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IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

STATEMENT OF LEANNE BEAGLEY

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I, LEANNE BEAGLEY, Director, Mental Health and Drugs, Department of Health & Human Services, SAY AS FOLLOWS:

1. I am the Director of Mental Health and Drugs Branch in the Department of Health and Human Services (**DHHS**). I report directly to the Deputy Secretary of the Mental Health, Wellbeing, Ageing and Social Capital Division of DHHS. As of 1 August 2015, following a restructure within the Mental Health, Wellbeing, Ageing and Social Capital Division of DHHS, I assumed responsibility for the 'Alcohol and Other Drugs' portfolio, in addition to my existing functions as Director, Mental Health. The Chief Psychiatrist of Victoria commenced reporting directly to me on 1 August 2015. I have held the position of Director with responsibility for the mental health portfolio in DHHS since June 2011, although the title of the position and the scope of the role have been revised during this time.

2. In line with the devolved governance structure of the Victorian health system, the Mental Health and Drugs Branch of the DHHS coordinates the management of the Victorian mental health and drug services systems, including program and funding policy, service performance, strategic policy development, and consumer, carer and national relations. The Mental Health & Drugs Branch is the system manager and does not have responsibility for direct service delivery.

3. Prior to becoming Director, Mental Health and Drugs, I have worked in mental health and family therapy positions, in various operational and management roles, since 1987. I have completed a Bachelor of Applied Science (Occupational Therapy), Graduate Diploma in Family Therapy, and a Masters of Business Leadership. I am currently finalising a PhD (Research) at the Royal Melbourne Institute of Technology titled Perspectives on Organisational Performance.

SCOPE OF STATEMENT

4. I have received a notice from the Royal Commission into Family Violence (**Royal Commission)** pursuant to s 17(1)(d) of the *Inquiries Act 2014* (Vic.) requiring me to attend to give evidence at the Royal Commission and to provide a written witness statement.

5. I understand that I am asked to provide information about the Victorian Dual Diagnosis Initiative (**VDDI**).

CONTEXT

6. The VDDI is a cross-sector initiative funded by the Victorian Government. The objective of the VDDI is to build the capacity of the workforces in the mental health and alcohol and other drug treatment sectors to recognise and respond effectively to people experiencing concurrent mental health and substance use disorders.

7. Dual diagnosis in the VDDI refers to people who have concurrent mental health and substance use disorders. Clients with dual diagnoses are common in both mental health and alcohol and other drug treatment services. It is estimated that dual diagnoses have been found in between one third and one half of clients of mental health and alcohol and other drug treatment services. The co-occurrence of these problems and disorders adds complexity to assessment, diagnosis, treatment and recovery.

8. The mental health and alcohol and other drug treatment sectors operate in Victoria in separate funding and service streams.

9. Three sectors are involved in the VDDI:

   9.1 clinical mental health services (including acute services and outpatient and outreach services);

   9.2 community sector mental health services; and

   9.3 alcohol and other drug treatment services.

<u>Clinical mental health services</u>

10. The clinical mental health services are directly managed by Health Services with governance through Health Service Boards. Clinical mental health services are

managed by public hospitals and provide assessment, diagnosis, treatment and clinical case management to people with a serious mental illness. They include inpatient and outpatient adult mental health services, child and adolescent mental health services, and aged persons mental health services as well as a range of specialist services. The majority of clinical mental health services are provided in the community rather than in hospital settings.

11. In 2014-15 clinical mental health services assisted 63,466 consumers, with 22,799 inpatient admissions. The majority of clients access clinical treatment in community settings (outpatient and outreach services). Based on earlier studies from around 2003, it is estimated that the size of the workforce is over 5,000. Current state funding for the clinical mental health sector is $1.18 billion per year.

12. Clinical mental health services predominantly recruit from five core disciplines: psychiatry, nursing, social work, occupational therapy and psychology. Specialist tertiary qualifications are applicable to each of these professions. The national registration and accreditation scheme for the health professions, administered by the Australian Health Practitioner Regulation Agency (APHRA), regulates all the disciplines except for social work. Social Workers are required to be eligible for membership with the Australian Association of Social Workers.

State – funded mental health services provided through non government organisations

13. The community sector mental health services are managed by the non-government organisations through their boards. Community sector mental health services are delivered by a range of providers, including standalone mental health services, community health services, and welfare services. They focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from illness. Community sector mental health service programs include day programs, social support services, residential support services, planned respite and mutual support and self help services.

14. In 2014-15, non-government organisations delivered services to approximately 12,350 consumers. In 2012 (prior to recommissioning of the Psychiatric Disability Rehabilitation Support Service and the Alcohol and Other Drug Treatment programs) the size of the workforce was estimated to be 1,328 people. Current state funding for the non-government mental health services sector is approximately $126.3 million per year.

15. There is no standard minimum qualification requirement for this workforce. However, around 40 per cent of the workforce in 2012 had a mental health specific qualification such as Bachelor of Psychology, Bachelor of Mental Health Nursing or Certificate IV in Mental Health. Of these workers, 40 per cent had mental health specific qualifications at the Certificate IV level, and the rest at bachelor and diploma levels.

Alcohol and Other Drug Treatment Services

16. The government funds mostly non-government organisations to provide alcohol and other drug treatment services across the state. Services delivered include information; advice and support services; counselling; residential and non-residential withdrawal; rehabilitation; care and recovery coordination; youth-specific services; aboriginal services; and pharmacotherapy. There are also services for families and other people who are affected by another's alcohol and/or other drug use. In addition, the government funds a range of prevention and research activities related to alcohol and other drug use.

17. In 2014-15, alcohol and other drug treatment services assisted 27,721 consumers. In 2013 (prior to recommissioning) the size of the workforce was estimated to be 1,470 people. Current state funding for alcohol and other drug treatment services is $33.8 million for prevention and control, and $147.5 million for treatment and rehabilitation.

18. A Minimum Qualification Strategy (MQS) has applied to the alcohol and other drug treatment workforce since 2006. The requirements of the MQS for existing workers are:

    18.1 a qualification specialising in alcohol and other drugs or addiction studies equivalent or above the Australian Qualifications Framework Certificate IV in Alcohol and Other Drugs Work; or

    18.2 four alcohol and other drug treatment core induction competencies which can be gained on the job and any other specific work competencies required for the role.

19. The requirements of the MQS for new workers entering the sector are:

    19.1 a Certificate IV in Alcohol and Other Drugs Work for workers without a qualification; or

19.2 four alcohol and other drug treatment competencies from the Community Services Training Package for workers entering the sector with a health, social or behavioural science tertiary qualification.

20. In 2013, more than two-thirds of respondents to the Victorian Alcohol and Other Drug Workforce Survey reported having a formal qualification in alcohol and other drug treatment or addiction studies. Nearly 82 per cent reported having a formal health, social or behavioural science qualification.

DEVELOPMENT OF THE VDDI

21. The discourse around dual diagnosis emerged in Victoria in the 1990s when the community and clinicians became aware of the increasing number of people with severe concurrent mental illness and substance use problems being excluded from specialist services and the growing complaints from service users and carers about 'lack of access, poor integration, and differing responses' (Bridget Roberts (2013) *The seeds of dual diagnosis discourse in an Australian state*, Mental Health and Substance Use, Vol 6, No. 4, 325 – 328 at 327).

22. The increased visibility of the issue was attributed in part to the deinstitutionalisation of public psychiatric hospitals and the mainstreaming of mental health and alcohol and other drug treatment services into general health services. At the same time, classifications of mental disorders and substance use were multiplying and professionals were formally recognising the frequency and harms of their coexistence. Underlying all these influences was the enduring systemic challenge of providing continuity of care in a system that separated mental illness from alcohol and other drug problems, and specialist treatment from primary health and social support (Roberts (2013)).

23. While the literature highlights that it is likely that integrated services are better suited to providing flexible treatment arrangements for consumers than separated drug and mental health services, there is growing consensus that effective care for the majority of clients with dual diagnosis disorders requires access to a variety of models of care and a range of skilled, professional carers (see **Attachment LB-3,** page 21).

24. It was recognised that a systems response is required that can ensure that people with dual diagnosis issues are identified regardless of which sector they present in, and will be connected to the organisations that will provide the various types of

support required and facilitate stronger relationships and formal partnerships between sectors. It was also acknowledged that a lack of workforce confidence to respond to issues outside their immediate area of expertise and responsibility, and concern around exposing demand that could not necessarily be met, was contributing to a lack of integration around services for people with dual diagnoses.

25. Accordingly, the VDDI was developed and established to provide a systems response for people with dual diagnoses in Victoria.

26. The first pilot dual diagnosis teams, the Substance Use and Mental Illness Treatment Team (SUMITT) and Eastern Hume Dual Diagnosis Initiative, were funded by the Department of Human Services in 1998.

27. Two years later, the VDDI was established when the Mental Health and Drugs Policy and Services Branches of the Department of Human Services funded four dual diagnosis teams and associated rural services to improve existing treatment responses for people with co-occurring mental illness and substance use problems and disorders.

28. Funding for the teams of dual diagnosis specialists was provided to the health services. The make up of these teams was determined by local needs at the individual health service level. Positions within the teams included consultant psychiatrists, dual diagnosis workers such as nurses, occupational therapists, psychologists or social workers, a registrar, and program coordinators.

29. Between 2000 to 2004, the VDDI was progressively extended to include additional staff positions with a dual diagnosis focus in Mobile Support Teams, the Psychiatric Disability and Rehabilitation Sector (community sector mental health services), residential rehabilitation services, housing services and the Victorian Aboriginal Health Service. Youth specific staff were also funded as part of the existing VDDI teams.

30. In 2004, an evaluation of the VDDI was undertaken by Turning Point Alcohol and Drug Centre. This evaluation recommended the development of a more systematic approach to dual diagnosis service provision in Victoria. A copy of the 2004 evaluation is attached as **Attachment LB-1**.

31. Responding to the 2004 evaluation, the 2005-06 State Budget provided for an additional three VDDI projects. These were:

31.1 **The VDDI Education and Training Unit** to provide a strategic and systematic approach to dual diagnosis knowledge and skill development across the mental health and alcohol and other drug treatment workforce.

31.2 **The Reciprocal Rotations Project** which supported staff to undertake education and training experience in another service system as part of a wider staff development activity to increase their skills and knowledge about dual diagnosis.

31.3 **The Strengthening Addiction Psychiatrist Project** which increased the availability of psychiatrist advice and support for bio/psycho/social assessment, treatment and management of clients with complex dual diagnosis needs.

32. In 2007, the Department of Human Services released the policy *Dual Diagnosis: Key directions and priorities for service development* (***Key Directions* policy document**), a cross-sectoral policy that clarified priorities and direction for dual diagnosis service development in Victoria. A copy of the 2007 *Key Directions* policy document is attached as **Attachment LB-2**.

33. Under the National Partnership Agreement on Homelessness, Commonwealth funding was received to commence the Homeless Youth Dual Diagnosis Initiative in 2009. This initiative had the objective of providing an effective response to co-occurring mental health and substance use problems and disorders for young people accessing homelessness services.

34. The VDDI was further evaluated in 2011 by Australia Healthcare Associates. A copy of the 2011 evaluation is attached as **Attachment LB-3**. The evaluation found that the VDDI had had a dramatic impact in building recognition that dual diagnosis was a shared responsibility and had broken down the significant demarcation that had previously existed between alcohol and other drug treatment and mental health services. The evaluation found that the 2007 *Key Directions* policy document (see **Attachment LB-2, page 21**) had been central to the shift in practice through its Dual Diagnosis Action Plan and Service Development Outcomes.

35. The evaluation noted that the reform process was not yet complete and that there was further progress to be made, for instance in the area of integrated treatment and further development of partnerships. The evaluation recommended potential

areas for enhancement in the areas of governance, systems management, and workforce development.

36. Following the release of the evaluation, the Department of Health established the Statewide Dual Diagnosis Reference Group in 2011 to advise on the development of the framework for dual diagnosis practice in Victoria and develop statewide strategic directions and goals for the initiative. The VDDI leadership group were highly motivated to progress work on agreeing strategic directions and establishing goals.

37. In November 2011, SUMMIT, one of the four metropolitan dual diagnosis teams, developed the Alcohol and Other Drug Withdrawal Practice Guidelines designed to provide a comprehensive management approach to working with consumers withdrawing from alcohol and/or substance use within the North Western Mental Health acute inpatient and residential services. The Department of Health recognised the quality and value of this work and, with permission, circulated the guideline for use by other services. A copy of the guideline is attached at **Attachment LB-4.**

38. In 2013-14, the Department of Health issued a Bulletin articulating the strategic directions for dual diagnosis initiatives. The purpose of this was to reinforce the importance of and requirement to provide dual diagnosis capable services into the future. A copy of the bulletin is attached at **Attachment LB-5.** The Strategic Directions are discussed further below, at paragraph 56.

The VDDI: Workforce Development

39. The VDDI is primarily a workforce development initiative designed to equip the mental health and alcohol and other drug treatment sectors with the ability to recognise and respond effectively to people presenting with co-occurring mental health and substance use problems and disorders. It has aimed to increase the capacity of the existing workforce, rather than increasing the size of the workforce. Much of the systemic change that has occurred has been due to the long term and iterative nature of the VDDI.

40. The key objective of the VDDI is to ensure that treatment planning and the needs of people who have both mental health and substance addiction issues are addressed by both sectors as part of their core business. In order for this to occur, it was necessary to drive cultural change by both changing practices at the frontline, and also by specifying clear government policies and expectations. Further, the

development of cooperative inter-service arrangements and formalised referral pathways was a central tenet of the initiative. Building capacity of the workforces to identify and assess for dual diagnoses and then to undertake treatment planning tailored to the individual needs of a person were key objectives of the VDDI.

41. The VDDI was not intended to provide additional direct treatment, other than in a small number of very complex cases.

42. I address the main features of the VDDI below.

Dual Diagnosis teams

43. As referred to above, the VDDI established four specialist dual diagnosis teams for the state. The four teams were established under the auspices of Melbourne Health, St Vincent's Hospital, Eastern Health and Southern Health. Statewide coverage was established under a 'hub and spoke' model with the establishment of dual diagnosis workers in eight rural centres, each attached to one of the four metropolitan lead agencies.

44. Specialist teams were comprised of various positions such as specialist dual diagnosis workers and consultant psychiatrists.

45. The funding was directed to specialist teams of dual diagnosis clinicians to provide tertiary, secondary and a small number of primary consultations to organisations delivering mental health or alcohol and other drug and treatment services. Clinicians across the sectors had access to dual diagnosis specialists to help them learn 'on the job'. The objective was to create a network of capacity builders who would cross-pollinate skills and understanding by developing the capability of hospital and community based alcohol and other drug, and mental health treatment services to improve the health outcomes of people with a dual diagnosis. The role of these specialists was also to build robust partnerships and referral pathways between the three sectors. To provide more detail on the role of the dual diagnosis clinician, a recent job description for the position of dual diagnosis clinician with the Nexus Dual Diagnosis Service (St Vincent's Health) is attached as **Attachment LB-6**.

Education and Training Unit

46. The Dual Diagnosis Education and Training Unit (**ETU**) was established in 2005-06 to develop and deliver dual diagnosis education programs to Victorian mental health

and alcohol and other drug treatment services. The unit provided a strategic and systematic approach to dual diagnosis knowledge and skill development across the mental health and alcohol and other drug workforces.

47. Funding for the ETU was redistributed from 2015-16 and the ETU was disbanded. The Department of Health & Human Services' expectation is that the workforce is now dual diagnosis capable, the culture and practice of services promote appropriate treatment planning that reflects the needs of consumers, and that mechanisms have been established for skilling new workers through qualification pathways.

48. This is clearly reflected in the service specifications issued by the Department of Health in 2014 in the recommissioning processes for the Psychiatric Disability Rehabilitation and Support Services (now known as the Mental Health Community Support Services program) and the Alcohol and Drug Treatment Programs.

Reciprocal Rotations Project

49. The Reciprocal Rotations Project was funded in the 2005-06 Victorian State Budget to support staff to undertake placements in different parts of the mental health and alcohol and other drug treatment service systems.

50. The focus of this was to enable clinicians to work across the sector and learn new skills that they could bring back to their organisations. Significant funds were allocated to allow for backfill of staff. The 2011 evaluation (see **Attachment LB-3**) considered that the investment in this project was not realised, particularly at the organisational level. There were instances of skills drainage from the alcohol and other drug treatment sector into the mental health sector due to differences in pay scales. Following the 2011 evaluation, the Reciprocal Rotations Project was discontinued and the funds were reprioritised within the broader dual diagnosis program.

Strengthening Addiction Psychiatrist Project (2005-06)

51. This project was funded to:

    51.1 Increase the access of the workforces to secondary and tertiary consultations with psychiatrists;

51.2 provide additional advice and support for assessment, treatment and management of clients with complex needs; and

51.3 build capacity in addiction psychiatry and addiction medicine more broadly.

52. Four metropolitan health services were funded as part of the project, which created new positions in these services. These positions were intended to create access to specialist consultation services across the catchment (not just the host agency) and also coordinate education and training and leadership in dual diagnosis.

53. The experience of this program was that many of the specialist psychiatrists were soon obliged to undertake direct service delivery for the most complex cases and that caseloads were reducing capacity for them to build skills within the workforces. There will always be potential for 'mission creep' in workforce building initiatives within systems where there is consistently high demand. This needs to be closely monitored.

***Key Directions* Policy Document**

54. As referred to above, in 2007 the Department of Health released the *Key Directions* policy document, a cross-sectoral policy designed to promote a systematic approach to service provision through integrated assessment, treatment and care in both mental health and alcohol and other drug treatment services. The 2011 evaluation characterised this document as a critical turning point for change in the progress of the VDDI and one that provided the necessary leverage for the commencement of the reform process across the three sectors. While the 2011 evaluation also referred to some limitations of the 2007 *Key Directions* document, it was noted that it was well regarded by all sectors (see **Attachment LB-2**).

55. Central to the development of the 2007 *Key Directions* policy, was the agreement of both the mental health and alcohol and other drug treatment sector that the following five service development outcomes were necessary for effective responses to dual diagnosis within both sectors:

55.1 Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as core business in both mental health and alcohol and other drug treatment services.

55.2 Staff in mental health and alcohol and other drug treatment services are 'dual diagnosis capable', that is, they have the knowledge and skills

necessary to identify and provide integrated assessment, treatment and recovery.

55.3 Specialist mental health and alcohol and other drug treatment services establish effective partnerships and agreed mechanisms that support integrated care and collaborative practice.

55.4 Outcomes and service quality for dual diagnosis clients are monitored and regularly reviewed.

55.5 Consumers and carers are involved in the planning and evaluation of service responses.

Victorian strategic directions for co-occurring mental health and substance use conditions (2013)

56. As referred to above, in October 2013, the Department of Health developed the following four strategic directions for dual diagnosis practice to promote consistency of practice and to guide the next stages of development of the sectors' ability to recognise and respond effectively to people presenting with dual diagnoses:

56.1 Improve outcomes for people with co-occurring mental health and substance use conditions and their families and significant others.

56.2 Provide integrated screening, assessment, treatment and care for people experiencing co-occurring mental health and substance use conditions.

56.3 Facilitate integration of the systems and services responding to people with co-occurring mental health and substance use conditions and their families and significant others.

56.4 Further develop dual diagnosis capability of Victorian clinical mental health, alcohol and other drug treatment services and mental health community support services sector organisations and workforce.

Recent Evaluation: The Rural Workforce Innovation Grant Program Case Study Synthesis (2015)

57. Service provision in rural Victoria faces considerable challenges because of the geographical, population and socio-demographic profile of its rural population.

These challenges are further compounded by a range of issues including staff shortages, high levels of staff turnover and difficulties recruiting new staff.

58. In 2013-14, the Department of Health invited expressions of interest from mental health and alcohol and other drug treatment providers for small grants to document existing workforce innovations. The funding was not to develop and implement innovation, but rather to fund a dedicated resource within the service to develop a case study of the innovation and to reflect on the challenges and benefits that have been produced through the initiative.

59. Twelve case studies were included in the synthesis, including case studies of the VDDI Rural Forum (VDDIRF), and the Hume Region Dual Diagnosis Education Collaborative. The report concluded that the VDDIRF members have provided support for rural workers and the resources it has developed are widely used across Australia and New Zealand. A copy of the DHHS report *Rural Workforce Innovation Grant Program Case Study Synthesis*, dated June 2015, is attached as **Attachment LB-7**.

Signed by **LEANNE BEAGLEY**)
at Melbourne)
this 9th day of October 2015)

LEANNE BEAGLEY

Before me [redacted]

An Australian legal practitioner
within the meaning of the
Legal Profession Uniform Law (Victoria)