health since 1992. My main current role at RANZCP is as Chair of the Subcommittee for Advanced Training in Addiction Psychiatry, RANZCP Committee for Training since August 2014, with associated ex officio duties.

3 Since November 1997, I have worked in Clinical or Medical Director roles for mental health services or components in Victoria and Queensland. In these roles, I had responsibility for operational performance, clinical service delivery and quality improvement, including as service Administrator or equivalent role under several Mental Health Acts.

4 Prior to being appointed the Chief Psychiatrist in Queensland, I was the Medical Director of Mental Health at Townsville Hospital. In my role at Townsville Hospital, I worked across multiple different service types including in a Secure Mental Health Rehabilitation Unit, Prison Mental Health Service, Community Forensic Outreach Services, inpatient and community mental health services and the Alcohol, Tobacco and Other Drugs Service (**ATODS**) due to my generalist experience and requirement as a Clinical Director in filling

vacancies. I was additionally an Adjunct Associate Professor at the Medical School at James Cook University in Townsville.

5 Until July 2017, I maintained a significant clinical load, never less than a 0.5 FTE clinical load for a full-time psychiatrist.

6 In Victoria, I was the sole psychiatrist in an inner-city Homeless Outreach Psychiatric Service and a Mobile Support and Treatment Service between 1993 and 1997. In 1997, I was a psychiatrist as part of a continuing care team, including responsibility for the inpatients of the teams. At Peninsula Health from 1998-2003 I worked across most clinical teams including Acute Care, Adult Inpatient, Continuing Care, Mobile Support and Treatment Service and residential rehabilitation settings. Between 1992 and 2003, I worked in general adult private practice for approximately two sessions a week in Victoria.

7 Since 2012, I have developed clinical expertise in addiction, furthering my prior interest in how this can be extended across into mental health services, with a focus on substance use disorders and other mental health disorders. I completed Queensland Opioid Treatment Program (**QOTP**) training to become an approved QOTP prescriber in 2012.

8 I have a particular interest in quality improvement, service development and governance. From 2002 to 2018, I participated biannually in accreditation surveys of health services around Australia, including most recently, to the National Safety and Quality in Health Service Standards.

9 My curriculum vitae is attached to this statement.

10 I make this statement in my role as Chief Psychiatrist and Chief MHAOD Officer, MHAOD Branch, Clinical Excellence Queensland.

QUESTIONS FOR PANEL MEMBERS

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

11 A best practice service response comes from a consideration of the consumer's point of view and what the consumer needs. I consider that one of the problems we have in our mental health services is that we are often not thinking comprehensively about consumer needs. We, as service providers, tend to limit our thinking to our perspective on the consumer's needs based on our capacity or service, rather than consistently considering them from a consumer and carer perspective. In my view, no one service of any kind can meet every need that a person may have, but we may be able to treat people with severe

mental illness better with a more comprehensive approach to identifying and addressing needs.

12 For people with co-occurring disorders of whatever kind, we know that they do experience problems in the way services combine and work together to meet their needs. We also know that some consumers with multiple needs fall through the gaps. This is not just limited to health services, but in relation to other social, educational and other types of services that may be required to assist a consumer.

13 In the specific context of co-occurring substance use and other mental health disorders, it is important to acknowledge that there are a variety of other disorders that a consumer may face. It is important to not limit a consumer's experience to co-occurring substance use and other mental health disorders (the term I prefer to avoid the limiting and inappropriate 'dual diagnosis'). In my view, it should be recognised that language can be problematic here: the often used phrase 'dual diagnosis' can limit other health issues that a person may be facing, including other co-occurring health related problems, other mental health disorders including other specific substance use disorders and other physical health disorders. Limiting language such as 'dual' diagnosis tests the professions' capacity to hold all a persons' multiple disorders in mind and refer to them in aggregate, so terms such as co-occurring disorders ought to be accepted to recognise and not lose the context of many other co-occurring health related problems.

14 However, in response to the question, I consider that mental health services should understand and incorporate substance use disorders as mental health problems. In my view, substance use disorders are mental health disorders and should be treated by specialist mental health services in the same way as other mental health disorders such as anxiety, depression, psychosis etc. If mental health services approached substance use problems from this perspective, then a best practice mental health service response is one that is able to identify and appropriately and effectively treat any kind, or kinds, of mental health disorder that a person presents with. This is not intended to indicate that mental health services should take the place of sub-specialist alcohol and other drugs (**AOD**) services but rather that mental health services should complement AOD services. This is because a mental health service has a particular focus on acute and crisis presentations of people with substance use disorders and on co-occurring mental health and substance use disorders. These issues are addressed in some specific aspects further.

15 Treatment services tend to define themselves as a service that provides 'x' or 'y' service, often to specific populations. In relation to substance use and other mental health disorders, we have tended to separate our services and create distinctions between them. This is a fundamental problem in the way we choose to structure and define our services and to deliver services within those structures for consumers. In my experience,

consumers do not tend to identify their treatment needs as being distinctly a mental health and substance use disorder in this way. Some consumers certainly do, however they may have needed to identify it in this way due to existing structures, at times being expected or required by service providers to make such delineations. Our service responses need to consider what an individual's different problems might be, be equipped to identify each of an individual's problems and then subsequently approach these problems appropriately. These service responses may include physical health problems, and other issues that are often secondary to mental health problems such as accommodation and financial difficulties. Services need to take steps to address these issues and not consider a substance use disorder as a side-effect of mental health issues or as a form of "self-medication" for mental health issues (a term sometimes used but which lacks any coherent conceptual, logical or evidence base). Substance use disorders should instead be considered by mental health services as a core problem that needs to be addressed for their patients. Additionally, sub-specialty addiction services should be addressing other mental health disorders as core problems. I would consider such approaches to be best practice.

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

a. how do you define 'integrated care'

b. what are the ways this can be achieved?

16 Integrated care would be similar to what I have discussed in paragraphs 14-15 above. We need to have a shift in our language in another way. For example, AOD problems are often not recognised by services as substance use disorders. However, substance use disorders are recognisable mental health and behavioural disorders in our standard classification system. Simply by narrowing addiction to AOD problems we have also narrowed our focus and excluded behavioural addictions including gambling and internet gaming which are significant clinical problems for a large proportion of patients in mental health services and AOD services. As discussed, in our current structures, there is a clear separation between addiction and mental health. However, as a system, we need to be prioritising the treatment needs of an individual irrespective of these distinctions within service and system structures.

17 My view is that if a mental health service is defined currently as a service that does not primarily treat substance use disorders, then this should change. A mental health service should recognise that it does treat substance use disorders and implement integrated service structures. I am not suggesting that all mental health and addiction treatment services must be fully integrated, although, such integration has many benefits and

should be encouraged where possible, particularly in remote areas and other regional areas with small numbers of available practitioners. Such integration would encourage the development of a critical mass of practitioners to provide services which more effectively meet the mental health and addiction care needs of the local community.

18 We should however consider addiction services structurally as being part of wider mental health and behavioural disorder-type services. Such a change would assist in creating a mindset that the workforce in mental health need to take responsibility for the AOD care of their patient group, and vice versa where appropriate, and support the delivery of more integrated clinical care to our patients. It would also emphasise the overlap in patient groups and the expertise required in service delivery. The prevalence of, and morbidity associated with, co-occurring substance use disorders with other mental health disorders in both types of services, even if different in type, requires such structural approaches.

19 We also should recognise that all those involved in mental health treatment and care need to develop the basic requirements and skills to deliver care in relation to assessment and treatment of substance use disorders. In my view, the lack of integrated care currently is a problem of a mindset that substance use is not a core part of mental health. Unless this mindset is changed, I cannot see how integrated care can be provided. This is because while we have completely separate addiction services without any links to mental health services, we will always have a separation of addiction issues from mental health services and an attitude in mental health services that treatment for addiction is not part of their core responsibilities. Similarly, in addiction services, there should be a move away from the mindset that they do not treat mental health problems and that they need to be separate from mental health services. While there are some addiction sub-specialists in mental health services, it is not seen by many as a core part of what mental health service providers do. As such, integration for mental health services would include addiction treatment becoming part of its core business for all services and staff. While recognising that specialisation is valuable, all services need to be considering their patients holistically from a more generalist perspective. I should also note here that I use the terms sub-specialist, generalist specialist and generalist to indicate three levels of expertise in relation to areas such as addiction within a wider mental health system.

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

20 This can be considered from a number of perspectives and clearly must include “bottom up” input from consumers and carers, however in this situation it is important to recognise that narrowing the focus too much with regard to the consumer/carer experience can limit

the capacity to gain representative or meaningful input. Excessive segmentation by co-morbidities or other specific types of experience can unhelpfully limit the capacity of consumers and carers with other experiences of care to represent a consumer and carer perspective. I consider that in order to get to this point it is essential that any future redesign of the mental health system so it could be more integrated would also need "top down" changes since it would require structural changes and would need to be represent a government decision supported at the highest levels by health departments. That is a challenge, because there is not a consistent approach to integrated care of co-occurring mental health and substance use disorders by health services and health service providers across Australia. The Commonwealth government has more of a focus on addressing the supply of substances and harm reduction. Prevention approaches of the Commonwealth tend to focus its perspectives about addiction related health services, both outside and within health, narrowly on addiction to the exclusion of mental health, though this may also be simply due to the historical separation of mental health and AOD services. Emphasising these separate streams leads to exclusion of the role of mental health services in addressing addiction related presentations.

21 The lack of integration of mental health and addiction services at Commonwealth and state levels causes various challenges, including in relation to service funding, service models and workforce planning. Considering the jurisdictions in Australia from an AOD perspective, there are significant barriers to integration because there are separate AOD service systems, often quite different between jurisdictions, particularly in relation to levels of AOD service delivery by local health networks (**LHNs**) (which are called Hospital and Health Services (**HHS**) within Queensland) and linkages between LHN services and non-government services, with significant differences in funding approaches. These separate AOD service systems remain relatively undeveloped and inconsistently organised. Such separate AOD service systems unsurprisingly tend to advocate strongly against integration, perceiving their autonomy as threatened and emphasising the potential harms of a lack of support for substance use disorders treatment from a larger mental health service system which lacks an understanding of the needs of people receiving treatment for primary substance use disorders and of the service system. Mental health service systems equally tend not to embrace integration.

22 There is thus a mutually distrustful dynamic between mental health and AOD services which is unhelpful and which impacts most particularly on patients with co-occurring substance use and other mental health disorders, and particularly those with severe problems in each. There are no evident levers outside state health departments supported centrally by governments for changing this. There are certainly challenges with any approach to integration which would require long term commitment and effort and would vary with the starting position of any jurisdiction, but in my view if current system divisions and mindsets continue then it will not be possible to develop appropriate

systems for effective care of people with co-occurring substance use disorders and other mental health disorders. A key requirement for this is likely to be the further development of a stable addiction service structure in addition to ensuring clear links between mental health and addiction as discussed below.

23 As Chief Psychiatrist, I represent Queensland on the Safety and Quality Partnership Standing Committee (**SQPSC**) of the Mental Health Principal Committee. As a general principle, clinical aspects of addiction are not discussed at SQPSC because a number of jurisdictions represented indicate that responsibility for clinical AOD care falls outside the mental health branch or equivalent within the department of health. It is then not possible to meaningfully consider at the committee co-occurring substance use disorders.

24 Consideration of safety and quality matters in relation to AOD clinical care do not seem to be held consistently in any Australian jurisdiction because of the significant differences in the structures of clinical AOD service systems. If they do happen at all, such as in forums like the National Drug Strategy Committee, the focus is not on clinical service provision or mental health related issues. Safety and quality matters similarly generally exclude, or at least cannot meaningfully include, consideration of co-occurring substance use disorders with other mental health disorders. This means in my view, people who may be able to meaningfully contribute, address and make decisions around co-occurring substance use disorders, are not in the room either in mental health or AOD governance structures. Because substance use disorders are not discussed in SQPSC, it is not possible to effectively consider issues relating to safety and quality mechanisms particularly for co-occurring substance use and other mental health disorders in either mental health service or AOD service settings. Again, in my view this separation particularly impacts on consideration of co-occurring substance use and other mental health disorders and related safety and quality concerns but is applicable more widely.

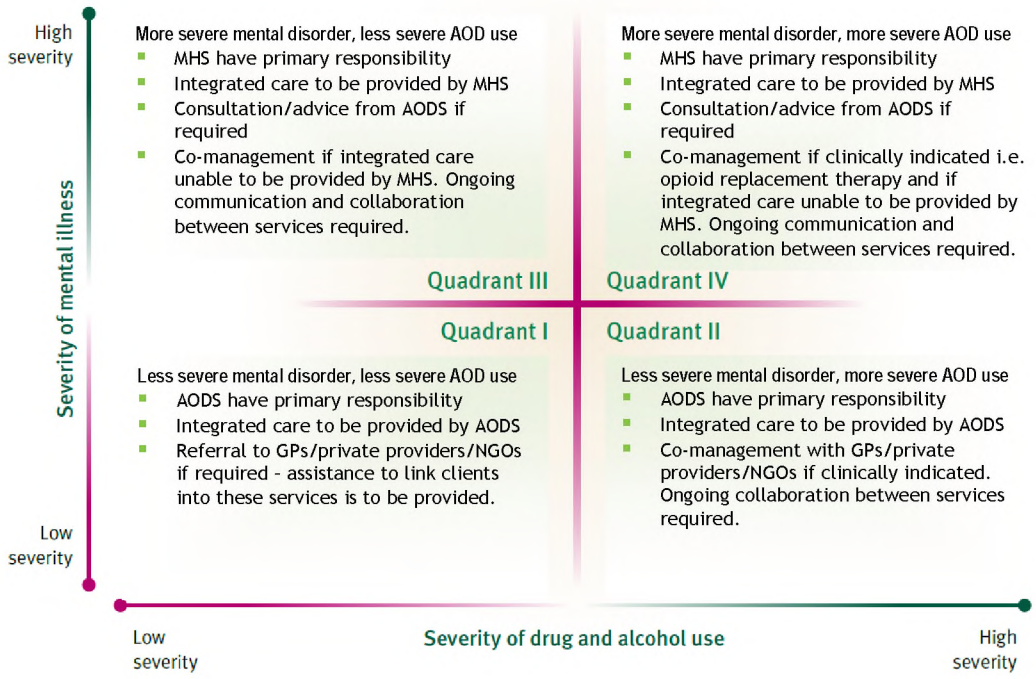
25 I also consider it is worth noting that changes in such processes would require both individual jurisdictional and Commonwealth leadership. At the Commonwealth level this would need to be demonstrated through bodies such as the National Mental Health Commission to allow integrating effective care of people with co-occurring substance use disorders and other mental health disorders. I consider that is how we can address the change in the longer term. Individual jurisdictions can certainly take significant steps, for example Queensland and Tasmania have integrated mental health and AOD service structures at LHN and departmental level to significant degrees and are continuing work to enhance the level of integration, while emphasising the maintenance and extension of addiction specific expertise. New Zealand seems to have achieved far greater integration of service delivery than any Australian jurisdiction. However, most of the other jurisdictions represented at SQPSC appear to have less integration or focus on integration, with some seeming very clear about maintaining absolute separation between

mental health and AOD services. In my view this highlights the dilemma, including at a national level.

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

26 Focussing from a clinical governance perspective on co-occurring substance use disorders, Queensland Department of Health released a Dual Diagnosis Policy in 2008 and Dual Diagnosis Clinical Guidelines in 2011. In considering responsibility for different combinations of severity of mental health and co-occurring substance use disorders, these guidelines use the well known four-quadrant model (as inserted below from the Queensland Dual Diagnosis Clinical Guidelines).

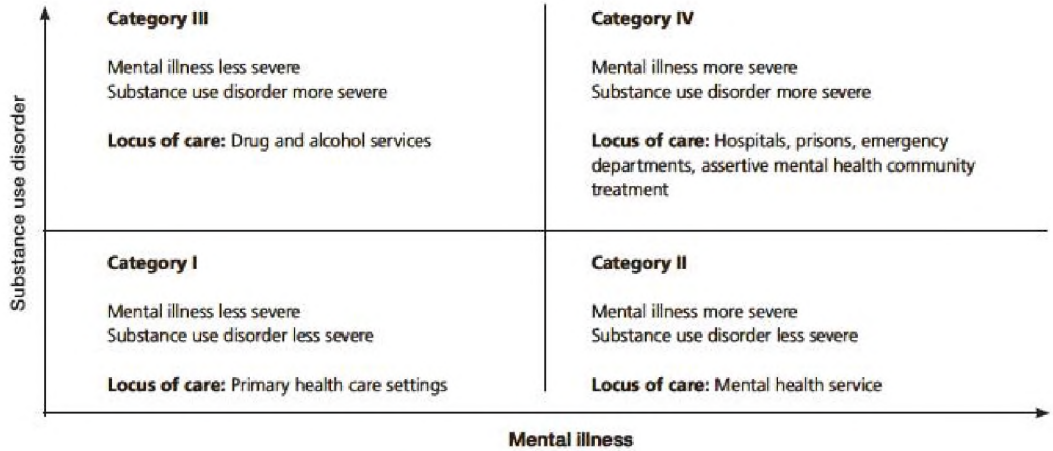
Figure 3
The Quadrant Model for understanding co-occurring mental health and alcohol and other drug use disorders (dual diagnosis)



27 As shown, this schema uses a continuum of less or more severe substance use disorders and mental health disorders each on separate axes, creating four quadrants, of both less severe, both more severe and one of each, as a guide for responsibility for service provision. Patients are therefore assessed in relation to the severity of their addiction and

mental health issues (for example, a person may be assessed as having a more severe mental health issue with a less severe addiction issue, or vice versa).

28 This model has been the Queensland MHAOD Branch's broad clinical governance policy since 2011 and it remains a guide, however is under review. The model is inevitably simplistic with limitations including the identification of severity and the failure to adequately consider the role of primary care in this specialist carve up. It is important to recognise that patients with co-occurring substance use disorders and other mental health disorders at the less severe end (Quadrant I) in reality should be best considered as requiring primary care treatment rather than specialist mental health or AOD service treatment. If a patient fits best in Quadrant II or III then it will be most appropriate in general that they receive treatment at the service focussed on the more severe and higher need problem type. This service should also be able to support treatment of the less severe disorder or to liaise with primary care in its joint management. For example, if a person has an anxiety disorder, their GP could refer them to a specialist psychologist or psychiatrist or a specialist mental health service. If they also use substances in a harmful way, this should be identified and treated by the psychologist or psychiatrist (or a specialist mental health service) treating the person's anxiety disorder. However, in a Quadrant IV situation, where both disorders are more severe such as an alcohol dependence and a bipolar affective disorder, the question becomes, what happens then? The variation from the NSW Clinical Guidelines - For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings (https://www.health.nsw.gov.au/aod/resources/Pages/comorbidity-report.aspx) highlights this issue, variations in the model and also particularly variations in approach at Quadrant 1.



Adapted from Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol* (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

29 There are differences in the way that jurisdictions have approached this question, but to my understanding no jurisdiction can claim it currently has this problem solved in relation to its public sector mental health care of people with co-occurring substance use disorders. Queensland's policy, using the four quadrant model, is that if a person has a severe mental illness, such that they are being treated by a public sector mental health service, then that mental health service should also be treating the person's substance use disorder. So in a Quadrant IV situation - for example, where the person receiving treatment for a bipolar affective disorder from a mental health service requires treatment of alcohol dependence, this should also occur within, and by, the mental health service. If the person was receiving treatment from an AOD service, then the AOD service would consider whether they had capacity to appropriately treat both the substance use and mental health issues, which might vary with acuity of the mood disorder. If not, the AOD service could refer a person to a mental health service for treatment.

30 In Queensland, there was a clear expectation that the mental health system treat people with co-occurring mental health and substance use disorders. Mental health services could seek advice or a primary consultation from ATODS but continue to treat the substance use disorder, with the proviso that co-management may be necessary in some exceptional circumstances. A particular example of an exceptional circumstance is the opioid dependence treatment in circumstances where the primary responsibility for the person's substance use disorder treatment sits with the mental health service.

31 There are no performance measures available in relation to the expectation identified in the paragraph above, but my observation is that this policy has not been able to be effectively implemented to date in Queensland, similar to other jurisdictions that I am aware of both nationally and internationally, largely for the separate mindset reasons noted earlier. We have recognised this however and are implementing various approaches which will support the more effective implementation of this policy.

32 In some other jurisdictions, my understanding is that in such a Quadrant IV situation, the policy is the treatment of the substance use disorder is not the mental health service's responsibility, but requires referral to an AOD service. However for patients receiving treatment from specialist mental health services for severe mental illnesses such as schizophrenia and bipolar affective disorder, it is comparatively rare, on the available evidence and anecdotally in ongoing practice, for such patients to be linked effectively with another service providing substance use treatment.

33 Therefore, at present mental health and AOD service systems are not clear about policy nationally in relation to the treatment of co-occurring substance use disorders and other mental health disorders, particularly where both are more severe, and where a service is unsure whether they should be treating all these disorders. This has significant deleterious impacts on a variety of policy approaches to improving the care of patients

across all four quadrants, but particularly patients that fall within Quadrant IV. One deleterious impact that is immediately evident is in the training of mental health and addiction specialists across disciplines.

34 Although a de-integrated approach is adopted in all jurisdictions, in routine clinical practice, if not in policy, the evidence is that de-integration does not work since if both are expected to, neither the mental health or AOD systems are likely to be able to appropriately and effectively engage patients with co-occurring substance use and other mental health disorders. To implement integrated care consistent with clinical guidelines and the evidence, we need to accept that patients with severe mental illnesses with co-occurring substance use disorders must receive integrated treatment from their specialist mental health services and service providers. This requires the recognition on behalf of such services and providers that this is their responsibility.

35 The challenge is that mental health services have historically not considered this as their role and are not resourced appropriately to treat co-occurring substance use and other mental health disorders. The resources lacking particularly include staff with attitudes and skills in such treatment. By this I mean that staff do not see it as core business to treat substance use disorders in specialist mental health services. There is good evidence that there is a lack of training, knowledge and skills in our mental health service providers in relation to substance use disorders, so that even when they acknowledge the necessity of treating co-occurring substance use disorders, mental health services do not know how to effectively provide treatment.

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

36 Mental health services stream on the basis of severity of symptoms, associated risk and functional outcomes. Co-occurring substance use disorders have a significant impact on these but generally, in my view, streaming should not be required solely on the basis of the substance use disorder a patient may have. This is because patients in any stream with a severe mental illness will also have a high prevalence of substance use disorders impacting negatively on their illness severity, risk and functioning which should be seen as requiring effective treatment at all levels and streams.

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

37 In my view, the mental health workforce does have the basic knowledge and skills to be able to offer treatment for substance use disorders. I reiterate that I consider the main issue to be one of mindset – that mental health services historically do not want to treat

substance use disorders but rather want to externalise responsibility for that problem, arising for many reasons including the perception of lack of skills, knowledge and resources. From a technical clinical perspective for specialist mental health service providers, substance use disorders are relatively straightforward. The standard problems seen by mental health services are problematic use of tobacco, alcohol, cannabis, amphetamine type stimulants and then opioids and sedatives, with other substances less frequent in most settings. The acute specialist mental health presentations as a result of harmful substance use are often in the form of psychosis, self harming and suicidal behaviours, and depression and anxiety.

38 In my view, it is a comparatively straightforward task for the mental health service provider workforce to identify appropriate evidence-based treatment for persons presenting in this way and to provide treatment and care including continuing monitoring. The actual treatment for substance use disorders is not the challenge. It is rather the conceptual challenge that the mental health service system, and providers, do not consider treatment of substance use disorders to be their responsibility. The mental health service system is not wanting to offer such treatment or at times to identify treatment options for substance use disorders as it is simpler when a substance use disorder is identified to tell patients to go to a separate AOD service. This issue in relation to mindset goes across all disciplines of mental health.

39 Mental health service providers do have the basic knowledge and skills (although they often need further development) but the attitudes are problematic because they accurately reflect the current structures. Mental health service providers who do not perceive themselves as having responsibility for treatment of substance use disorders co-occurring with other mental health disorders will inevitably not adopt attitudes which are holistic and person-centred because they are instead service focused. This is an outcome of our service system structures and their impact on our training models across health generally, and in both AOD and mental health services particularly. When such structures persist over extended periods, practical expertise does not develop effectively due to lack of routine practice, even in the presence of core knowledge and skills. However, service systems have capacity to change this and ensure such expertise. Some service providers provide very effective services at the individual practitioner and patient care levels, but it has been very uncommon in my experience for this to occur consistently at wider team or service levels.

40 In my view, having clinical addiction services seen as a key sub-specialty area which forms a part of a wider mental health service system, which is in turn part of the wider health system, is the best structure to enable the alignment of service delivery across both AOD and mental health treatment. It will also enable effective treatment of co-occurring substance use disorders and other mental health disorders. However, as I

understand it, in Victoria, one of the challenges is that specialist clinical addiction services themselves are a patchwork across the state and that there are no formal linkages expected between them and mental health services. This is certainly not a problem only in Victoria.

41 Queensland has similar AOD service models to those funded nationally, including in Victoria, with substance use withdrawal, counselling and rehabilitation provided in community-based and in residential rehabilitation settings provided by non-government organisations with various funding sources including through the Queensland Government. My understanding is that the Victorian approach of intake and streaming to those services is quite well structured.

42 However, in Queensland, there is a clinical AOD service within each of the 16 LHNs and HHSs. My understanding is that Victoria does not have consistent clinical AOD services available similar to those in Queensland HHSs.

43 I understand that this Royal Commission excludes consideration of AOD services. However as highlighted above, structurally, without a functional clinical AOD service linked closely to LHN or HHS services, including specialist mental health services, persistent or chronic pain services and consultation liaison services, my view is that it is not possible to establish effective models of service for co-occurring substance use disorders and other mental health disorders. Additionally, I consider that models of training for mental health and AOD service providers cannot be appropriately established in order to support effective treatment of addiction, including particularly co-occurring substance use disorders and other mental health disorders. This does not necessarily require any formal integration, but it requires clarity about the AOD service system and very close co-ordination. It is challenging to identify how to engage workforces across mental health and AOD service systems, from the point of view of developing expertise consistently. This is particularly so in relation to mental health clinicians treating co-occurring substance use disorders.

Question 6: What are the opportunities for joint mental health and alcohol and other drug workforce training and development?

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

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

44 In responding to this question, I will refer to some of the many small-scale examples that have developed in recent times in Queensland. However, I am not aware that any of these have been formally evaluated or that there has been assessment in relation to their efficacy, so this is simply my observation.

45 Queensland's MHAOD Branch has focussed on integration of mental health and AOD services over the past decade at least. Within Queensland Health, the re-linkage of the separate mental health and AOD parts of the Department occurred in the late 2000s. Queensland's integration has continued (which is demonstrated by the policy and guidelines) and since 2012 has extended with the creation of the HHSs. My formal role title is reflective of that integration.

46 By about 2016, most Queensland HHS mental health services and AOD services had been formally linked under the same governance structure. This means that clinical AOD services sit within the wider mental health and AOD services within Queensland Health HHSs, with line management reporting to an executive director or equivalent who has oversight across mental health and AOD services. Additionally, in almost every service the clinical director role has responsibility for both mental health and AOD teams. There are a few exceptions to this in some HHSs where AOD services have a separate clinical director reporting to the executive director.

47 The advantage to this structure, particularly from a workforce perspective, is that there is recognition by the executive director and at the HHS executive level of the linkages across addiction and mental health services. This generally applies to clinical directors also, who are generally psychiatrists with some oversight of psychiatric training within the HHS. That ensures that the MHAOD service leadership has a clear interest in recognising the needs and requirements of both the addiction service and the mental health service and the capacity to consider the needs and requirements of the people with co-occurring substance use and other mental health disorders who may not fit into standard structures. From this point, my experience suggests that there is the potential for creation of different modes of thinking about opportunities for crossover and linkages of training and co-development of the workforces' skills. We are seeing this occurring increasingly across Queensland, though such changes are not uniform and concerns remain among some specialist AOD services and providers within HHSs not adequately reflecting the needs of AOD services. However, some brief examples below of integration processes impacting on medical workforce planning and development in Queensland may be illustrative.

48 In Mackay, a northern city of approximately 125,000 and a catchment population of approximately 200,000, a psychiatric training program has developed only in about the last five years. Mackay does not have a medical addiction sub- specialist (in either addiction medicine or addiction psychiatry), however it has practitioners with practical expertise and now has generalist psychiatrists and medical staff that work in its AOD service. All of the psychiatry trainees in Mackay, currently about five, will have at least three months full time equivalent experience in addiction, including acute withdrawal and opioid treatment program delivery, during their three year basic psychiatry training. Their

mandatory six month consultation liaison psychiatry experience will also include AOD consultation liaison since the consultation liaison service is generalist.

49 In Townsville, a northern city of approximately 175,000 people and a catchment population of about 250,000 there is a long established psychiatry training program. There was no arrangement for psychiatry trainees to gain training experience in addiction prior to linkage of the Mental Health and Alcohol Tobacco and Other Drug Services in 2011. At the time of this formal linkage I became Medical Director for the ATODS as part of the wider program (then titled the Institute of Mental Health Alcohol Tobacco and Other Drugs Services). Since 2012, initially with about 12 psychiatry trainees, and now 16, all trainees gain practical training experience in AOD, most through a formal ATODS rotation but all via a shared consultation liaison psychiatry model which incorporates addiction. The two consultation liaison psychiatrists are also accredited addiction psychiatrists, one having trained in both consultation liaison and addiction within the service.

50 Three other psychiatrists have trained in Townsville since 2015, making a total of four psychiatrists who have completed the training experiences for addiction psychiatry, with two having obtained their Certificate of Advanced Training in Addiction Psychiatry (the **Certificate**). One other of these psychiatrists has completed a Fellowship in Pain Medicine and is finalising their Certificate. One rural generalist trainee completed advanced skills training in mental health which included experience in addiction and is now responsible for medical addiction treatment, including opioid dependence treatment, in a remote Queensland town which previously received this service via occasional visits from Cairns. Such generalist and sub-specialist expertise builds training capacity.

51 The above examples are provided because they are small scale and readily available for roll out. However, there are a number of larger scale examples of expertise building in larger HHSs. One issue that raises concerns in relation to structural integration is of addiction sub-specialists who perceive their skills as not being valued within mental health service settings. An example might be addiction medicine specialists who are not psychiatrists. My view is that in cities and larger towns the need for the skills of such medical addiction specialists are evident and the benefits of such expertise should be used as a resource across the service systems and not act in any substantive way as a barrier to such integration. I also believe that this applies to clinicians from other disciplines who have specialised their practice to addiction. However, I do think that in regional areas with much lower population density, generalism across all disciplines has increasing advantages and has the capacity to more effectively meet clinical need than sub-specialist models developed in metropolitan and regional city settings.

Question 7: What new roles, training and development are needed for MH and alcohol and other drug workforces to enable integrated practice?

52 Queensland Health's Medical Practitioner Workforce Plan for Queensland in 2017 (the **Plan**) recognised the need for the development of both psychiatry and addiction medicine workforces. In the Plan's Phase One, positions were funded by Queensland Health's Medical Advisory and Prevocational Accreditation Unit to support psychiatry training and medical addiction training, including the creation of medical addiction sub-specialist training positions in two HHSs which were filled in Cairns HHS and the Metro South HHS. Phase Two has also funded a pilot supported by the MHAOD Branch to develop an employment pathway for rural generalists with advanced skills training in mental health. We hope that this will address current and future shortages in the mental health workforce in rural and remote Queensland. This pilot is intended to demonstrate a pathway for rural generalists to provide a medical workforce for specialist mental health and AOD teams in rural and remote Queensland. Two HHSs, Torres and Cape and Central West, are employing rural generalists into these roles and early indications are that this is a viable model.

53 Consistent with the above approach to mental health and AOD service structures, my view is that medical addiction specialists should be considered as medical sub-specialists in addiction, whether they are addiction medicine specialists or addiction psychiatrists. The term addiction medicine is used sometimes because that is the AHPRA registration term for the group of addiction medicine specialists. There are comparatively few specialists in addiction medicine, with 33 in Queensland and 30 in Victoria in December 2019. However, this does not count many addiction psychiatrists who are not addiction medical specialists. In December 2019, there were 32 addiction psychiatrists in Queensland, of whom at least 10 were also addiction medicine specialists. Addiction psychiatrists and addiction medicine specialists have the same addiction sub-specialty skillset and can do the same work, but addiction psychiatrists who are not registered as addiction medical specialists do not count in many workforce plans. This creates a false impression that there are fewer addiction sub-specialists than in reality. It also limits thinking on options for expanding this group, as demonstrated by the north Queensland examples given above. There are no addiction medicine specialists in Queensland north of Bundaberg in the Wide Bay, about 1000 kms south of Townsville. There are however medical addiction specialists with at least three addiction psychiatrists in Townsville and at least one more in training in Cairns.

54 In my view, this demonstrates that separate mental health and AOD service systems may act to limit potential development of capacity in addiction and its extension into wider mental health services and that the separation of addiction medicine training from psychiatry may contribute to such restriction. Recent Queensland experience has been

that it is difficult to recruit addiction medicine trainees into new positions, but straightforward to recruit trainees in addiction psychiatry. In Queensland in 2014 there were four trainees in addiction psychiatry (in Australia a total of eight trainees). In 2019 there were 20 trainees in addiction psychiatry (with a total of 79 trainees in Australia). In Queensland in 2018 there were two trainees in addiction medicine, one of whom was already an addiction psychiatrist, (in Australia a total of 39 addiction medicine trainees) and 15 trainees in addiction psychiatry (in Australia a total of 68 trainees).

55 In Queensland, the MHAOD Branch is encouraging all HHSs to expand their capacity for medical addiction sub-specialist training, for both addiction medicine and addiction psychiatry, and to provide experiences in addiction for all psychiatrists. The latter training is a means of creating a mindset that all psychiatrists require addiction experience. We need to have a cadre of addiction sub-specialists, whether in addiction medicine or addiction psychiatry, but also need to ensure that all psychiatrists completing their training develop what has been termed "generalist specialist" experience and capacity in addiction if we are to effectively treat people with co-occurring substance use and other mental health disorders.

56 The development of generalist capacity among psychiatrists is essential to build a base to be able to effectively support general practitioners and other health practitioners to provide a standard level of care for mental health and AOD disorders, including for co-occurring disorders.

57 The numbers provide the rationale. There were 4085 psychiatrists in Australia in January 2020 (1110 in Victoria, 823 in Queensland) and 187 addiction medicine specialists, with a significant proportion of the latter being psychiatrists, perhaps about a third if the proportions across the country were the same as in Queensland.

58 This number of psychiatrists in Queensland means that a GP can have a patient seen for depression in the private psychiatric sector relatively easily, noting there may be a waiting list, that this does not apply in all regions equally and that of course financial constraints may limit this capacity. However, even if there were none of these constraints, to see an addiction medicine specialist or an addiction psychiatrist is a very different story. It is not possible for a GP, or other medical providers, to refer patients to these medical addiction specialists given the relatively low numbers of these professionals.

59 Medical addiction specialists clearly need to be involved in service delivery in relation to complex cases but to also effectively treat addiction at both a primary care and a specialist level, given its prevalence. In my view, we must ensure that all psychiatrists receive practical experience in addiction during their basic training. The essential key to creating such opportunities for training experiences in addiction in psychiatry in my view is the integration of AOD and mental health services. Medical addiction specialists can then

focus on the roles of particularly complex care case consultation, training and further specialist addiction service development and innovation, supported by appropriately targeted research, including effectiveness.

60 Taking Queensland as an example again, outside the southeast corner (i.e. roughly north of Bundaberg and west of Toowoomba), with a population of over one million, there are no addiction medicine specialists. As outlined above, in Townsville several new addiction psychiatrists have been trained and more are in training now in Cairns, however regardless a reliance on such medical addiction sub-specialists would not be a sensible way to approach the urgent need to develop an addiction capable medical workforce.

61 However, as Queensland's policy of integration has continued, in the same area outside the southeast Queensland corner there are approximately 120 psychiatrists employed in the public sector and 100 trainee psychiatrists. These trainee psychiatrists appear to me to be more culturally comfortable with recognising the fact they need to have training in addiction, not necessarily to become sub-specialist addiction psychiatrists but to be able to provide addiction at a "generalist specialist"' level. The clear policy direction of integration is beginning to change the mindset of psychiatrists around substance use disorders and leading to a growth of expertise in addiction. This expertise and mindset then support similar change in other health professionals working within mental health and AOD. In my view therefore creation of generalist specialist capacity in addiction among all psychiatrists remains the key to ensuring effective treatment of people with co-occurring substance use and other mental health disorders, however this requires a core capable sub-specialist medical addiction workforce assuming the roles identified above.

62 Queensland MHAOD services have been able to take actions to enhance training due to a degree of integration but we have also been creating and building positions gradually to ensure that psychiatry trainees are providing medical addiction services. This then transfers skills and knowledge to the wider mental health workforce. If psychiatry trainees have addiction training experience, this impacts on undergraduate medical students, junior hospital doctors, registered nurses and allied health professionals.

63 I understand that the Royal Commission has recommended that junior hospital doctors should have mandatory psychiatry rotations. In my view to address addiction as a core part of mental health, then junior hospital doctors should also have experience with co-occurring substance use and other mental health disorders. To do so it is essential that psychiatrists and doctors develop practical expertise in substance use disorders given the challenges our community faces in relation to these disorders and the particular roles of medical practitioners in relation to identification and management of alcohol use, chronic pain, opioids and sedatives and their overlap with suicide risk and the concerns relating to medical cannabis use and stimulants. These problems are all magnified for people with severe mental illness.

64 In addition, the integration of mental health and AOD services creates opportunities for disciplines other than psychiatry to make the shift and gain broader training exposure. This has been observed in Queensland to some degree, but it is comparatively early days in this regard. The current focus on psychiatry trainees is to some extent because they are a large group who are readily available, are interested in developing their skills in mental health including addiction and are required to complete this training as a core part of their curriculum and their assessment and in their structured training placements which can include addiction. These trainees will ultimately go on to assume clinical leadership roles within mental health services on completion of their highly specialised and extended training. However, as long as the mindset towards inclusiveness of AOD as core business is changing throughout the mental health service system, changes to training for other staff become feasible. For example, it is somewhat easier for nursing staff rotating through mental health units to get the relevant experience if there is collaboration and flexible approaches to transfers and placements. What is important is that nursing staff have the sense that they are capable and competent to treat substance use disorders when they are working across mental health and acute mental health inpatients unit. Currently, it is my impression that this is not the case. Having acute care nursing staff who are confident and capable and can screen and assess co-occurring substance use disorders makes an enormous difference. This thinking across all disciplines is important.

65 Queensland's development of rural generalist pathways has been very advanced nationally and we have more recently also focused on training rural generalists with advanced skills in mental health. In my view these generalists must be trained in addiction during their one year advanced skills training in mental health, which is consistent with the Australian College of Rural and Remote Medicine curriculum, although perhaps less consistent with the Royal Australian College of General Practitioners curriculum. In my view the suggestion of advanced skills training in addiction medicine within a rural generalist context is inappropriate since it is a product of specialist thinking. In my view, the focus should be on rural generalism rather than the isolation that can occur following the separation of services and specialty groups. It would be highly problematic if rural generalists with advanced mental health training or generalist psychiatrists did not have practical expertise in addiction if they are servicing rural areas. I am encouraging all services providing such training to ensure that their rural generalist trainees receive appropriate training in addiction, consistent with the Townsville training mentioned earlier.

66 I understand that Queensland may be leading the way in training rural generalist psychiatrists in mental health and AOD use. I also consider that generalist psychiatrists who wish to provide specialist remote care in addiction should be encouraged to do so through provision of professional development training and other supports. Such options may also be appropriately considered in Victoria. Finally, I consider that it is essential when talking about treatment to regional and more remote areas, that we need to train

staff and consider further the opportunities for telehealth, though the COVID-19 pandemic's impact may have made highlighting this need redundant.

QUEENSLAND REFORMS

Queensland's decision to organisationally combine mental health and AOD services in 2012

67 I was not at the MHAOD Branch when it became integrated which was prior to 2012. However, it is my understanding that as a result of an organisational restructure within the Department of Health. At that time responsibility for AOD clinical services policy and programs were linked with mental health while the prevention and regulatory functions went elsewhere in the department.

68 The creation of the Queensland Mental Health Commission (the **Commission**) emphasised the government's commitment to driving ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system in a co-ordinated manner. The Commission's guiding principles included the need for integrated approaches across government and non-government sectors and across wider social domains including health, housing, employment, education, justice and policing. It supported a whole of government strategic plan with the mental health and AOD sector being a key component of this.

Improvements to Queensland's reforms

69 Integration of mental health and AOD services has occurred at the MHAOD Branch level within Clinical Excellence Queensland and is part of the government's policy. I believe it is understood now by the mental health and AOD sectors that integration centrally is the government's direction. As noted above, this is reflected in the structure of the HHS MHAOD services. However, challenges remain about the best structures to support integrated approaches and practice and cultural change throughout the various workforces.

70 I consider cultural change can be approached through both 'top down' and 'bottom up' approaches within services. This is emphasised in discussions with the executive directors of HHS mental health alcohol and other drug services in Queensland, who now clearly accept responsibility for their AOD services as central parts of their roles and have led many cultural changes within their services. The MHAOD Branch convenes a senior leadership group with a monthly video conference with executive directors and clinical directors of all MHAOD services in all HHSs across Queensland to discuss issues relating to MHAOD.

71 Further, MHAOD holds a face to face strategic forum three times a year for this group. A forum two years ago focused on integration of MHAOD services. MHAOD services presented on the challenges they faced and the processes undertaken to integrate their services. The broad message from across the leadership group is that the AOD component of the work we do is just a standard part of the wider MHAOD system. The expectation and the reality is that executive directors and clinical directors treat AOD services as part of the mental health component of their services but have oversight and an understanding of what is occurring within AOD services in the same way that historically they have for acute inpatient mental health units and other mental health services. This is the top down approach.

72 At a different level, we have encouraged all services to consider strategies they can adopt to create training positions for trainee psychiatrists to have experience in AOD and for clinicians to rotate across MHAOD services. This is not an expectation of the MHAOD Branch, however we are certainly encouraging HHS MHAOD services to consider any such strategies to be adopted. We will continue to provide forums for executive directors and clinical directors to communicate these strategies and explain the rationale as to why these strategies are important. These are cultural changes - it is not something we can mandate.

73 We have seen cultural change precipitate practice change. For example, you can see cultural change in the way Queensland's Mental Health Clinical Collaborative has addressed tobacco dependence, which is a discrete physical health issue in addition to a substance use disorder. Queensland's mental health services have achieved significant gains over a number of years in the identification and clinical pathway completion for people with serious mental illness who are tobacco dependent in acute inpatient units and our community mental health teams. We have seen marked improvements in service recognition of tobacco use and completion of the smoking cessation clinical pathway. There are not yet clear improvements in reducing the smoking rate as an outcome, but there are clear changes in practice. I consider we need to be doing something along the same lines with all substances, and with other behavioural disorders such as gambling, internet and screen addictions. Addiction can come in many different forms and mental health services need to be more aware of addiction due to their prevalence and associated harms.

The delivery of integrated mental health and AOD treatment and support in Queensland

74 Queensland's dual diagnosis policy is online at https://www.health.qld.gov.au/__data/assets/pdf_file/0023/444632/ddpolicy_final.pdf Linked with implementation of that policy were dual diagnosis employment positions

between the mental health services and AOD services. The policy has not been evaluated, however the creation of the positions has not led to consistent approaches to treatment of co-occurring substance use disorders with other mental health disorders, since it was applied differently in different services. The dual diagnosis policy is clear in its intent but not specific at the level of service delivery or measurement of these, although at an individual level there are many positive examples of effective work with individual consumers and small groups. However, it can be very reasonably argued that the policy has created the integrated mindset that is leading to a greater acceptance of the reality of integration at a structural level in Queensland Health HHSs now.

75 In my view, we need to have clinicians with sub-specialist addiction capacity in supportive roles within mental health services on at least a transition basis but also be very clear about our overarching policy intent that clinical care and treatment should be provided in an integrated fashion. This means that all clinicians must have these capacities and must see this as their core business, not something to refer away as someone else's problem. To reach our policy aims we must focus on how we enable staff to develop skills and ensure that they use them in the interests of consumers with co-occurring substance use disorders with other mental health disorders to meet those policy intentions and goals.

Queensland's Connecting Care to Recovery 2016-2021 plan and its impact on collaborating and integrating mental health and AOD systems

76 MHAOD has encouraged consideration of further integrated models and supports the integration of mental health and AOD systems in Queensland's Connecting Care to Recovery 2016-2021 plan. This remains the ongoing intent.

77 One major policy change being implemented is the integration of the existing statewide information system for HHS clinical AOD services, the Alcohol, Tobacco, Other Drugs Services Information System **(ATODS-IS)** with the Consumer Integrated Mental Health Application (**CIMHA**). CIMHA is a state-wide clinical information system that supports mental health services in Queensland. There has been work over several years across both mental health and AOD services to identify the requirements and develop the specifications for this integrated electronic health record. This has included the updating of the existing mental health specific statewide clinical documentation suite used as forms within CIMHA to incorporate the needs of AOD services so that the suite works for both mental health and AOD documentation needs. This involved nearly two years of wide consultation, working party meetings and reviews to create the updated suite and the clinical pathway approach which addresses both mental health and AOD requirements. The actual forms were completed in late 2019 along with the outline of how they are intended to be used however work on the support materials and training packages is

continuing. The current scheduled release of CIMHA 5.0, to be now formally called the Consumer Integrated Mental Health Addiction application, is 24 October 2020.

78 The National Mental Health Service Planning Framework is being used in Queensland to guide mental health service planning. However, this framework is an example of the impact of the separation of AOD and mental health in our federal system since it does not address drug and alcohol services other than implicitly expecting that co-occurring substance use disorders will be treated by mental health services. This has meant that Queensland is also working on updating the Drug and Alcohol Services Planning Model (**DASPM**) in order to have a solid base for planning for AOD services. While separate models run the risk of unnecessary duplication, ensuring the DASPM is contemporary and fit for purpose in Queensland is a necessary stage for the development of a secure funding and commissioning foundation for AOD services. Ideally this would be transitional towards a more integrated planning approach.

79 However, this would require a national agreement. As such, the MHAOD Branch is in the process of using these national frameworks within Queensland, including in consideration of further broad planning, in as integrated a manner as possible. With the benefit of having the same executive directors within MHAOD services in HHSs involved in planning and Primary Health Networks also linking the two areas more consistently we anticipate being able to connect these up where necessary and appropriate. So given these processes, together with Queensland's integration, we aim to connect our planning and thinking within mental health and AOD services despite many broader frameworks being separate. This exemplifies that in Queensland, we are continuing with this cultural change and mindset that MHAOD treatment are not completely separate.

CO-OCCURRING MENTAL ILLNESS AND PROBLEMATIC AOD USE

Challenges for people with co-occurring mental illness and problematic AOD in accessing suitable support

80 One of the issues that arises as we connect up our workforces across mental health and AOD is that it highlights that some of the workforce are sub-specialists and some do not have formal subspecialty training or feel competent. It has sometimes been stated that addiction medicine specialists approach clinical problems from a physical health focussed mindset due to their background and are more attuned to physical health needs than mental health clinicians. Historically, this has been the case due to training, however, in my view this is a great prompt and reinforcement for those involved in mental health treatment, just as in addictions, that we must be more conscious of physical health problems. To some degree, this is not the great challenge that perhaps it was a decade ago. Psychiatrists and other mental health professionals are commonly required to recognise significant physical health challenges in order to effectively treat people with

severe mental illness and numerous strategies have been developed to emphasise the centrality of this over the past two decades which have gradually borne fruit. It is vital for mental health professionals to be aware of physical health issues, particularly when we know that people with co-occurring substance use and other mental health disorders, often have significant physical health problems, often at an even younger age than people with serious mental illness without co-occurring substance use disorders. Our health workforce generally needs to be acutely aware of these associated physical health issues in providing treatment. Our processes for monitoring treatment and decision making support need to support such practice.

81 A separate issue is the recognition that we may be looking at a different problem depending on which service setting we look at or work in. In sub-specialist AOD service settings, the more common mental health disorders co-occurring with substance use disorders are moderate anxiety and mood disorders, post-traumatic stress disorder and personality disorders (which are also complex but often not formally addressed in such service settings). In specialist public sector mental health service settings, the more common mental health disorders co-occurring with substance use disorders are schizophrenia and related psychotic disorders, including stimulant, cannabis and other substance induced psychotic disorders, severe mood disorders, both depression and bipolar affective, and severe personality disorders, at least in adult settings. This is largely because these are the target mental health disorders addressed by such services, since all have very high rates of co-occurring substance use disorders.

82 In my view, the key issue for consumers is the 'no wrong door' approach. We have long emphasised the centrality of engagement and that mental health services need to meet the consumer on their terms as much as possible for there to be effective engagement. This includes being prepared to address the consumer's needs to the maximal extent possible. In the setting of people with co-occurring substance use and other mental health disorders, it is clearly not helpful for the consumer to be either simply referred elsewhere, often dismissively, with a cold handover, which we know is ineffective. It is just as unhelpful if the substance use disorder is not appropriately treated by a mental health service which lacks interest or capacity in doing so. We need to create new models of care for provision of such services.

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

83 The nub of the problem is that people with co-occurring substance use and other mental health disorders are stigmatised. I observe unwitting examples of this from medical addiction sub-specialists and from psychiatrists and from other mental health and addiction professionals routinely. Terms such as "drug-induced psychosis", "self-

medication" and the use of epithets such as "behavioural" and "their choice" in relation to addictive behaviours are all stigmatising ways of blaming the patient and externalising the problem by health professionals. It often seems that no-one really wants to provide treatment to people with co-occurring substance use and other mental health disorders, largely for the reasons highlighted above relating to service systems. This means that no service provider is taking responsibility for the treatment of consumers with co-occurring disorders, in addition to there being a lack of knowledge and confidence in a clinician's own competence to provide such treatment. This applies even to some addiction psychiatrists who have capacity and knowledge but due to working in a separate service system distance themselves from the Quadrant IV patients and mental health service system difficulties. For some, sub-specialisation in addiction has been due to their preference to not work with people with severe psychosis and mood disorders in mental health service settings as noted above. This is perfectly reasonable as a personal career and work preference choice but it can also contribute to the stigmatisation of people with co-occurring substance use and other mental health disorders through the fortification of the artificial walls and boundaries between services, service providers and service provision. We need to be very alert to stigma in all settings.

84 I consider another harm worth considering is in relation to misdiagnosis. For example, in my view there is a significant problem of mental health services identifying people as having substance induced psychotic disorders which is then used as a rationale to not provide longer-term treatment. My observation is that patients are often repeatedly diagnosed as having a "drug-induced psychosis", even at times or in settings where the drug proposed to be causing the problem is not specified. Historical information may be relied on that at some point, the patient has used various drugs or was seen by previous services in relation to AOD use. However, this may mean that an underlying schizophrenia or related psychotic disorder diagnosis is missed or the risks associated with an actual amphetamine or cannabis induced psychotic disorder are minimised. Evidence suggests that there are high rates of conversion of diagnosis over time from amphetamine or cannabis induced psychotic disorders to schizophrenia. Additionally, the clinical rationales for such diagnoses are often not clear. The effect is that mental health services may not be recognising that the person has a psychotic disorder that needs ongoing treatment, perhaps because their psychotic disorder is exacerbated due to substance use, sometimes over extended periods with significant associated harms for the patient and their supports.

85 In relation to treatment implications of such a misdiagnosis or inaccurate diagnosis, there seems at times to be an assumption by mental health service providers that a patient with a psychotic disorder with co-occurring substance use disorder should recognise this problem, not use substances and go to a specialist AOD service where they will receive treatment which will stop their substance use and that if abstinence occurs their mental

state will be fine. If any of the steps in this chain does not occur then it is the responsibility of the patient and not the mental health service. Such treatment processes are clearly not appropriate and fail to recognise that recurrent substance-induced psychosis is a very serious problem which requires active and assertive management. This issue is highlighted by Lappin, Sara and Farrell in their editorial *Methamphetamine-related psychosis: an opportunity for assertive intervention and prevention* (Addiction, 2017, 112, 927-928).

86 Such examples of misdiagnosis are not necessarily standard practice, but enough instances occur to suggest that this remains a not uncommon practice within mental health services. From previous experience and discussions with other mental health providers, including in other jurisdictions, I understand that such misdiagnosis occurs across Australia.

87 Even when a psychotic disorder is recognised as requiring continuing treatment, the co-occurring substance use disorders may mean that people get poorer treatment for their mental health disorder (that is often a psychosis, a mood-disorder or anxiety), when it is attributable to substance use. This can be based on stigma, a lack of education/training, not taking responsibility for the management of the disorder and referring the person on to another service provider or may simply exemplify poor practice (or a combination of these factors). This may mean that a patient will not be provided with the same treatment in the same way as other patients who are not seen as substance users.

88 In my view, the issue of misdiagnosis as discussed in the above paragraphs is not surprising given structural separations of AOD system from mental health. This separation enables compartmentalisation and externalisation of responsibility. However, I consider strategies need to be considered both jurisdictionally and nationally, including at the SQPSC, to improve our recognition of this issue, possibly through improved information relating to diagnostic variation with this particular focus.

89 An additional harm which affects particularly people with co-occurring substance use disorders with other mental health disorders is the over-prescribing of addictive substances for other clinical purposes by psychiatrists who do not recognise the addictive potential and possibly the risk for particular consumers. A frequent example is that of benzodiazepines, however there are other examples. This is best addressed by ensuring more practical addiction expertise for all psychiatrists through their training.

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

90 In my view, it was never appropriate or sufficient for mental health service providers to tell people suffering from a substance use disorder to simply stop using drugs or alcohol

and to go to an AOD service. In 2020 it is unacceptable. If this remains the treatment solution encouraged by our service structures, then we will continue to experience challenges in providing effective care to people with co-occurring mental illness and problematic AOD use. As I have discussed, a change away from this paradigm that is held by much of the mental health workforce due to longstanding structures and associated expertise and culture is essential.

91 I have also addressed this issue also in response to Questions 6 and 7 above.

UNDERSTANDING THE AOD SYSTEM

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

92 My observation is that there is not marked difference to the treatment approaches. My observation of the shift of psychiatry trainees from mental health services into AOD focused services is that it is quite a seamless, with no significant difficulties in relation to assessment or treatment beyond the specifics of medications and understanding how services are set up.

Reconciliation of the AOD sectors philosophy of voluntary engagement, treatment and self-help with the concept of compulsory treatment

93 It has been said by some in the AOD sector that mental health services have a culture of compulsory treatment and that the AOD sector does not compulsorily treat people due to its particular focus on motivational enhancement. In my view, this is a fallacy. It is certainly true that in some acute mental health inpatient settings and in other more secure and restrictive mental health settings, involuntary treatment can be common (for example in Queensland about 50-60% of patients in acute mental health settings are receiving involuntary treatment and there are similar proportions in most Australian jurisdictions to my knowledge). However, my experience in the mental health sector is that service providers are constantly working to engage consumers in appropriate and effective voluntary treatment and care. This is not as effective as it could be in all cases and so although there may be criticisms that the mental health sector will 'jump to involuntary treatment' too readily, these are generally not valid. Involuntary coercive treatment is not the fundamental intent of mental health services or routine practice within them.

94 There has been an increased proportion of patients receiving involuntary treatment within the population of acute inpatient units and in many adult community mental health teams, however, this relates significantly to resource allocation rather than the philosophy of the mental health system, so this is a biased sample. The majority of consumers seen by

mental health service providers. including by private practitioners, are treated and supported in the same way that AOD services treat and support their clients.

95 Taking a broader perspective, my understanding is that in Victoria, legislation exists for involuntary treatment for severe substance disorders. However, I am not aware how this legislation is used in practice. Additionally, my observation is that numerous other forms of coercive treatment do occur within AOD settings, for example in complying with court orders and child protection requirements. In my experience there is no great difference in the culture between mental health and AOD services in engaging a wider group of non-acute clients. There is a risk for both AOD and mental health service providers of using the notion of 'consumer choice' in relation to substance use as a proxy for not making assertive efforts to engage their patients with co-occurring substance use disorders and other mental health disorders.

Major gains in AOD service reform outside of Victoria

96 I am not able to identify where major gains have occurred in AOD reforms outside of Victoria, in part because the AOD service sector is dealt with so differently in every jurisdiction. In Victoria, Professor Dan Lubman, has led nationally in developing quality frameworks in relation to AOD treatment and Turning Point is recognised as one of several national leading agencies in AOD education and training.

97 I consider that one reason that Australia has not seen major reform in its clinical AOD service provision is the significant differences in jurisdictional approaches. This means there is a lack of a coherent strategic framework enabling longer term planning for AOD clinical services. This has various historical antecedents which continue to influence service system structures and governance arrangements, and there continues to be some stigmatisation of people with severe substance use disorders through moral and legal perspectives which result in the criminalisation of addictive behaviours.

98 From my perspective looking across both the AOD and mental health clinical systems in Queensland, the AOD clinical service system is far more fragmented than at least the public sector mental health service system in relation to service structure including its clarity of what should be more clinical and what should be more psychosocial. There are many competing and at times conflicting interests, as outlined above in relation to medical training and addiction. These include in relation to establishing long term workforce planning for addiction when addiction services are separated from mental health services. There are individual patches of excellence through some AOD services such as at Turning Point and in some mental health services with specific dual diagnosis or comorbid substance use disorders teams. However, these are difficult to roll out in routine service delivery since they tend to concentrate resources from across multiple standard LHNs or service structures and take consultation and resource development roles, often with only

limited clinical service delivery in relation to co-occurring disorders, because of its prevalence. These are vital as centres of excellence, resource development and training but they cannot be sufficient to address service needs for co-occurring substance use disorders in themselves due to their very high prevalence with associated resource implications. Additionally, such models have the potential to contribute to the mindset of externalising responsibility for treatment and care within mental health services and addiction services.

YOUTH

Barriers to young people seeking help and services in relation to addiction and problematic AOD use

99 The main issue in relation to for treating young people with problematic AOD use is that their substance use tends to oscillate over time and is often not sustained. From a treatment perspective this makes it difficult to know how to intensively treat a young person due to the very many factors influencing the behaviours of a young person. We know that there are high rates of substance use disorder amongst young people which generally gradually reduce over time. But we also know that there are factors including higher levels of substance use, lower psychosocial functioning and co-occurring mental health disorders that can identify which young people may be at higher risk of sustained problematic AOD use to the level that they develop substance use disorders. We have great difficulty responding with systematic approaches to these complex issues. I consider we should improve our ability to systemically identify higher risk young people when it comes to continuing or escalating substance use disorders. In my view the appropriate place for this to occur is in "generalist specialist" mental health service settings which consider alcohol and other drug use as part of their core business and are appropriately skilled to address this rather than in standalone sub-specialist AOD services.

100 I also consider there is a great opportunity for health services to have more consistent, simple and brief interventions with young people than we do across our services. With substance use among youth, structured approaches to screening and brief interventions are important as first steps for all primary care and specialist mental health services. There are significant opportunities in this regard with digital health interventions.

Innovative models for the therapeutic care of young people with AOD dependency outside of Victoria

101 Queensland Health's services are decentralised consistent with the population, however, there are several youth focused AOD service components including a statewide service providing education to young people called 'Dovetail'. Dovetail provides clinical advice

and professional support to members of the workforce, services and communities who engage with young people up to the age of 24 who are affected by problematic AOD use. This advice and support occurs in the form of free training, fact sheets and other useful documents, webinars, and telephone advice to any Queensland-professional who works with young people. Dovetail staff can provide advice to clinical staff about treatment plans, referral paths and responses to young people who are using AOD. Several individual HHSs have adolescent and youth focussed AOD services both within their AOD services and at times child and youth mental health services.

102 In Cairns, there is a service called Yeti (which stands for Youth Empowered Towards Independence). This is a youth support program with a particular focus on AOD. It is funded by the Queensland Health and the North Queensland Primary Health Network (and possibly other funding sources) and provides counselling interventions for young people from the ages of 12-25 who are 'at risk of, or engaging in, the use of illicit drugs who predominantly wish to reduce, stop or be safer with their drug use. Yeti focuses on providing holistic, flexible, youth orientated interventions to the young people who it treats that are intended to be an empowering, strength-based model of care. Yeti also attempts to engage with the family and carers of young people. Yeti has a range of programs including a day program, case management, therapeutic counselling, outreach services and research and evaluation. Yeti is a multidisciplinary service and employs a range of professionals including teachers, social workers, community workers, counsellors and psychologists. This means that Yeti can assist young people not just in relation to drug use, but also in respect of physical health issues, Centrelink issues, criminal justice issues and gender and sexuality issues or assist young people access other services through referrals. This has been and remains an effective service, however it is a local program that has developed over an extended period and extension into other places would require significant further consideration.

Merits and risks of a compulsory treatment service to support young people living with addiction

103 Compulsory treatment should only be utilised where there is clear evidence that it is useful. Additionally, there need to be appropriate legislative arrangements in place with protections in regard to human rights if compulsory treatment is to be used.

104 It is difficult to understand the rationale behind compulsory AOD treatment for young people, given that particular AOD use in young people tends to ebb and flow. When AOD use has become sustained and is clearly substance dependence, assertive and intensive treatment is important. However, I am not aware of any jurisdictions where it can be confidently asserted that assertive treatment for young people occurs. I am unaware of an evidence base for compulsory treatment. It seems to me to raise particular human

rights concerns. I am not able to identify any merits of compulsory treatment for young people living with addiction based on my understanding of effective AOD treatment.

POTENTIAL REFORMS

The ideal response for people in crisis with mental health problems and problematic AOD use

105 Mental health services deal with people with problematic AOD use including substance dependence in crisis settings every day. This is our routine practice. A very significant proportion of what mental health acute care teams see in emergency departments are mental health problems that are triggered by substance use disorders, or at least substance intoxication (which can lead to a person's presenting often with suicidal ideation or behaviour, but also aggressive and risk taking behaviours). This means the ideal response for a person in crisis with a mental health problem is the same as the ideal response for people who have co-occurring mental health and AOD problems, with linkage to continuing services as appropriate.

106 Currently, in Queensland, MHAOD services are working to minimise presentations of people in crisis to emergency departments, to create more options for crisis presentations and to expand our capacity in relation to crisis responses. HHSs are putting forward various different models that will be considered for possible statewide implementation in due course. These include community-based interventions with an emergency department or crisis centre links. The intention of diverting presentations from emergency departments is that people with mental health related crises are not sent to emergency departments but rather linked with other suitable crisis focused services. This could be people staying in places for up to 24 hours akin to a hospital type admission (but not in an actual hospital) or to more non-government organisation crisis supports that could be provided in a person's home as well as in a form of crisis accommodation for a period of time.

Community-based actions to improve crisis responses for people who have mental health problems and problematic AOD use

107 There has to be broad consideration of the options for community-based services to evolve in order to improve crisis responses. One way of doing this is to better identify the nature of the problems in order to better identify more specific strategies for their treatment.

108 There is evidence for screening and brief intervention in general practice and emergency departments leading to reductions in substance use for people with hazardous use of AOD, particularly alcohol. In Queensland, we have not implemented addiction focused

acute crisis services other than emergency departments systematically across all HHSs. My understanding is that specific evidence for any particular type of crisis interventions for AOD problems is limited, similar to effectiveness of these measures in mental health crises.

109 In Queensland, several HHSs have emergency department Drug and Alcohol Brief Intervention Teams (**DABITs**), based in the emergency department and without an outreach role. The intent is that if a patient in emergency department is identified as having any kind of substance use problem, they can be seen by a DABIT clinician who will offer structured screening and provide a brief intervention. Processes for linking these people with treatment once seen by DABITs remain inconsistent, however, there is some evidence for the effectiveness of this approach.

Strategies to address discrimination and double-stigma

110 As previously noted, in relation to staff attitudes I consider this can be best addressed as an issue which is due to culture, impacted by structures and processes, and training. Education alone is not likely to change the way people think. In my view, what is required is the development of practical expertise to address substance use disorders as mental health disorders, using stepped approaches. This requires supervised training experiences.

111 The QMHC examined stigma towards AOD problems and made recommendations for reform in its March 2018 report called Changing attitudes, Changing lives (https://www.qmhc.qld.gov.au/documents/changingattitudeschanginglives)

112 One specific example of stigmatisation of people with mental illness that should not be happening in 2020 is that some AOD residential rehabilitation services do not allow their residents to have any treatment with potentially addictive drugs. This specifically includes treatments prescribed for both substance use and other mental health disorders. I am not sure if such AOD services still exist in Victoria.

EXPLORING INTEGRATION

Assessing clients in order to stream service responses

113 This returns to ensuring that whatever work we are doing in the mental health service system is equally applied to people with co-occurring substance use disorders particularly when people present with a primary substance use disorder and are in crisis. A person presenting in crisis as a result of AOD use generally presents in first instance to a mental health service. Flexible but appropriately detailed screening and assessment processes and integrated service provision models should mean that regardless the nature of the key problems are identified and appropriate management strategies planned. The very

high prevalence of co-occurring substance use and other mental health disorders means that efforts to stream become generally not a useful approach as previously indicated.

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

114 My argument is that we must recognise the need to compromise current jurisdictional and Commonwealth policies and strategies in relation to mental health and AOD as much as is necessary to effectively address the issues of co-occurring substance use and other mental health disorders. In my view, maintaining strategy and policy integrity means that people with substance use disorders in general (and particularly those with co-occurring other mental health disorders) will continue to receive ineffective treatment. We should recognise that differences across jurisdictions and the failure to acknowledge this key issue at an inter-jurisdictional level is highly problematic. However as outlined earlier these wider inter-jurisdictional governance processes are limited by their scope so that they are prevented from having adequate oversight of these issues, but see themselves as bound to continue to focus on "mental health" or "AOD" with narrow definitions. Until these barriers are addressed in our thinking about structures, we can expect to continue to have the difficulties in changing culture and mindset at a service level. The only solution that I can see to begin the work to address this problem is for all the relevant governments to work together to integrate mental health and AOD systems in a way where both service systems feel engaged and concerns about risks that are posed are addressed. In my view, such 'working together' would require recognition at these higher levels that these services and their management structures above need to be integrated if we are to address co-occurring mental health and substance use. Again, this does not mean that we do not have separate sub-specialist services. As outlined above without effective specialist addiction service capacity in cities and training services this process will not work. It means rather that the overlap is being recognised, that the training and the associated mindsets are integrated and that people with serious mental illness with co-occurring disorders receive integrated treatment. In my view, integrated training will also expand capacity to treat co-occurring mental health and substance use.

Examples of commissioning working well to offer holistic treatment and to enhance coordination between service providers

115 I am not aware of local, national or international specific examples where commissioning has worked well to encourage this greater coordination between services providers and to treat people holistically. My experience in respect of commissioning is in Queensland, which has examined integration and strategies to strengthen and enhance addiction services, and also to ensure that there is good crossover of staff that can cover both mental health and AOD needs of our consumers.

116 If commissioning is being considered in relation to co-occurring substance use disorders, my view is that strategies still need to be implemented to support mental health services to change their culture. I think this change comes about through training. As such, commissioning training experiences need to be carefully considered.

117 Queensland has previously commissioned dual diagnosis co-ordinator roles as standalone separate service providers. However, this does not change the behaviours and culture of the mental health workforce. This is because the AOD part of treatment is not integrated into generalist mental health services. I also do not consider that a training experience alone will change culture, as this also comes through experience of or intention to implement such a changed culture. In my view, the solution is not specifically about the commissioning of new services but rather supporting cultural change.

118 See paragraph 78 and following re planning which guides commissioning.

WORKFORCE CAPABILITIES TO SUPPORT INTEGRATION

The extent that AOD services need to access specialist mental health expertise

119 I have discussed in this statement the training and experience enhancements needed and particularly focussed on the mental health workforce (see paragraphs 52-66 above). However, I also consider that the skills and training of AOD staff would benefit from strengthening.

120 We need to be clear in our expectations of AOD staff. My broad approach is that if we can upskill our mental health services such that they see co-occurring substance use disorders as something they can treat, we do need to also ensure that the AOD workforce has skills in identifying mental health symptoms. This is particularly so, given that a AOD problem can present urgently with psychosis or suicidality.

121 I do not consider the AOD workforce needs to be upskilled in mental health to the same level required of the mental health workforce in AOD. This is partly explained by recognition that in the Queensland version of the four quadrant model, mental health service providers are responsible for treatment of all co-occurring substance use disorders in patients for whom they have responsibility. This is in contrast to AOD services who can appropriately refer some aspects of treatment for commonly prevalent mental health disorders (though clearly some clinicians provide expert mental health treatment within AOD service settings). Mental health services also provide acute assessment services with extended hours into emergency departments and in community. They also frequently address crisis presentations triggered by substance use disorders. Accordingly, for mental health services, enhancing understanding and practical expertise in AOD is essential given that mental health service providers are already treating people with substance use disorders. Up to 1 in 8 patients admitted to adult acute mental health

inpatient units in Queensland have a primary diagnosis of substance use disorders. Basic training for psychiatrists includes assessment and treatment of substance use disorders as core competencies. However, for addiction clinicians who have not had basic mental health training or any significant experience in mental health, developing mental health expertise will be more challenging. However, in saying this, it is my understanding that addiction medicine specialists are required to have six months training experience in mental health service settings. This means that addiction medicine specialists who are not psychiatrists should nevertheless be able to recognise and initiate treatment for other mental health disorders when necessary and appropriate. As medical practitioners they have a thorough understanding of basic principles and will have the skills and training to do the basics in relation to "high prevalence" mental health issues such as anxiety, depression, post-traumatic stress disorder and trauma. However, in practice often these issues are dealt with more appropriately in primary care. Allied health staff, psychologists and social workers in general are capable of readily providing services in a more integrated way within AOD services. However, from an efficiency perspective, it is important that the AOD sector works closely with primary care rather than having to upskill to treat all mental health disorders. In my view this does not apply for mental health services in relation to all substance use disorders.

122 The mental health workforce does not currently usually see itself as appropriately providing opioid dependence treatment. In my view, the mental health service system should provide opioid substitution therapy to consumers with serious mental illness who it is treating. Such a change in practice requires a mindset which acknowledges the implications of Quadrant IV and therefore sees opioid dependence treatment as simply another psychotropic medication that mental health services provide. We are a long way from this approach in Queensland, but this is the direction that our current policy should see us moving in.

CONSULTATION-LIAISON PSYCHIATRY

Ensuring that the physical health needs of clients are considered in assessment and treatment, alongside their mental health needs

123 I will again start by discussing psychiatrists since they are the medical practitioner within a standard mental health team. Ensuring patients' physical health, raises the question of how we design training for psychiatrists that fits them best to meets the needs of individual patients and the wider community in the second half of the 21st century. I consider that the training psychiatrists should receive should include addiction, old age and child and youth experiences to better reflect our community needs. The existing training addresses the latter with a formal mandated six months experience and similarly addresses acute, adult and consultation-liaison (**CL**) psychiatry. Other clinical training experiences which are not currently essential but would benefit the psychiatrist of the future are formal

experience in intellectual disability, chronic (or persistent) pain and eating disorders. This is not an exhaustive list since certainly a clear focus on general physical health care and forensic aspects of psychiatry are also of importance. All medical practitioners and nurses must have training and experience in physical health care and it must be recognised as being important to all mental health practitioners so I am unclear as to why this is being considered under the heading of CL psychiatry.

124 Considering how to best train psychiatrists in addiction requires understanding of the current training requirements and processes. The RANZCP psychiatrists training program has five years of prescribed training, three in basic training and two in advanced training. The basic training period is very busy with specified rotations and it would be a great challenge to change these requirements to enable the flexibility to include any mandatory time allocation in addiction. From a jurisdictional and service provider perspective, this means that we must focus on encouraging trainee psychiatrists and their training services to obtain or provide relevant experience.

125 Simply, the role of CL psychiatry is to assess and treat patients with general medical conditions and co-occurring mental health disorders, usually at the request of a medical, surgical or other hospital team. These mental health disorders often include substance use disorders. I have considered the possibility of enhancing this experience with a number of CL psychiatrist colleagues and in principle it would seem that this is not a problem, with addiction having historically been clearly recognised as a central role for CL psychiatrist. However in practice, there are many barriers to requiring all trainees to have appropriately supervised and supported CL addiction experience within their mandatory CL psychiatry training. These include the current separation of service models with separate CL addiction teams in some hospitals, as well as the sense of a lack of competence shared with other non-addiction psychiatrists.

126 I consider that there is an opportunity that when a trainee psychiatrist completes their training in CL psychiatry, this should include CL addiction experience. There should be the appropriate upskilling of CL psychiatrists with medical addiction subspecialist input, ideally working on a shared basis and in an integrated model, within a larger CL MHAOD service (at least in larger hospitals). This would also be a comparatively simple way to ensure that all psychiatry trainees get an integrated addiction experience in one service. Additionally, in my view, all psychiatrists and trainees should now also become opioid dependence treatment providers and training programs should ensure this as early as possible during their training.

127 An issue of significance in health generally is the management of chronic or persistent pain. CL psychiatry is actively involved in the treatment of chronic pain, however, this is not a mandated training experience. In my view, the CL psychiatry training rotation should also include gaining experience in relation to chronic pain. I recognise that this would

pose practical difficulties for many services providing psychiatry training and therefore is challenging. However, in setting up integrated mental health and AOD services and expectations for the training of our service providers, training and experience in chronic pain management is essential.

128 I am unaware of how chronic or persistent pain services are structured in Victoria. I am also unsure whether it is feasible for training and experience around chronic pain management to be implemented in Victorian services. However, in my view it is an important part of both mental health and AOD service delivery. Among the many reasons I consider training and experience in chronic pain to be essential in both mental health and AOD specifically, is because some of the medications used to treat patients suffering from chronic pain, such as gabapentinoids and opioids, require real time monitoring. In my experience, many patients in acute mental health services currently are on such medications for chronic pain management and psychiatrists do not seem competent in managing the medication and pain management aspect of their patient's care. This is particularly important given the not infrequent addiction to, or reliance on, these types of dependence-inducing medications to treat chronic pain. In my professional experience, I did not feel confident in managing opioids, since they had never been a routine part of my prescribing practice, prior to becoming an addiction psychiatrist. I have observed similar patterns for other psychiatrists. In my view, all psychiatrists should have the experience and confidence to be able to manage any psychotropic drug, including opioids, and also to play a role in management of complex chronic pain in patients presenting to mental health services and in general medical settings where CL services are provided. I consider this a significant safety issue from the perspective of good clinical care, opioid stewardship, the quality use of medicine and also in effective suicide risk management.

129 In my view, the physical health needs of consumers with severe mental illness are best considered as a routine part of assessment and treatment and are mandated on a regular basis for those receiving continuing longer term care. Queensland's Mental Health Clinical Collaborative (the **Collaborative**) has had a project which examines interventions in physical health, including metabolic monitoring, and this has been associated with significant improvement in mental health services. As part of the CIMHA 5.0 release, Queensland is introducing a new 'Physical Health checklist' which will take the place of the existing Metabolic Monitoring form'. The Physical Health checklist is intended to support MHAOD clinicians further in the screening process for and preventing consumer healthy habits and health related risks. Attached to this statement and marked **JR-2** is a copy of Physical Health Screen checklist. It may be possible in coming years to use this checklist for further, more specific interventions relating to particular aspects of the form, though this will require a quality improvement approach.

Shortages in the supply of Consultation-Liaison specialists in Queensland

130 I am not aware that there are any shortages in the supply of CL psychiatry specialists in Queensland or more broadly. In my experience, many psychiatrists enjoy CL work and the primary rate limiting factor to employing CL specialists is in relation to the funding of such positions. This funding issue falls between mental health services (which need to provide such services for the benefit of the consumers) and the standard expectation of all medical disciplines to provide consultation to other specialties.

131 Consistent with my earlier statements as to combining CL psychiatry and AOD services, I would strongly argue that the CL mental health services should all include AOD. However, as noted although not rejected in principle there are barriers to this from some CL psychiatrists and CL AOD clinicians. I agree that changing service structures and patterns is a difficult process and this is one that requires practitioner flexibility and service support for more generalist models of practice.

QUALITY AND SAFETY, REGULATION AND OVERSIGHT

Regulation, monitoring and support of quality and safety in Queensland's mental health system

132 As Chief Psychiatrist, I have oversight of aspects of the Queensland mental health service system under the Act. I have statutory responsibilities under the Act for its administration, including the ability to make policies to facilitate its proper and efficient administration and to make directions about patients within the mental health system. Chief Psychiatrist policies are mandatory for anyone (such as administrators of authorised mental health services, authorised doctors and authorised mental health practitioners) performing a function under the Act. The Act promotes least restrictive interventions and the delivery of patient centred treatment and care. The Chief Psychiatrist policies reflect the responsibility to protect the rights of all patients receiving involuntary treatment and care in Queensland and the rights of voluntary inpatients in authorised mental health services.

133 The Chief Psychiatrist also provides consultation and specialist advice regarding the clinical care and treatment of people with mental, behavioural and neurodevelopmental disorders, with a particular focus on those receiving services within Queensland Health's MHAOD services.

134 The Office of the Chief Psychiatrist (the **OCP**) strives to improve outcomes and promote recovery and for the rights of, consumers with substance use disorders and other mental health disorders. It provides support, advice and direction to MHAOD services in providing clinical care. The OCP leads mental health legislative policy analysis and development and contributes to legislative policy processes in other Queensland Health work units and government agencies. The statutory functions of the Chief Psychiatrist under the Act are

supported by compliance monitoring and related policy and system development and management of the interface between the mental health and justice systems.

135 The OCP supports clinical governance activities to promote high quality and safe MHAOD services, consistent with clinical standards. This includes providing advice and direction in relation to quality improvement and safety initiatives at a state and national level; leading development of clinical policy and guidelines; and facilitating collaborative learning and sharing of best practice among MHAOD services. The OCP supports the Chief Psychiatrist's power to investigate any matter relating to the treatment and care of a patient in an authorised mental health service.

136 The OCP and the wider MHAOD Branch working within Clinical Excellence Queensland aims to take a broad strategic approach to improvements in quality and safety of mental health alcohol and other drug service delivery in Queensland. Particular examples of recent quality improvement projects implemented by the MHAOD Branch and overseen and monitored by OCP include some processes to improve the care of people experiencing suicidality, to minimise restrictive practices (including seclusion, physical restraint and mechanical restraint), to improve assessment, management and monitoring of physical health, to improve substance use related service delivery and care planning, to improve in the assessment and management of violence risk in people with serious mental illness and to enhance capacity of MHAOD services in implementing quality improvement processes.

137 In Queensland, an initiative that is recognised for its effectiveness is the Mental Health Clinical Collaborative (the **Collaborative**) auspiced by Metro North HHS MHS, chaired by Professor Brett Emmerson and funded by the MHAOD Branch. The Collaborative brings mental health clinicians representing services from across Queensland to develop agreed clinical indicators and jointly consider ideas, develop and implement collaborative strategies and measure their impact on improvements in clinical practice. The Collaborative has done work in relation to tobacco use and dependence and physical health monitoring among other topics. Queensland mental health services have used this collaboration as a strategy for improvement, particularly focussing on people in adult community mental health services and inpatient units.

138 An outline of the work of the Collaborative is at the Equally Well website at https://www.equallywell.org.au/wp-content/uploads/2019/06/Physical_health_and_mental_health.pdf

139 The 'Mental Health Sentinel Events Review', commissioned by the MHAOD Branch in 2015 (the **Review**). engaged external experts to review homicides in Queensland linked to mental health and treatment in mental health services. Recommendations were made relating to management of patients at risk of aggression towards other people.

Queensland at that time had a comparatively low rate of homicide in Australia linked with mental health services, however this continues to be an important issue. The implementation of the recommendations arising from the Review was finalised in June 2019. Many of its recommendations focussed on support for mental health service clinicians to better identify and manage risk. The MHAOD Branch has completed significant work implementing the recommendations arising from the Review. Further detail is available at https://www.publications.qld.gov.au/dataset/mental-health-sentinel-events-review-2016/resource/8deb25e2-419a-46f1-a820-fee77af9149e

140 Specific violence risk assessment and management projects which were linked with, or arose directly from, this Review included the creation of Assessment and Risk Management Committees (ARMCs), which mental health services are required to form under the leadership of a clinical director. There has also been the creation of a three tier framework of violence risk assessment and management, which included creation of a Violence Risk Assessment and Management tools at the second tier. These tools each aim to support both individual clinicians and teams to identify ways in which to monitor the quality of the work they do, to identify key issues or areas that need to be focussed on and to work on improvement strategies in those areas. They also support the role of the administrator and clinical directors in oversight of these processes within each authorised mental health service.

Changes to strengthen quality and safety arrangements as part of Queensland's Mental Health Act reforms

141 One recommendation of the Review in 2015 was the creation of a mental health and AOD quality assurance committee (**QAC**) which was subsequently established. Currently, the QAC is looking at clinical incidents within HHSs and how to improve the investigation and effective sharing of lessons from such incidents. The QAC is also considering the implementation of safe environment and ligature risk audits in residential mental health service settings and how to effectively support restorative just culture principles in such situations and investigations.

142 The work relating to violence risk in particular the ARMCs has flowed from Chief Psychiatrist policy changes consistent with the recommendations from the Review.

The principles, characteristics and components of contemporary, best practice regulatory approaches to safety and quality in mental health service delivery

143 In relation to regulation, it is essential to consider how to measure actual practice, recognising the burden to mental health service providers in implementing and responding to any regulatory requirements. In general, our approach is to improve clinical practices in relevant areas. While there is a need for regulation under the Act, we need

to consider how we can protect the rights of patients, support clinicians to effectively implement treatment and care and at the same time engage patients, support persons and staff in a collaborative process of improvement - which we can measure while minimising any regulatory burden.

144 A challenge for contemporary regulatory approaches (at least within health), is how to use quality improvement mechanisms and improvement science to tackle important clinical safety and quality issues and to do so in a collaborative way with consumer involvement in setting up overarching processes that match individual need. Key to such approaches is high quality information, and with the CIMHA electronic health record (see paragraphs 77 to 79 above), the MHAOD Branch has continued to take steps to improve its capacity to provide data in increasingly real time in order to inform quality improvement within HHSs and across the state. Linkage of practice improvements such as creation of the Violence Risk Assessment and Management process (see paragraph 140 above) with measures of performance are vital to be able to measure practice and guide implementation efforts.

Changes to regulatory approaches in mental health in Australia and internationally

145 In relation to regulation, the OCP aims to ensure that people's rights broadly, but particular in relation to the Act, are protected. The OCP does so by monitoring the particular ways in which interactions with health service systems might impinge upon these rights. We are also considering what behaviours and prompts might support good practice.

146 In my view, regulation is a broad means of implementing change, which needs to be supported by focussed quality improvement. To be more specific and detailed in such work, we need to collaborate with staff, support persons and consumers to support best practice and avoid wherever possible more regulatory-type approaches. A collaborative improvement approach is the ideal direction I would envision in the future.

Examples of innovative best practice in regulating quality and safety in mental health service delivery

147 As outlined above, the utility of regulation in promoting innovative best practice is largely dependent on implementation activities and collaborative change processes. The Act contains a number of significant measures aimed at aligning regulatory requirements with contemporary clinical practice, that are in turn supported by a range of implementation activities. The OCP has implemented or supported collaborative improvement methodological approaches in a number of aspects of its work in conjunction with HHSs, (including a Zero Suicide in Healthcare multi-site collaborative project) and the MHAOD Clinical Network funding of a 'Brief Breakthrough Collaborative' structure. The Zero

Suicide in Healthcare multi-site collaborative has engaged HHSs in a collaborative focussing on implementing suicide prevention pathways. The Brief Breakthrough Collaborative plans to adopt a new topic on a rolling six monthly basis with leadership on each occasion from an HHS and a central facilitation role with one HHS. The initial planned collaborative on care planning was rapidly diverted in March 2020 to a less formal collaborative on MHAOD service responses to COVID-19 pandemic. The OCP anticipates such approaches to develop further.

148 An example of these measures is the introduction of a 'less restrictive way' framework within the Act which provides regulatory guidance for clinicians working under alternative consent mechanisms (for example an Advance Health Directive or guardian) when providing involuntary treatment and care. Embedding these measures within the Act has contributed to increased patient involvement in decision-making, however this is only due to significant implementation activities relating to training, guidelines and broader cultural changes within the mental health system. As a result of the introduction of the 'less restrictive way' framework within the Act, the use of alternative consent mechanisms within Queensland in relation to mental health treatment is also readily able to be monitored through enhanced data collection capabilities.

149 Similarly, when commenced in 2017. the Act introduced tighter regulations for the use of seclusion and mechanical restraint (including a requirement that the Chief Psychiatrist approves all instances of mechanical restraint), and for the first time, introduced provisions relating to physical restraint use and inappropriate medication use. These measures continue the national aim of reducing restrictive practice use within mental health services and are again supported by significant implementation activities, including ongoing monitoring and data sharing across and within services to continually promote and enhance safe mental health service delivery.

ROLES AND RESPONSIBILITIES OF THE CHIEF PSYCHIATRIST IN QUEENSLAND

The statutory functions and powers of the Chief Psychiatrist in addressing quality and safety in service delivery

150 Specific statutory functions for the Chief Psychiatrist within the Act include making policies and practice guidelines about the treatment and care of patients of authorised mental health services; ensuring the rights of patients are protected while balancing these rights with others, promoting community awareness and understanding of the Act, and monitoring and auditing compliance with the Act. Each of these roles contribute to the delivery of mental health services.

151 The Chief Psychiatrist may also initiate investigations under the Act about any matter relating to the treatment and care of any patient in an authorised mental health service.

Additionally, the Chief Psychiatrist may take a range of actions (including for example immediately suspending all leave) in relation to an individual forensic patient, or a group of forensic patients (i.e. those patients detained on a forensic order) in response to a matter that poses a serious risk to the life, health and safety of a person or to public safety.

Factors critical to fulfilling the role of Chief Psychiatrist

152 A key component of successfully being able to fulfil the Chief Psychiatrist is visibility of what is occurring across Queensland within mental health services. As noted above, Queensland has the significant advantage of the comprehensive statewide database (the CIMHA) which enables comprehensive access to mental health records of any patient receiving services from an authorised mental health service, or public sector mental health service, in Queensland. The OCP and the MHAOD Branch utilise data from CIMHA routinely to monitor service delivery and inform future service delivery. At the individual patient level, CIMHA also enables the Chief Psychiatrist to complete relevant statutory functions (e.g. approving particular leave or mechanical restraint) in a way that is fully informed by the patient's record.

153 Additionally, in a devolved health system (such as that operating in Queensland), strong and open communication channels between the OCP and authorised mental health services are a critical component of achieving statewide consistency in service delivery and compliance with the Act.

Challenges in fulfilling the role of Chief Psychiatrist

154 Although CIMHA and communication pathways support the role of the Chief Psychiatrist, it is still the case that in Queensland, delivery of mental health services is the ultimate responsibility of independent HHSs. There can, at times, be a tension between ensuring that these independent services comply with the requirements of the Chief Psychiatrist's policies and guidelines, while at the same time being responsive to their relevant Boards and Chief Executives.

155 CIMHA continues to develop its capacities but was originally designed with a focus on community mental health services and MHA requirements, including within inpatient settings. It does not have some functionality that might be required in an inpatient electronic health record (eHR). It is nevertheless used as such in many HHSs, however the more recent development of a shared electronic medical record across health and outside mental health services, has raised the challenge of enhancing integration across these systems and ensuring an emphasis within HHSs of continuity of care across electronic health records.

Changes to the role of the Chief Psychiatrist in Queensland since the Mental Health Act 2016

156 The Chief Psychiatrist role under the Act has largely been continued without significant changes from the repealed *Mental Health Act 2000* (Qld). Some additional functions, such as approving all mechanical restraint use (a power previously vested in authorised doctors), have been included however in general the role has remained reasonably consistent.

157 In terms of legislative provisions, the current Act does strive to make decisions and processes more transparent than may have been the case under the repealed Act. In this way, the Act is more prescriptive about the role of the Chief Psychiatrist than previously in requirements for annual reports and making policies and guidelines publicly available.

The variation in the role of Chief Psychiatrist across jurisdictions

158 There is some variation in the roles of Chief Psychiatrists and the structures of their Offices around Australia. The OCP sits as a key component of the MHAOD Branch of Clinical Excellence Queensland within Queensland Health. Some approach such matters structurally (from what I perhaps simplistically consider a more legalistic regulatory perspective) and consider that embedding within the MHAOD Branch is a problem since the Chief Psychiatrist role can be perceived as lacking independence from the administering department. I have independence in my statutory role as Chief Psychiatrist, but I am employed within the department, with nothing different about my employment. I am personally very comfortable with this arrangement consistent with the earlier discussion around influencing practice by improvement (i.e. by moving towards an approach of minimising regulation where possible and maximising the focus on how clinicians can support consumers most effectively and appropriately by using quality improvement processes) and becoming increasingly structured as recognised in the term improvement science. Improvements in matters currently closely regulated including involuntary treatment and restrictive practices are ideally approached clinically by prevention through improvements in clinical practice. This entails consideration of models of service for MHAOD services. In my view, to influence those measures, it is better to be part of the discussion within the Department at the MHAOD Branch rather than have regulatory purity with a more limited capacity to influence such models and processes for monitoring and improving, both within the MHAOD Branch and with HHSs.

159 I understand that in some other Australian jurisdiction the role of Chief Psychiatrist is more independent from a health department. I do not consider that a 'wrong' approach, but I do think if a Chief Psychiatrist sits outside the department or a MHAOD Branch, then they run the risk of being not as aware of current activities in MHAOD services and less able to measure and plan service delivery changes and improvements. However, I

acknowledge that a more separate Chief Psychiatrist role and office could potentially create greater change and intervene as an external force more effectively, particularly in situations where more dramatic change might be needed. I accept that this may be the case and acknowledge this tension, however my view would be that a steady and incremental approach is more effective, and more consistent with the integration of mental health services within wider health service structures.

RESTRICTIVE PRACTICES

Reasons for the variation of seclusion and restraint rates between jurisdictions

160 Queensland has seen a significant reduction in relation to the use of restraint and seclusion over the past decade. We started from a high use of both but since about 2013 we have reduced these rates markedly - though we continue to not perform as well as some other jurisdictions in this regard in relation to our rates of restraint and seclusion. We have focussed and continue to focus on reducing the rates of restrictive practices in Queensland and I believe this has been a factor in Queensland's rates reducing. This area will require ongoing effort, with particular tensions relating to the effective and least restrictive management of risks of aggression and the protection of other consumers and staff, recognising workplace health and safety requirements.

How to reduce restrictive practices

161 In my view, the key to reducing the rates of restrictive practices is to identify its use as a problem and to establish quality improvement approaches around its use. This is what occurred in Queensland and the MHAOD Branch has continued to push mental health services to monitor and act on their data about rates of physical and mechanical restraint and seclusion. This enables us to look at services that are outliers or demonstrate changes in relation to the use of restraint or seclusion, both positive and negative. We supportively emphasise to mental health services that we need to continue working to reduce these rates.

162 The MHAOD Branch has recently considered challenges in our high security inpatient services in forensic mental health-type inpatient services. These services historically have higher rates of restraint and seclusion, and we are supporting them in considering their approaches and comparing them to other jurisdictions. In some jurisdictions, patients in inpatient forensic mental health services can be slightly hidden because some of these patients are in correctional settings and not more general hospital environments. This means that there are sometimes challenges with fully understanding the rates of restraint and seclusion in prisons or forensic health inpatient services. These numbers are not always included in national rates due to such difficulties in comparison.

163 We have supported staff from different forensic mental health settings in Queensland to visit Victoria and NSW to observe the strategies being implemented in those states. It is important to note in this regard that patients in seclusion longer term form a very small cohort of patients and that this is based on the individual risks of these patients, with some marked differences to more to routine practice in other clinical settings.

164 The reduction of restrictive practices and seclusion across all types of mental health services remains a challenge for Queensland. This issue has been identified by OCP as one that requires continuing work and a review following an increase in rates of seclusion statewide in 2019 following many years of steady reduction. The increase in Queensland's rates may also just show that we have made improvements that were easily achievable and that the next steps to further reduce restraint and seclusion may be more difficult.

Safeguards and oversight measures under the Queensland Mental Health Act 2016 for restrictive practices.

165 The Act prescribes many safeguards and oversight measures in relation to the use of seclusion and mechanical restraint. As outlined earlier, these provisions are only as effective as implementation measures that are utilised to support them.

166 Key provisions of the Act related to seclusion and restraint use include that all use of mechanical restraint must be approved by the Chief Psychiatrist; patients who are mechanically restrained must be continuously observed and strict time frames applying to seclusion and mechanical restraint use. An important development in the Act in relation to overseeing seclusion and mechanical restraint use has been the introduction of 'reduction and elimination plans'. These plans outline measures to be taken to reduce and eliminate the use of seclusion and/or mechanical restraint on a patient and to reduce the potential for trauma and harm. The plan reinforces efforts to proactively reduce the use of restrictive practices on a patient by ensuring close consideration of restrictive practices by clinical leadership within authorised mental health services, including monitoring, accountability and a focus on safe, less restrictive alternatives. These issues are then considered both in relation to individual instances and on a statewide basis from both a broader clinical governance and narrower legislative compliance perspective within the OCP.

167 As noted above, the Act also introduced provisions relating to the use of physical restraint and inappropriate use of medication. While these provisions are not prescriptive in the same way as provisions relating to seclusion and mechanical restraint, they have enabled more comprehensive oversight mechanisms to be developed, including data collection, on these important regulated practices.

The impact of safeguards and oversight measures under the Queensland Mental Health Act 2016 on the use of restrictive practices

168 It is difficult to separate out measures associated with the Act from those due to the continuing quality and safety related clinical improvements which have been sustained, However a key focus is the ongoing facilitation of attention to, and measurement of, restrictive practices as part of implementation of the Act and associated policies supported by improvement efforts in relation to accessibility of information through CIMHA.

The impact of Covid-19

169 In relation to questions regarding the changes to MHAOD services in response to COVID-19 and possible opportunities, the Queensland MHAOD Clinical Network had already auspiced and funded a clinical collaborative which had begun to work but was expecting to do most of its work in the period March through May. This was problematic in the context of the pandemic. As a result, this Clinical Network auspiced collaborative moved to a virtual collaborative focussed on COVID-19. It met weekly with MHAOD services interested in doing so. We found there was good uptake by MHAOD services to this. Recently the Clinical Network provided a brief overview to the Queensland Clinical Senate on 18 May 2020 which focussed on the issue of lessons for practice arising from COVID-19 across the health care system. This overview, the MHAOD Clinical Network Healthcare during COVID-19, is attached to this statement and marked **JR-3**.

170 The approach to the COVID-19 pandemic is also an opportunity for new approaches to be discovered and sustained throughout the MHAOD sector. However, the process for identifying these opportunities and making them, will require further active consideration by myself and the MHAOD Branch.

sign here ► 

print name John Reilly

date 29/05/2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JR-1

This is the attachment marked 'JR-1' referred to in the witness statement of Dr John Reilly dated 29 May 2020.

Brief resume Dr John Joseph Reilly

Current position: Chief Mental Health Alcohol and Other Drugs Officer, Office of the Chief Psychiatrist (OCP), Mental Health Alcohol and Other Drugs Branch (MHAODB), Clinical Excellence Queensland, Queensland Health since July 2017. Statutory Mental Health Act role as Chief Psychiatrist.

General and Specialist Registration with Medical Board of Australia till 30/9/2020.

Academic and professional qualifications

M.B., B.S.: University of Melbourne (Uni of Melb), 1984

Diploma of Psychological Medicine: Uni of Melb, 1994

Graduate Diploma of Epidemiology and Biostatistics: Uni of Melb, 1995

Fellow Royal Australian and New Zealand College of Psychiatrists (RANZCP), 1992

Selected experiences in current role

- Membership Safety and Quality Partnerships Standing Committee of Mental Health Principal Committee, AHMAC, as Chief Psychiatrist.
- Chair, MHAOD Quality Assurance Committeee.
- Queensland Health Violence Risk Assessment and Management Framework: release of framework and associated statewide training implementing this.
- QH MHAOD service clinical documentation form integration linked with CIMHA 5.0 release scheduled for October 2020.
- May-June 2020: Release of updated Chief Psychiatrist policies.
- Continuing OCP leadership of an SQPSC auspiced Fifth National Mental Health Plan project updating National Safety Priorities for Mental Health Services.
- Continuing OCP sponsorship of project for establishing pathways for employment packages for Rural Generalists with advanced skills in mental health to enhance sustainable medical workforce in rural and remote settings.

Clinical and management experience prior to current role

<u>Consultant Psychiatrist: public sector St Vincent's, Melbourne</u>

1992 - 1997: crisis assessment, intensive case management and homeless service teams across community and inpatient settings, including sessional drug and alcohol services.

<u>Senior Leadership roles (Clinical Director/General Manager/Chief Psychiatrist)</u>

1997 - 2004: Director of Psychiatry, Peninsula Mental Health Service (PMHS), Victoria.

1997 - 2001: General Manager of PMHS; member Peninsula Health Executive.

2004- 2009: Clinical Director, Secure Mental Health Unit then Adult Mental Health Service, Townsville Mental Health Services

Clinical Director, Institute of Mental Health & ATODS, Townsville: 2009 to 2013

Acting Director of Mental Health and Executive Director, MHAODB, Queensland Health April of 2014 & 2017.

Acting Chief Psychiatrist, MHAODB, May-July 2015.

Clinical and quality improvement focus

Focus on service development and governance and standardizing clinical information to support quality care. An adult generalist clinical practice and leadership expectations has triggered interest and capacity in some specific areas including electroconvulsive therapy, psychological treatment of borderline personality disorder, early psychosis, addiction including particularly co-occurring substance use and other mental health disorders and psychodynamic psychotherapy.

This has led to a governance focus on integration of alcohol and other drug services with other mental health services and in rural generalist training and practice, with leadership of delivery of a QH MHAOD Branch project developing proposed models for Queensland regional and remote mental health service delivery in 2010-2011.

Training and educational roles

Extensive involvement in undergraduate psychiatry and postgraduate RANZCP training within mental health services since Fellowship. Current relevant roles are:

- Chair, Subcommittee for Advanced Training in Addiction Psychiatry (SATADD) of RANZCP Committee for Training, August 2014-current, with ex-officio membership of Committees for Training and Faculty of Addiction Psychiatry.

Authorship of nine papers in peer reviewed journals relating to clinical psychiatry, service use, quality improvement in mental health services, particularly relating to information gathering and storage, and possibilities for smartphone use in telehealth

Brief overview of other roles, interests and achievements

- Clinical Review team member and a leader on at least five Office of Chief Psychiatrist Clinical Reviews in Victoria 1998 to 2002.
- Member, Ministerial Advisory Committee, Mental Health, Vic. DoH 2001-02.
- Member, Queensland MHAODD Early Psychosis Advisory Group 2010-2011.
- Member, Queensland Health ECT Training Committee 2010-2012.
- NSQHS & NSMHS accreditation team membership as ACHS Surveyor: 2003-2020.
- Chair, NQ Mental Health Clinical Cluster Committee, 2016- 2017
- Member, QH Adult MH Clinical Collaborative Steering Committee 2010-continuing.

I certify that the above resume is true and correct as at May 2020.

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ATTACHMENT JR-2

This is the attachment marked 'JR-2' referred to in the witness statement of Dr John Reilly dated 29 May 2020.

Physical health screen

Tips and tricks for this form <hyperlink>

Metabolic screen		General health and substance use	
Height (metres)	<autopopulate>	Have you seen your GP in the last year?	☐ Yes ☐ No
Weight (kg)	<Text, fixed length>	Have you been experiencing any side effects from your medications?	☐ Yes ☐ No
BMI (kg/m^2)	<autocalculate>	Have you had two or more falls in the last 12 months?	☐ Yes ☐ No
Waist (cm)	<Text, fixed length>	**Date of substance use and addictive behaviour screen**	<populate date>
Blood pressure	<Text, fixed length>	Tobacco substance involvement score	<populate>
Pulse	<Text, fixed length>	Alcohol substance involvement score	<populate>

Food and nutrition	
Does your weight affect the way you feel about yourself?	☐ Yes ☐ No *(if yes consider further enquiry)*
Are you satisfied with your eating patterns?	☐ Yes ☐ No *(if no consider further enquiry)*
Have you lost weight recently?	☐ Yes ☐ No
Have you gained weight recently?	☐ Yes ☐ No
If yes, how much weight? *If BMI <18.5 or >25 consider further assessment options*	☐ 1-5kg ☐ 6-10 kg ☐ 11-15 kg ☐ >15 kg
Do you eat or drink foods with high fat and/or carbohydrate content (e.g. soft drinks, lollies, cakes, biscuits, fast/battered food, pies, hot chips) every day?	☐ Yes ☐ No

Diabetes	
Have you ever had diabetes, including during pregnancy?	☐ Yes ☐ No
Do you currently have diabetes?	☐ Yes ☐ No
If current diabetes tick all that apply:	☐ Dietary control ☐ Medication

Physical activity, sedentary behaviour and pain	
Did you sit for 7 hours or more yesterday?	☐ Yes ☐ No
On a typical week, do you do >150 minutes of moderate physical activity? ***(18-64 years old only)***	☐ Yes ☐ No *Refer to Guidelines for under 18's and over 65's*
Is this currently reduced due to health and physical limitations?	☐ Yes ☐ No
Do you experience persistent pain?	☐ Yes ☐ No
If yes, and is not currently receiving pain-related treatment, consider further assessment options	

Oral health	
Do you have pain in your teeth or bleeding gums when you eat or brush your teeth?	☐ Yes ☐ No
Do you commonly experience a dry mouth?	☐ Yes ☐ No
Have you had a dental health check in the last year? ***(>14 years old)***	☐ Yes ☐ No

Additional physical health screens and information (consider utilising these screens and information to further explore health issues based on results of questions above and clinical enquiry. Results of additional screens and action proposed to address the results should be transcribed into the initial management plan)

Diabetes Australia risk calculator	Cardiovascular disease risk calculator
Malnutrition Universal Screening Tool	My Health for Life
Sexual health risk check	QuEDS admission guidelines (Queensland Eating Disorders Service)
Healthy Teeth for Life	Falls risk screening – Stay on Your Feet

Pathology

<ability to import pathology results>
<RTF, expanding, wrapping>

Initial management plan

<RTF, expanding, wrapping>

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JR-3

This is the attachment marked 'JR-3' referred to in the witness statement of Dr John Reilly dated 29 May 2020.

May 2020

Mental Health Alcohol and Other Drugs Statewide Clinical Network

Through a project jointly managed by Metro North and Metro South Hospital and Health Services (HHS), the Mental Health Alcohol and Other Drugs Statewide (MHAOD) Clinical Network is supporting public MHAOD services to share innovative ideas, information and resources regarding the planning and delivery of safe, effective and efficient healthcare during the COVID-19 pandemic. This is being achieved through the coordination of regular information exchange meetings and the collation of resulting information and resources. All HHS MHAOD services are invited to participate.

Challenges, opportunities and solutions in COVID-19

The COVID-19 pandemic has created new challenges for all services, in particular:

- How to deliver care in the present while planning for the future.
- How to deliver person-centered care while keeping the community/population safe.

These challenges and solutions have been explored in relation to key topics through statewide virtual information exchange meetings. Some of the key points are listed below.

Inpatient Care

Solutions implemented

- Mental health inpatient ward processes and layouts were not previously designed for managing infection. Changes have been implemented across the state.
- Plans and processes in place to manage COVID-positive mental health inpatients in medical wards where possible and appropriate.
- Education of staff in donning and doffing of personal protective equipment (PPE).
- Simulation scenarios beneficial for highlighting issues for mental health and emergency department (ED) staff.
- Implications of legislation (primarily *Mental Health Act 2016* and *Public Health Act 2005*) on non-compliance with self-isolation or quarantine have been determined in different scenarios and fact sheets produced in some services to guide practice.

Care in the Community

Telehealth solutions for Video/Virtual Care

Solutions implemented

- Preferable video/virtual care solutions were matched to scenarios/care settings.
- Anecdotal feedback is that some consumers prefer virtual care – time savings, less travel, less parking costs, greater flexibility and potential stigma reduction as there is reduced need to attend a mental health clinic in person.
- Early data suggests Did-Not-Attend rates appear reduced while increased use of video/virtual care is offered.

Models of care for implementation in the 'new normal'

- Routinely offering appointments through telehealth as an option where appropriate has been suggested as a desirable component of the 'new normal' for community based MHAOD services. Current indications are that for some consumer groups this is likely to improve engagement with services. The proportion of services that may best be delivered via telehealth-based appointments is yet to be explored, and this will vary according to service location and consumer population.

Key challenges

- Concerns highlighted regarding use of virtual platforms for consumer care, including security, availability, privacy, consumer lack of devices/data.
- Lack of availability of hardware and software is an issue for staff and consumers.

Housing and accommodation

- Department of Housing and Specialist Housing Services (SHS) have funding to provide crisis accommodation for people at risk of homelessness during COVID-19, including short-term hotel accommodation and longer-term options in studios at a vacant student building in Toowong, Brisbane.
- MHAOD services can approach the SHS in their area for information, with communication strategies between SHS and MHAOD services to be determined.
- Information available in a weekly state-wide housing link-up hosted by Q Shelter.

Issues for specific at-risk populations e.g. consumers on Clozapine

- International consensus statement on the use of clozapine during the COVID-19 pandemic has been submitted to the TGA, although not progressing quickly.

Expanded/alternative models of care

- Some MHAOD services are exploring alternative models for efficient and safe management of clozapine clinics, including utilising GP practices, nurse-led clinics or using portable hemocues (blood testing devices).

[For reference – survey questions from QCS are as follows:

Please provide the following information, in relation to the delivery of healthcare during the COVID-19 Pandemic:

- *New models of care that have improved patient outcomes, experiences receiving and/or providing care and better effectiveness and efficiency*
- *Existing models of care that have been expanded successfully*
- *Models of care that we should start to implement*
- *Low benefit care that has/should be stopped*
- *Things that have not worked well.]*