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Productivity Commission
GPO Box 1428
Canberra ACT 2601

7 February 2020

Dear Sir/Madam,

**RE: Productivity Commission's Inquiry into Mental Health - Draft Report**

The Victorian Alcohol and Drug Association (**VAADA**) welcomes the opportunity to make a submission to the Productivity Commission in respect of its draft report, developed as part of the ongoing inquiry into Mental Health (**Draft Report**). VAADA reiterates the recommendations included in its initial submission to the Productivity Commission,[1] and now takes the opportunity to provide feedback on aspects of the Draft Report from our perspective as an AOD sector peak.

VAADA commends the Productivity Commission on developing a comprehensive and well-researched Draft Report that acknowledges the high prevalence of co-occurring mental health and substance use issues experienced by individuals in the community.

The Draft Report correctly identifies substance use as a significant contributor to comorbidity in individuals experiencing mental health issues, noting that the rates of comorbidity amongst those seeking treatment are considered 'the expectation, not the exception', with rates ranging from 47% to 100%.[2] This submission will focus its attention on the need to respond to service users experiencing comorbid disorders.

Treatment services must provide a more holistic, client-centred and co-ordinated response if they are to achieve improved outcomes for those experiencing comorbid disorders. The Draft Report explores the status of comorbid disorders with regard to treatment, resourcing, governance, the siloed structure of the alcohol and other drug (**AOD**) and mental health sectors, and the challenges associated with developing and maintaining workforce capability.

However, while the Draft Report identifies and explores a number of these key issues, we feel it has missed the opportunity to make recommendations which would address these issues.

**Section 9.3: What more should be done to address comorbidities?**

The Draft Report notes that, 'These reforms are not especially focussed on comorbidities, but the Commission is seeking further feedback from stakeholders on how alcohol and other drug services should be funded were it to pursue a more ambitious reform option'.[3] VAADA believes there is a need for the Productivity Commission to explore best practice solutions from national and international jurisdictions.

The Productivity Commission has identified four key features required to enable the treatment system to respond to the needs of service users with comorbid disorders. These features are:

- integrated funding and governance;
- co-ordinated care;

[1] Victorian Alcohol and Drug Association, *Submission to the inquiry into the social and economic benefits of improving mental health*, Submission no. 403, Collingwood, 2019, p. 5.
[2] Productivity Commission, Mental Health, *Draft Report*, Canberra, 2019, p. 324.
[3] Productivity Commission, *Draft Report*, p. 329.

- specialised workforce development; and
- stronger evidence and accountability.

VAADA agrees that these four components are integral for the effective treatment of co-morbid disorders. Unfortunately, the Draft Report fails to make specific recommendations regarding the translation of these priorities into practice. VAADA urges the Productivity Commission to consider the following such recommendations for inclusion in its final report. VAADA believes these will address what contributes to the development of an improved treatment response to comorbid disorders.

*Integrated Care*

VAADA recognises that the promotion of co-ordinated care activities such as access (including the 'no wrong door' policy) and the development of clear integrated pathways for service users are priorities. However, the type of integration discussed in the Draft Report is neither detailed nor sufficiently comprehensive.

The Draft Report defines 'integrated care' as being 'sectors working together and aligning their practices and policies to deliver high quality mental healthcare'.[4] However, what this means in practice, and what this looks like on the ground, remains undefined. This vague definition is considerably more limited than that promoted by Australian and international AOD and mental health experts. The best practice for service integration, promoted in a substantial amount of literature promote integrated care models that involve a much greater level of synthesis than that described in the Draft Report. Researchers carrying out a study on effective models of care for comorbid disorder for the New South Wales Mental Health and Drug and Alcohol Office recommended that 'both the individual's substance use and mental health condition are treated simultaneously by the same treatment provider or service. This approach allows for the exploration of the relationship between the individual's substance use and mental health condition under guidance from the treating team'.[5]

In accordance with this advice, VAADA reiterates that a best practice model of care for the treatment of comorbid disorders is one which involves the provision of specialist programs that address AOD and mental health issues concurrently. Such a model goes well beyond 'sectors working together… to deliver high quality mental health care'. Rather, such a model requires a fundamental up-skilling and capacity building across AOD and mental health. Under such a model, AOD would be included within the core mandate of care of mental health services and vice versa.

Services, whether primarily mental health or AOD, must be capacitated to provide treatment services that are holistic. That is, they do not identify a client's mental illness or AOD issue as outside of their framework of care. This shift, again, promoted by experts in both fields, would require significant changes to the infrastructures and workforces of each sector: up-skilling, capacity building, workforce development, etc. Under such a model, the services linkages described in the Draft Paper would be a safety net: the baseline standard for all services.

Critically, this type of integration does not involve one sector subsuming another at a governance or funding level, but rather, should occur at the program level. A dedicated program addressing co-morbidities, managed by either an AOD or mental health service, would offer access to individuals via referral from either sector. Further, this service would be staffed by workers who have appropriate qualifications and training in both AOD and mental health. VAADA urges the Productivity Commission to

[4] Bywood, Brown and Raven 2015, cited in Productivity Commission, Draft Report, p. 335.
[5] M Deady et al, *Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check Review*, NSW Ministry of Health, Mental Health and Drug and Alcohol Office, 2015, p. 8.

include a recommendation in its final report that a program of service integration be developed, funded and implemented.

*Capacity Building*

Funding dedicated to building the physical and workforce capacity of the AOD sector to respond to comorbid disorders has been inconsistent. This has led to difficulty establishing a qualified and appropriately skilled workforce. From 2007, the Commonwealth's Improved Services Initiative (**ISI**) and subsequent Substance Misuse Services Delivery Grants Fund (**SMSDGF**) programs offered valuable capacity building resources to the AOD sector in relation to mental health issues over the course of a decade. A report on the programs' outcomes noted that, 'Services reported making significant achievements in developing policies and procedures which extended well beyond increasing organisational and sector capacity to provide mental health and substance use comorbidity screening and assessment, treatment and referrals'.[6] These Federally-funded capacity-building programs achieved positive results and saw a clear growth in the AOD sector's ability to respond to service users experiencing comorbid disorders.

Unfortunately, the SMSDGF was abolished in 2016, when the Drug and Alcohol Program was created. Funding was subsequently directed to the Primary Health Networks (**PHNs**) for disbursement. Whilst AOD treatment agencies continue to deliver face-to-face services, there is now diffuse focus and no clearly targeted capacity for specialised workforce training in AOD and mental health. Nor are there adequate resources to develop integrated programs or develop relationships with mental health services.

VAADA urges the Productivity Commission to recommend dedicated funding for capacity building projects within both the AOD and mental health workforces to improve responses to service users presenting with comorbid disorders.

Ideally, capacity building funds should also be allocated to both the AOD and mental health sectors to develop an integrated response to the treatment of individuals with comorbid disorders. This would include scope for planning, development and delivery of integrated programs, and requisite infrastructure resourcing as well as governance, policy and procedures, workforce training and development. A requisite of this funding should be to explore and establish improved pathways and linkages between AOD and mental health services.

*Justice*

The Draft Report includes a comprehensive overview of the link between AOD use, mental illness, and contact with the criminal justice system. As the Productivity Commission notes, there is significant overlap between the three areas. The Draft Report clearly recognises the increased use of illicit substances amongst those with mental illness as a likely contributor to their over-representation in justice statistics, noting that 'there is evidence that people with substance use comorbidities are at an increased risk of offending compared to those diagnosed with a non-substance mental illness alone'.[7]

This cohort is not only at increased risk of offending, but also of significant additional harms. Those who experience a combination of AOD, mental health and contact with the justice system are particularly vulnerable. This cohort is highly marginalised, often disengaged from treatment and other services, and has an increased risk of death through overdose and suicide. To illustrate this, data provided to VAADA by the

[6] National Improved Services Initiative Forum 2010, *Outcomes from the National Improved Services Initiative Forum: A Tale of Two Systems. A Report Prepared by the Australian State and Territory Peak Alcohol and Other Drugs (AOD) Non-Government Organisations*, Adelaide, 2011, p. 5.
[7] Productivity Commission, *Draft Report*, p. 596.

Coroner's Court of Victoria in 2019 shows that, of a sample of 220 Heroin related deaths occurring in 2017 90 of these individuals or 41% of deaths related to persons who had previously been incarcerated.[8]

Whilst the Draft Report provides a comprehensive overview of these interlinked factors and existing responses (including court programs, correctional programs and facilities), it fails to capitalise on the opportunity to improve outcomes for this cohort. Despite the Productivity Commission's recognition that substance use contributes to mental illness among individuals in contact with the criminal justice system, none of its four recommendations in respect of Justice address this issue. The acute vulnerability and risk of harm among this cohort makes it imperative that the Productivity Commission make recommendations to address this and improve outcomes for this vulnerable cohort.

VAADA reiterates the recommendation included in its initial submission to the Productivity Commission's Inquiry into Mental Health that:

> Measures aligned with justice reinvestment, which champion an uplift in support services in high risk areas, the reduction in administrative offences and an emphasis on policies which address disadvantage should be prioritised. Ongoing support beyond the prison gate, amounting to long term supported community integration covering a range of support services, should also be funded.[9]

To improve outcomes for this cohort (and subsequently, the broader community), there must be a dedicated recommendation focused on developing enhanced discharge plans for prisoners to support them through the difficult and dangerous period following their release. The development and adequate funding of links to stable housing, AOD and Mental Health treatment providers, and other appropriate aftercare services is crucial to ensure that this cohort remains engaged and supported. Otherwise, any chance of successful rehabilitation and reintegration into the community is effectively lost the moment they are released.

In addition to the above, VAADA makes the following recommendations:

- The development of a shared vision and culture between the AOD and mental health sectors with regard to the treatment of service users experiencing comorbid disorders, including the development of an overarching treatment framework that sets out common goals and measurable outcomes at both the agency and client level. This should also involve establishment of a minimum data set for this cohort, and the provision of additional capacity building funds to upgrade data management systems.
- The formulation of a workforce strategy outlining the required qualifications and training to be employed in integrated comorbid settings.
- The inclusion of co-morbidity in the four existing draft recommendations made in relation to Justice.
- The inclusion of AOD in the list of health professions (at P.368 of the Draft Report) most relevant to people with mental ill-health, and include comorbid disorders as a separate category in any targeted workforce training and upskilling.

VAADA looks forward to the publication of the Productivity Commission's final report, and trust that the feedback provided in respect of the Draft Report is seriously considered. In the meantime, should you have any questions regarding VAADA's submission, I may be contacted

[8] Coroners Prevention Unit, Coroners Court of Victoria, Correspondence to the Victorian Alcohol and Drug Association, 30 August 2019.
[9] VAADA, *Submission to the Inquiry*, p. 7.

Sincerely,

Sam Biondo
Executive Officer
Victorian Alcohol and Drug Association