Submission by the Self Help Addiction Resource Centre (SHARC) the Royal Commission into Victoria's mental health system

July 2019

The Self Help Addiction Resource Centre (SHARC) appreciates the opportunity to make this submission to the Royal Commission into Victoria's mental health system.

SHARC's submission focuses on the significant issues faced by individuals, families and community due to alcohol and other drug (AOD) use dependency, how the current system is serving their needs and how it might be improved.

About SHARC

Established in 1995 to promote self-help, peer-led approaches to recovery from addictions, SHARC works with over 8500 individuals and families annually. Our staff are professionally trained individuals who also bring personal experience of the impact of drugs and alcohol. All programs are significantly supported by volunteers.

Mission

> To provide opportunities for individuals, families and communities affected by addiction and related problems to recover and achieve meaningful, satisfying and contributing lives.
>
> To provide models of practice for family support, consumer participation and peer based recovery support; and influence practice in the field of addiction and other related health domains.

SHARC programs include:

Residential Peer Programs: supporting those on their recovery journey with accommodation, counselling and life skills. Encompassing three programs: the Understanding & Support Women's Recovery Program; Oxford Houses (men and women); and Residential Support Services (young people up to age 25).

Family Drug Help: assisting families impacted by alcohol and drug use of a family member or significant other. FDH programs include: a 24/7 helpline; family psycho-education programs; family counselling; and community volunteer-led, family peer-support groups. Also developing programs to assist families affected by gambling.

Peer Projects: facilitating and demonstrating the benefits of including people with lived experience in programs and services, and building the capacity of services to engage and support peer workers.

Association of Participating Users (APSU): ensuring the voice of people who use alcohol and drug services is central to policy and service development. Programs include training and supporting consumers to contribute to community debate and policy development; championing the role of consumer participation and meaningful consultation; and advocating for systemic change in the AOD sector on behalf of consumers.

Our submission

In preparing this submission, we have consulted with and surveyed staff, volunteers, clients, program participants and community. Included in this submission are direct quotes from those consultations. We have restricted our comments to the questions most relevant to our area of work and on which we are qualified to comment.

The connection and cross-over between MH and AOD[1] is well established with substance use dependency recognised as a mental illness in its own right and up to 50% of people with a diagnosed mental illness have a life time substance use challenge.

People with a dual diagnosis are more likely to experience:

- Higher rates of relapse, hospitalisation and use of emergency services
- Increased cognitive deficits – reduced learning / memory / concentration
- Decreased adherence to treatment
- Increased criminal offences and likelihood of incarceration
- Increased MH symptoms – delusions / hallucinations / thought disorder
- Increased likelihood of suicide and early mortality
- Increase likelihood of becoming homeless.

This is demonstrated daily in SHARC's own programs. For example, our youth residential program, Residential Support Services, has recorded a dramatic rise in applicants' pre-admission self-report of the use of (highly psycho-active) crystal methamphetamine and GHB. The vast majority (93%) of our residents report having a MH diagnosis with the majority of them reporting experiencing at least one psychotic episode.

While there has been much effort undertaken to better connect the MH and AOD services, especially by the Victorian Dual Diagnosis Initiative, there remains significant gaps and issues to address.

[1] Abbreviations used in this submission:
MH = mental health
AOD = alcohol and other drugs

SHARC responses to Commission questions

1. **What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?**

The stigma and discrimination associated with AOD use is real for many people in our community. Affecting people, and their families and friends, who have used or are using alcohol and/or other drugs, even years after ceasing drug use, the impact on people's emotional, social, family, education and work life can be extensive and longstanding.

Some of the work currently being undertaken by APSU demonstrates the many fronts that stigma and discrimination needs to be addressed on.

a. The Alcohol and Other Drugs Anti-Stigma Language Guidelines: development of guidelines which reflect the position that alcohol and other drug use is a public health issue, rather than a criminal justice issue.

These guidelines are intended for use by staff of government departments; AOD services; community, youth, human services and health professionals; and all others interacting with people who use alcohol and other drugs.

b. Impact of denial of Working with Children's Check – research and development of a position paper. Includes effects on employment opportunities, parenting roles, access to education etc.

c. FlipSide: quarterly publication by AOD service consumers by consumers. A platform for the stories and experiences of consumers.

d. Straight From the Source podcast: broadcasts stories which challenge stereotypes around addiction and substance use and opens up conversation around the areas of life where substance use intersects such as mental health, homelessness, family violence, parenting issues and the criminal justice system.

Ingrained stigma was a consistent issue of concern raised in the consultations conducted by APSU with service users. SHARC commends to the Commission the separate submission from APSU which provides detail on those consumer consultations.

There are fundamental differences in the type of stigma and discrimination being experienced depending on:

- whether presenting with a MH or an AOD issue: MH is more likely to be seen as a medical issue while AOD use is often viewed as a defect of character.
- which type of drug is involved: some drugs are more acceptable to society.

What can be done

Conduct an ongoing community based communications campaign promoting both MH and AOD use as medical issues.

Widespread adoption and promotion of the Alcohol and Other Drugs Anti-Stigma Language Guidelines.

Investigation into the barriers being experienced by people with an AOD history and addressing these barriers.

Placing greater emphasis on the value and expertise that those with lived experience can bring to AOD programs and services. SHARC is working with DHHs to support the development of a strong AOD lived experience workforce.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

We wish to draw the Commission's attention to a number of specific system issues which reduce the efficacy and accessibility of services, and which need to be addressed.

A. Chronic lack of AOD step-up, step-down beds

Research into the impact of homelessness suggests that safe secure housing has a dramatic impact on: a person's mental health; their capacity to establish helpful relationships with health and welfare providers, their capacity to engage with employment, study and meaningful activities; and to recover from their emotional challenges.

There is a desperate need for safe and secure housing for people wanting to change their lives

Whilst there are acute residential services for people with MH challenges, e.g. acute psychiatric units, and people with AOD challenges, e.g. Therapeutic Communities, only MH services offer coordinated step-up and step-down services such as ARCs. However, there are few coordinated step-down services for people exiting AOD residential rehab services or other intensive programs.

Access to an increased number of supported housing beds is essential for people to experience good mental health and to engage effectively with wrap-around services. As recently reported in the case of the tragic death of Courtney Herron, many people are denied access to AOD treatment if they have no housing.

Residential Peer Programs at SHARC receive up to 20 queries per week that we cannot accommodate. Clinicians and managers attending a recent forum of AOD supported accommodation providers echoed our experience.

This gap has become increasingly clear. Whilst we are highly supportive of the increased number of residential rehabilitation beds being provided in Victoria, we are concerned that the new funding contracts did not require post-discharge residential programs. This is particularly important for those new residential rehabs offering admissions limited to 90 days when the sector broadly accepts that people using Crystal Meth experience cognitive deficits, associated impulsivity, poor consequential thinking and planning for far longer than this length of time.

Our youth program (admitting people 18 – 25) shows that over 95% of them are homeless on assessment and 93% have a diagnosed mental illness, yet they stay an average of 10.3 months. Those who stay beyond 6 weeks are well engaged with a GP, MH services where appropriate, family integration programs and counselling, a dietician if required, recreational and creative

activities and a community of recovering peers. At 3 months in the program most are employed or studying part-time.

These results are directly attributable to their stable accommodation which enables them to make robust connections with health and welfare services, learn living skills such as effective communication, re-engage with family and develop a supportive network of peers who share their drug-related and aspirational goals.

What can be done: Provide an increased number of adequately resourced step-up step-down beds / programs. Trial and evaluate at least 2 models. SHARC's peer model has been assisting people to successfully recover from substance dependency for 30 years and we have a detailed institutional memory, remaining in contact with people admitted to SHARC from the late 1980s until now.

B. Lack of opportunities for integrated care for clients with a dual diagnosis – the need for in-house complex care coordination for residential and step-up step-down programs.

Most of SHARC's clients present with a dual diagnosis and require effective MH and AOD support and treatment.

The vast majority of AOD services do not have in-house MH clinicians and vice versa. If a client requires integrated dual diagnosis treatment, their primary service team must negotiate treatment from a secondary service, AOD to MH or vice versa.

Effective integrated treatment includes referral, regular confidential communication, the development of an integrated care / recovery plan, case conferencing and the capacity to respond quickly to any changes in the client's health e.g. relapse or stress.

These activities take considerable resources that are rarely reflected in existing tenders and staffing profiles.

There can be many barriers to accessing a secondary service: it may be some distance from the primary service; the client may require transportation and/or escorting to attend; the service may use different clinical language from the primary service; have little understanding of the other service's treatment processes; and have no capacity or interest in integrated care e.g. they may see their work as specialist and, somehow, separate or more important.

It would greatly benefit clients if they could access a complex care coordinator within AOD residential services who understands the client's needs, the service's processes and the sector and whose role would include completing comprehensive dual diagnosis assessments, developing cooperative relationships with relevant services and supervising colleagues as they learn to respond effectively to clients with complex challenges.

What can be done: Fund in-house complex care coordinators as part of the staffing profile of residential and step-up step-down programs. SHARC's RSS program has had access to a part-time complex care coordinator (funded by a local PHN) who has effected complicated referrals to a number of health and welfare agencies including CYMHS and Headspace and we have seen dramatic improvements in people's MH status. This position is funded on a year by year basis.

Getting help as a dual diagnosis client is difficult, I've been seen by an AOD worker, referred to Mental Health Services for my mental health only to be told after assessment that yes I am unwell, but not unwell enough to receive a service". Service User, APSU consultation.

C. Lack of affordable accessible eating-disorder treatment / support for people with MH and AOD challenges

More than 90% of the women we admit to our services report some challenges with their relationship with food and 20% have been diagnosed with a formal eating disorder.

When people with eating challenges cease their use of alcohol and other drugs, it is common for them to experience a relapse into unhealthy eating or purging behaviours. This has an impact on their mental and general health and can trigger further alcohol or other drug use.

We have been accessing some limited support from a community health service for individual residents identified as having significant eating disorders but would benefit from similar support for those with emerging problems, client-education groups and staff training / supervision.

What can be done: Train and increase the numbers of eating-disorder competent dieticians in community health services, and fund them to provide in-reach, consultation and supervision to residential and step-up step-down services.

D. Lack of access to affordable and effective treatment for PTSD symptoms for people in recovery from AOD challenges

For many people, once they cease using alcohol and other drugs they begin to experience significant trauma symptoms that have been muted by the substance use. Symptoms include insomnia, episodes of panic, dissociation and flashbacks. For some, these symptoms occur within weeks of withdrawal from substances, for others it may take a number of months or more.

Whenever people experience these symptoms, they are at risk at relapsing into substance use or other unhelpful behaviours e.g. dysfunctional eating patterns.

At this time, people need quick and easy access to affordable effective treatment. However most clinicians providing treatment for PTSD work as private practitioners and are funded through MHCP where they also request a gap payment. Many of these clinicians are not AOD-competent and are not sure how to respond to people wishing to remain drug-free while addressing their stress.

It would be beneficial if generalist AOD counselling services were funded to train and mentor senior clinicians to work with people experiencing PTSD, including training in EMDR or similar, and if these services had the capacity to fast-track clients at risk of relapse and those in longer-term recovery.

At present, these services are funded to provide services to people who are using alcohol and other drugs or those in early recovery and are not funded to provide support to people who have been drug-free for some time.

What can be done: Increase access to specialist PTSD practitioners within AOD counselling services for people in early and longer-term recovery from AOD challenges.

6. **What are the needs of family members and carers and what can be done better to support them?**

SHARC's Family Drug Help (FDH) program works with families, carers and communities across Victoria, resourcing and supporting them to better cope and survive the impact of AOD use. Peer support strategies that we utilise include: a 24/7 helpline staffed by trained volunteers with lived experience of family drug use; psychoeducation programs; and community peer support groups; along with professional family counselling.

As well as drawing on FDH's 20 years plus of working with family members and carers, FDH conducted a survey of family members on their experiences of the MH and AOD systems (see summary attached.). The key issues arising include:

- A dedicated focus is essential to address the mental health needs of the family members and carers. Stress, anxiety, depression, grief, anger and social isolation are common emotions, and can escalate if not addressed. As well as improving their mental health needs; they are in a better position to support and help their loved one to seek and maintain treatment.
- The FDH family counselling service cannot meet demand with waiting lists of 12 weeks and more. Along with expanding the capacity of this service, capacity building within more general family counselling services to support the MH needs of family members and carers would be beneficial.
- Accessing support for a loved one: many family members seek help and support to 'rescue' their loved one; a first priority before they can even begin to think about their own needs. When surveyed, many reported difficulties in understanding, accessing and navigating the MH and AOD systems.

"An integrated approach to service provision which demands clear communication between all services. Currently the system is far too complicated to navigate."

- Waiting lists: families are frustrated with the difficulty and anxiety of trying to keep their family member committed to seeking treatment while waiting on a treatment spot.

"Where there is actually a service available, wait times are excessive, not allowing people to get the support needed when it's needed the most."

- Dual diagnosis – the problems faced of seeking help for a family member for both MH and AOD issues. Difficulties included: being shunted between services; MH services not wanting to engage until the AOD issue is resolved; differing approaches and information being offered. There is an urgent need to develop and deliver a more concurrent treatment system – with both service systems working better together.

"There was nowhere to treat both at same time. Kept being bounced between the two services"

- Communication: many families and carers feel left out of the loop. On one hand they are expected to take responsibility and provide support for the person involved, but then are also often shut out of treatment and post treatment discussions.

"Wasn't given any information re loved one even though I was promised progressive reports. No one asked about my wellbeing."

- Family peer workers: having trained and supported family peer workers deployed across hot spots of crisis to support family members e.g. at Hospital Emergency Departments and courts would greatly improve support for families and improve treatment outcomes.

"Family is not well considered or supported. Family Peer Workforce needs to be introduced into Hospital ED's and Rehabs to meet the growing needs of families in crisis."

7. **What can be done to attract, retain and better support the mental health workforce, including peer support workers?**

Whilst the peer workforce is well established in the MH sector, the AOD sector has been slower to adopt, support and integrate peer workers.

Since 2014, SHARC has dedicated energy and resources to supporting the development of the peer workforce in the AOD sector. SHARC's Peer Projects works alongside the Victorian Department of Health and Human Services (DHHS) to support the growth, development and sustainability of Victoria's AOD peer workforce and coordinate Victoria's AOD Peer Workforce Community of Practice.

Peer Projects deliver services under the SHARC Peer Worker Model, a framework that works to ensure a quality, consistent and sustainable peer workforce and includes:

- SHARC Peer Worker Training
- Peer Worker Practice Supervision
- Organisational Readiness Training

From this perspective, we have identified the following as needed to effectively attract, retain and better support peer workers on the AOD sector.

1. A national workforce strategy for the MH/AOD peer workforce that describes the required activity needed to adequately support and develop the workforce and is carried out in partnership and with leadership from consumer workers. The strategy will assist policy developers, funders, consumer workers and their employers, and will be useful for organisations planning to employ consumer workers.

2. A national development framework for the peer workforce to ensure a quality, consistent and sustainable peer workforce via the following activities:
    - Organisational Readiness Training and Sector Capacity Building
    - Peer Worker Training
    - Peer Worker Practice Supervision
    - Peer Workforce Community of Practice

3. Organisation readiness is key. encompassing:
    - Understanding and recognition of the value of Peer Work
    - Endorsement and encouragement by committees of management
    - Developing shared expectations about what peer workers actually do - the tasks they are responsible for - but more importantly, how peer workers go about their work
    - Proper planning, implementation and support
    - Identification and training of staff champions, including formalizing their role by adding it to their position description

- A framework for development and sustainability
- Appropriate resources, according to local needs
- Integration into service design and delivery

4. Provision of Peer Worker specific supports
   - Training, supervision, networking and ongoing professional development opportunities.
   - Peer workers are offered peer worker specific training, as like in any professional discipline, they need quality, standardised training and ongoing professional development.
   - Supervision provided that is specific to the peer work discipline and ensures that the peer workforce is strategically and meaningfully supported in their role.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

A. Reduce relapse and increase the joined-up nature of AOD and MH services by establishing and funding effective step-up and step-down community residential programs that articulate with more intensive programs.

The Labor Victorian Government has increased the numbers of AOD Residential Rehabilitation beds which is welcomed. However, previous reform of the AOD treatment systems saw the removal of supported accommodation (step-up step-down) as a treatment type for adults. This has resulted in people exiting expensive intensive support services to face homelessness or fragile accommodation at the very time that they need to focus their personal resources on re-engaging with society, education or employment and rebuilding their lives.

We believe that every inpatient / residential AOD and MH service should have step-down beds that assist people to adjust to more responsibility and less support whilst retaining some structure and treatment.

SHARC has a 30+ year history of providing cost-effective peer-based supported accommodation and would be happy to engage with a working group to develop such programs.

B. Fund complex care and recovery coordination within residential and supported accommodation programs

To correct the disconnection between drug-free, supported accommodation services and complex care and recovery clinicians housed in external sites that offer NSP, drug-replacement services and similar harm reduction services.

It is worth noting that our closest complex care coordination service is a service where our young vulnerable clients would have to share space with drug-affected people accessing needles and syringes and seeing their drug-replacement doctor.

C. While continuing to use the Victorian Dual Diagnosis Initiative (VDDI) consultants, consider engaging in-reach AOD clinicians for MH services for primary and secondary consultation and effective referrals to the elements of the AOD sector.

Addressing the lack of complex dual diagnosis-competency in MH acute services, staff turnover, resource-challenges, staff profiles, heavy case-loads, competing priorities and other organisational challenges which continue to limit the uptake and establishment of dual diagnosis-related skills.

Whilst continuing to receive training and secondary consultation from dual diagnosis consultants, having experienced AOD clinicians attend MH settings on a regular basis e.g. at least one day a week per setting, would provide opportunities for primary, secondary and tertiary consultations, supervision, mentoring and robust referrals for appropriate AOD interventions and support.

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Attachment 1

Family Drug Help community survey for Royal Commission into Victoria's mental health system – Summary of responses