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Submission

Whole of Government Alcohol and Drug Strategy – Community Consultation

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Psychiatric Disability Services of Victoria's (VICSERV) role

VICSERV is a membership-based organisation and the peak body representing community managed mental health services in Victoria. These services include housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self-help, respite care and Prevention and Recovery Care (PARC) services.

Many VICSERV members also provide Commonwealth funded mental health programs.

VICSERV welcomes the opportunity to provide a submission to the Whole of Government Alcohol and Drug Strategy. It is estimated that around 75 per cent of people with an alcohol and/or substance use problem may also have a mental illness.[1] VICSERV is very interested in this issue considering that many users of its member services have a dual diagnosis. Furthermore, many of VICSERV's members are involved in the Victorian Dual Diagnosis Initiative (VDDI) which has in their experience resulted in a cultural shift when dealing with this client group.

This submission and the recommendations focus on:

- The social determinants which affect prevention, early intervention, treatment, education, regulation and law enforcement activities for people with a dual diagnosis
- How the whole mental health and alcohol and other drug (AOD) service system can be better integrated for seamless and efficient service system responses
- The power of partnerships and in particular the successes of the Victorian Dual Diagnosis Initiative (VDDI) and the recommendations coming out of the *VDDI Evaluation Report*
- The research and evidence-base for treatment in the community and community-managed AOD/mental health services
- Workforce development to build a workforce capable of identifying and working with dual diagnosis clients.

In addition, VICSERV is currently preparing a paper to be released in October which will include contextual information for improved service systems and a pre-prepared position on what is needed to make it happen.

In formulating this submission every effort has been made to consult with VICSERV members in accordance with the *VICSERV Policy Consultation Framework*. Whilst member input informs this submission, the views posited are not necessarily shared by all of the membership.

[1] http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Dual_diagnosis

1. How should prevention, early intervention, treatment, education, regulation and law enforcement activities be tailored to take into account the needs of people with a severe mental illness?

In the context of persons with a severe mental illness and co-occurring drug and/or alcohol dependency, unmet needs in health, housing, education, work-force participation and social inclusion are important factors which hinder recovery. Mortality rates for persons with mental illnesses have been found to be up to 2.5 times greater than that of the general population.[2] This is an example of a cycle of disadvantage with a gap in physical and mental health needs affecting individuals as well as whole groups of people in terms of collective life expectancy. These social determinants must be taken in to account when tailoring prevention, early intervention, treatment, education, regulation and law enforcement activities. A holistic approach requires a whole of government response and strategy. The Victorian government is to be commended for recognising the need for such an approach through its strategy.

Alcohol and other drug misuse by people with a severe mental illness is related to quality of life issues. That is investment in flexible housing options, employment, education and initiatives that discourage the continued social exclusion of this group will assist in meeting these needs and make enormous improvements on future outlooks.

In terms of prevention, it is important to consider the reasons for high prevalence of drug and alcohol misuse amongst those with a severe mental illness. One probability is the self-medicating effects and relief from unpleasant symptomatology arising from mental illness. This in itself indicates that if prevention strategies are to be successful, they must provide good treatment options for both the mental illness and co-occurring drug and/alcohol issue. The current medications for some serious mental illnesses have deleterious side-effects such as heart disease, diabetes and obesity. Providing good alternatives to these such as newer medications, tailored education and training options, community-based health programs and initiatives to assist people to connect with their community are all important.

VICSERV's *Pathways to Social Inclusion Proposition Papers* identify several successful interventions in health, education, workforce participation, and housing.

In the context of housing, supported social housing models have proven to be effective in breaking the cycle of disadvantage. Supported housing provides for stable housing with access to supports on a flexible basis. The following are the key tenets of effective social housing:

- An explicit focus on people recovering from severe mental illness
- An orientation towards the whole person in all their complexity
- The provision of secure and ongoing tenure in appropriately designed and located housing stock
- Comprehensive and coordinated ongoing support tailored to individual needs
- The house must be a home (not a 'residential treatment setting')

[2] Psychiatric Disability Services of Victoria (2008) *Pathways to Social Inclusion: Proposition Papers*, VICSERV, Melbourne, pp. 65-66

- Housing must be stable and long term (not time limited) to break into iterations of homelessness
- Choice of housing must be based on consumer preference
- Consumers must be housed as members of the community, not residents of a program
- Housing should foster consumer control of their environment
- Housing that keeps levels of stress manageable should be selected
- Housing should be located in neighbourhoods with a mix of residents (consistent with community norms) to minimise stigma
- Housing must have an appearance consistent with the neighbourhood
- There must be support available that is individualised and flexible
- The levels of support required at any given time must be defined by consumers
- Support must occur in the person's home (rather than in a transitional environment)
- Services must be responsive to the needs of different population groups e.g. indigenous communities, culturally and linguistically diverse communities, younger people, older people, and people with complex co-morbidities including dual diagnosis and substance use disorders
- There should be a separation of housing and support services either by different providers or different functions within the one organisation to minimise conflict and ensure integrity of service delivery
- There must be interagency collaboration between housing providers, support providers, clinical services, government and other services relevant to the client group
- There must be ongoing advocacy to address stigma and discrimination experienced by people living with severe mental illness in their neighbourhoods and communities.[3]

Housing initiatives that have successfully embraced some of the above principles include the Housing and Support Program (HASP) Vic, Whirrakee Housing and Support Service 'Mental Health Pathways' Vic, Neami/Supported Housing Ltd Initiative Vic, Project 300 Qld, and the HomeGround Supportive Housing Initiative Vic[4].

In the context of workforce participation, what has been shown to work are programs and strategies based on the following:

- Eligibility for employment services based on consumer choice, not job readiness
- Integration of disability employment services with mental health care
- The goal of competitive or open employment
- Rapid commencement of job searching activities
- Job placements based on consumer preferences, strengths, experience, and interests
- Continuing support to retain employment
- Income support and benefits counselling

[3] Psychiatric Disability Services of Victoria, op. cit., pp. 99-100
[4] ibid, pp. 100-104

- Continuous availability of intensive onsite workplace support
- Multidisciplinary teams to coordinate treatment and vocational interventions
- Alliance between staff and consumers in rehabilitation
- Strategies to counter workplace stigma.[5]

To date there is no specific initiative that combines all of the above. Further, '[w]hilst avoiding a model-versus-model scenario is recommended, it is also important to acknowledge that some consumers may not be in a position (or may not wish) to consider competitive or open employment. For them, a stigma-free work environment – such as those provided through sheltered workshops, transitional employment/clubhouse models, and social firms – may be desired to rebuild work and social skills and confidence'.[6]

Similarly, with education, there is no particular model that captures all the key components of successful learning. These components are articulated as follows:

- Academic and functional assessment
- Assistance with career choice
- Skills teaching (e.g. study skills, stress and time management)
- Utilisation of equipment (e.g. computers)
- Assistance in enrolment and access to campus-based services.[7]

Examples of successful programs include the Orygen Youth Health IPS Initiative, Mental Illness Fellowship Victoria and St Vincent's Hospital Supported Employment Initiative, Mental Illness Fellowship Victoria Training and Education Program, and the Bendigo Bank Disability Employment Program.[8]

Another key tenet to avoiding chronic disadvantage is good health outcomes. The physical health needs of persons with a mental illness are often neglected with clinicians concentrating solely on their mental health needs or viewing complaints of somatic ailments as manifestations of the person's mental illness. Some psychiatric medications, as mentioned previously, also have serious side-effects affecting physical health.

Good practice in meeting physical health needs entails:

- 'Routine use of a standard checklist and collection of core information concerning physical health amongst all health professionals
- Adequate resourcing of psychiatric services to carry out physical health tasks
- Refresher training for psychiatrists (and key members of multidisciplinary community psychiatric teams) that includes elements of detection, management and prevention of physical health conditions

[5] Ibid., pp. 85-86
[6] ibid., pp. 86-87
[7] ibid., pp. 87
[8] ibid., pp. 88-89

- Specific multidisciplinary teams with broad medical and psychiatric expertise and training as the basis for enhanced models of shared care
- Formalised programs to address training and other issues at regional and state levels
- Employing physical health staff in inpatient wards and developing in-reach services
- Investment in linkages between primary and sub-acute/acute care e.g. the development of dedicated physical health link workers
- Improving in referrals and other aspects of service coordination
- Specific programs that deliver individual or group interventions such as smoking cessation for people with schizophrenia, walking groups, yoga and pilates sessions, health and wellbeing days'.[9]

While health, housing, workforce and education participation are key, social inclusion is also important in breaking the cycle of disadvantage. Strategies which are required to build social inclusion consist of but are not limited to:

- 'Partnerships between different levels of government (federal, state/territory and local) and across different departments (e.g. mental health, health, justice, housing, employment and education)
- Investment in evidence-based community supports for early intervention, recovery, and relapse prevention in order to rebalance the current and (over) emphasis on a crisis driven acute based mental health system
- Integrated service delivery and improved multidisciplinary care
- Engagement of consumers, carers and families in developing policies related to treatment and care
- Recognition of and investment in evidence-based peer support models that support the journey of recovery
- Better understanding and recognition of the roles of carers (including adult family members, children, and others) and investment in supports that meet their specific and changing needs
- Responsiveness to the unique needs of individuals along multiple and intersecting axes of differences, e.g. gender, age, ethnicity, language, culture, indigeneity, age of onset, stage and type of illness etc. – that is a comprehensive understanding of, and approach to, diversity
- Development of a social inclusion and mental health research agenda
- Investment in evidence-based community awareness raising and education initiatives, demonstrating the links between social inclusion and recovery/relapse prevention'.[10]

It is the experience of some of VICSERV's members that the current VDDI 'no wrong door' policy has been successful in achieving the intended outcome of clients being accepted into programs, screened for drug and/or alcohol issues and assessed as required. In terms of taking into account the needs of people with a severe mental illness in the context of AOD treatment, VICSERV wholly supports the recommendations of the VDDI

[9] ibid., p. 72
[10] ibid., pp.61-62

Evaluation Report, particularly those concerned with performance monitoring, screening and assessment tools.

With regard to regulation, governance recommendations proposed by the report if implemented by government will provide clarity in terms of roles, reporting requirements, and consistency in approach. In particular, the recommendation that a common vision for responding to people with dual diagnosis issues be established is pertinent and should be the cornerstone for the Whole of Government Strategy.

In terms of law enforcement, initiatives such as the Assessment and Referral Court (ARC) List at the Melbourne Magistrates' Court as well as the Drug Court have had a positive impact on the ability of people before these courts to address the issues which keep them within the revolving door of the justice system. The successes of these programs are not just in their diversionary affects but more so because they take into account the real issues behind a person's encounter with the justice system. In particular, the ARC List has demonstrated the flexibility required in law enforcement to deal with situations whereby a person's severe mental illness can act as a barrier to adhering to agreed outputs. VICSERV is of the view that the ARC List be expanded across metropolitan Melbourne as well as regional Victoria.

With the increase in fatal police shootings of people with a mental illness of late, there is a real concern that law enforcement activities are not being informed by best practice when dealing with individuals with severe mental illness and under the influence of alcohol/drugs. Mandatory on-going training in peaceful dispute resolution interventions as well as education in dual diagnosis issues is key to a better tailored law enforcement workforce.

2. What changes could be made to the current treatment system to improve access and build stronger pathways for people who have serious drug and alcohol issues?

The VDDI has been proven to be successful in improving the treatment system since its inception in 2001. With a focus on partnerships and co-location of teams of clinical, PDRS and AOD workers, the initiative has had some success in improving access to treatment and building stronger pathways for people with serious drug and alcohol issues as well as co-occurring mental illness.

A long standing barrier to access and improved service pathways has been long waiting lists which is a reflection of the lack of capacity of services to meet demand. There is often a small window of opportunity between the time a person comes to the realisation that they need assistance and getting them that assistance. Anecdotal evidence suggests that people in need of treatment are 'dropping off' waiting lists.[11] There is a real need for more available residential drug treatments at the time that the person is ready to commit.

Accessibility can be improved through a cross-sectoral approach to the issue including overarching formal agreements between services, coordination enhanced through joint education and training, cross sectoral networks and increased knowledge of referral

[11] Victorian Alcohol and Drug Association (September 2011) VAADA submission to the consultation into the Whole of Government Alcohol and Drug Strategy, Melbourne

pathways and treatment options. Furthermore, reconfiguration and local area planning including the co-location of services, particularly AOD and mental health, would increase the accessibility to treatment options and referral pathways. Population based local area planning with the view of ascertaining local needs and then catering to that population is a priority. Cross employment of staff may also assist in more timely interventions for clients.

Peer work has also been identified as mechanism for building stronger pathways for people with a serious mental illness as well as drug and/or alcohol issue. Feedback from VICSERV members is that the Personal Helpers and Mentors (PHaMs) Program has been successful in assisting people with a severe mental illness in the navigation of the system as well as getting access to services. Whilst a Commonwealth initiative, PHaMs is worthy of mention particularly for its potential to cross-over into the AOD sector and to engage more people in the recovery process. Even though this cross-over has already begun, it needs to be expanded and resourced adequately.

Consumer and carer involvement are key to the engagement process and for enabling access to services. Whilst carer and consumer involvement across the community-managed mental health, AOD and clinical sectors is already a legislative requirement and opportunities for carers is encouraged, members have reported that individual participation generally fluctuates.

As one member pointed out:

> *'The AOD sector considers Family Inclusive Practice as core business. Mental Health Services are focussing on the inclusion of family, carers and significant others into the treatment process. The continued expansion of the Beacon Strategies should be considered to give practitioners baseline skills regarding family inclusive practice.'*

The main point being is that family inclusive practice is something that is continually being developed and there is a need to articulate and educate workers in the field in this practice.

3. How can different agencies work more closely in partnership to prevent the misuse of alcohol and drugs and the harms associated with alcohol and drug misuse and to help people overcome their alcohol and drug problems?

The VDDI Evaluation Report makes some very pertinent points about partnerships between agencies as well as clinical mental health teams. As mentioned above, there is a need to explore and back opportunities for co-location as part of a wider health and social wellbeing planning framework. In this respect, VICSERV supports the recommendations 2.2.1 and 2.2.2 of the VDDI Evaluation Report.

There has also been suggestion that funding for agencies is contingent on demonstrated partnership capability as well as linking funding to partnership models. Feedback has suggested that the mental health alliances were worthwhile and can work however they must be clear about what the partnership is trying to achieve. Furthermore, such partnerships in addition to good governance and theoretical aspirations must also have a practical tinge to allow for generation and implementation of initiatives.

Examples of good partnership initiatives include:

- The Central Grampians Area Mental Health Services and Community-Managed Mental Health services have participated in weekly shared case management for many years and over the period of the VDDI, have included AOD case managers of clients with dual diagnosis
- Staff members with dual-diagnosis portfolio responsibilities shared between services
- Cross-service collaboration and participation in shared education opportunities as appropriate.

However partnership is not only about collaboration of services. The Government needs to include in its Strategy a framework for appropriately consulting with the sectors. For instances where there are consultations for AOD issues, the mental health sector needs to be involved in that process. Where the issue is housing, again the community managed mental health sector needs to be consulted about important decisions. Otherwise there is a real risk of setting up a system that has a siloed approach to dealing with issues, develops fragmented responses and discontinuity in treatment systems. Human issues are not compartmentalised; responses should not be either.

4. How can our research and evidence base be improved to inform an assessment of the outcomes of the Strategy and priorities for future action?

In the development of the strategy, this is the time to build on research and the evidence base for AOD and mental health provided by the community sector. That is the reason why it is VICSERV's view, that a concise literature review needs to be developed looking at community managed mental health and the AOD sectors. Included would be a review of practice, consumer and family initiatives as well as a determination of positive actions arising out of the findings. This will also give a sense of what the priorities will be going into the future. Ideally, this research undertaking would be subcontracted to VICSERV or/in conjunction with another appropriate peak body to truly inform assessment and outcomes of the Strategy.

5. How can we build the skills of relevant workforces to better identify and respond to people with alcohol and drug problems?

In terms of cross-sectorial education, with the roll out of the dual diagnosis initiative, VICSERV has experienced an unprecedented demand for its dual diagnosis training. As one of VICSERV's member agencies reported the 'increase in education and skills across services has provided in house proficiency to deliver concomitant service'. Indeed, VICSERV's *Training Needs Analysis* conducted in 2010 indicates that dual diagnosis training is one of the highest priority development needs of the community managed mental health sector.[12] Feedback from members suggests that a second tier of VICSERV dual-diagnosis training be developed to meet this demand and develop the sector. This training is not only relevant to the community-managed mental health sector, but could also be rolled out to people in other sectors such as clinical, housing, education and employment.

In addition, opportunities for cross-sector networking and liaison would be productive in building the skills of the relevant workforce. An example of this to date has been the work

[12] Psychiatric Disability Services of Victoria (2010) *VICSERV Training Needs Analysis Report 2010*, VICSERV, Melbourne

of the Melbourne Drug Alliance which hosts short presentations on practice issues and an opportunity to share knowledge and build referral pathways through networking. A VICSERV member agency also suggested that it would be valuable to hold a forum for dual diagnosis portfolio holders on a regular basis as a way of maintaining momentum on practice and strategic issues. Such forums and networking opportunities also would assist in the building of confidence in the skills developed through training.

A number of VICSERV members have indicated agreement that an increase in reciprocal rotations between mental health and drug and alcohol agencies would be beneficial in building on partnerships as well as increasing confidence in working with clients not within their 'core' skill set. Such an initiative needs however to be supported by government and adequately resourced.

Another way in which skills can be developed is through monitoring and appropriately addressing issues as they arise. For example, the results of the requirement for all staff of community managed mental health services to use Assist Assessment should be appropriately monitored with identified gaps to be followed up with commensurate funding for training.

In addition to skills, systems need to be established and well supported to allow for better care coordination between sectors. As one member pointed out:

a) 'Practitioners from both services should have an understanding of the function and the philosophies of the other
b) Practitioners from both services should have the ability to screen and provide appropriate interventions if co-occurring issues are identified
c) Practitioners from both services should have the ability to develop and coordinate integrated treatment plans as part of Individual Recovery Plans
d) Practitioners from both services have a solid understanding of the referral process'.

6. Are current treatment services meeting the needs of people seeking treatment and how could they be improved?

Since the introduction of the 'no wrong door' policy which many agencies have adopted instances of turning away people in need of assistance has significantly decreased. How meeting the needs of people seeking treatment can be improved include addressing the reasons behind instances of refusal of service if and when they occur. These reasons include systemic, organisation as well as individual failures such as the creation of silos, lack of understanding about dual diagnosis, lack of knowledge about referral pathways, attitudes and values of practitioners as well as ever changing opinions on what constitutes best practice.

However, in agencies where close partnerships with other services have been built and there is a shared case management system that facilitates client outcomes, client needs are being better met.

Timely access to treatment needs to be improved. As indicated above, there is a significant lack of timely access to AOD detoxification and rehabilitation services. This often necessitates the person seeking treatment to leave their community and support infrastructure to access services available in distant areas. For example, in the Grampians

region alone there in only one residential service available and that is limited to the 16-24 age group. One approach is to increase the provision of AOD and mental health outreach services. Again, this raises the issue of the need for better localised planning to meet the needs of individuals requiring access to services.

Furthermore, the range of services available needs to be adequate to deal with the complexities of individuals seeking assistance including homelessness, trauma, physical health issues, unemployment and education. Therefore services, whether they are within the mental health or AOD sector, need to be able to provide flexible treatment options that are person centred and recovery orientated. In addition, service attitudes need to be improved through furthering education and exploration of core values. For instance it has been recounted that some AOD agencies have refused treatment to persons on medication for his/her mental illness. This is due to the lack of understanding about mental illness and the needs of people in their recovery process. It is time that these are taken into account.