



Purple
Orange

• research • consultation • training
• policy • publication • evaluation

**Submission to
Social Development Committee enquiry on
comorbidity**

ABN: 16 464 890 778

104 Greenhill Road Unley SA 5061

PO Box 701 Unley Business Centre SA 5061

t: (08) 8373 8333 f: (08) 8373 8373 e: admin@juliafarr.org.au

w: www.juliafarr.org.au

Table of Contents

1.0 CONTEXT OF A GOOD LIFE	3
2.0 THE NATURE OF THE ISSUE	3
2.1 Facilities in South Australia currently treating people with a dual diagnosis including the Margaret Tobin Centre and James Nash House.....	4
2.2 The level of training offered to general practitioners, psychologists, psychiatrists and other relevant professionals in the area of dual diagnosis and possible measures to enhance that training.....	5
2.3 Information given to individuals and carers on how to manage a dual diagnosis.....	6
2.4 Supports to individuals and carers in managing and living with a dual diagnosis.....	6
2.5 Any other matters.....	6
3.0 REQUEST TO MEET.....	7

1.0 CONTEXT OF A GOOD LIFE

Considering the history of disability and service responses to disability, considering the key elements of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), considering the key values underpinning the development of the National Disability Insurance Scheme, and considering intuitive goodness in any person's life, it can be asserted that a good life might be characterised by the presence of the following:

- authorship of our own lives (often described as control and choice)
- having valued roles in community life and economy (often described as inclusion).

As set out in JFA Purple Orange's Model of Citizenship Support¹, a good life is characterised by such valued roles (termed Citizenship) and by the decisions we make (termed Personhood).

Unlike *citizenship*, Citizenship is a dynamic experience: it can rise and fall depending on the person's circumstances. The extent to which any person can naturally take up Personhood and Citizenship is influenced by the degree to which that person lives with vulnerability. For the purposes of this submission we define vulnerability as the presence of circumstances that can adversely impact on the person's capacity to build authorship of their own lives and the person's capacity to take up valued roles in community life and the economy.

We therefore believe that any formal response to people living with comorbidity needs to be anchored on supporting the person to move into roles of Personhood and Citizenship.

2.0 THE NATURE OF THE ISSUE

Comorbidity, based on the description in the Committee's terms of reference for this enquiry, relates to a complexity of circumstances where a person living with intellectual disability or acquired brain injury is also experiencing issues of mental illness or chronic substance misuse.

Each circumstance by itself represents an increase in the person's vulnerability. The presence of more than one such circumstance can create a 'more-than-the-sum' effect on the person's vulnerability.

For example, service responses to mental illness can be anchored on the principle of recovery. However this can sometimes seem difficult to reconcile for a person who lives with intellectual disability or enduring brain injury where the notion of recovery is more problematic.

¹ Williams, R. (2013), *Model of Citizenship Support: 2nd edition*, Julia Farr Association Inc, Unley South Australia

Similarly, service responses to chronic substance misuse can be anchored on notions of the role of purposeful decision-making and a corresponding momentum to change habits. However, this can seem difficult to reconcile for a person whose intellectual disability or enduring brain injury can lead to complicating considerations because of diminished capacity for decision-making and habit-changing.

Having considered the context of a good life, and the link between co-morbidity and increased vulnerability, this submission now considers the main elements in the Committee's terms of reference.

2.1 Facilities in South Australia currently treating people with a dual diagnosis including the Margaret Tobin Centre and James Nash House

This submission offers no specific commentary on the current specific roles and practices of the services known as Margaret Tobin Centre and James Nash House.

Instead this submission offers commentary on what might be the limitations of such venue-based services, particularly when thinking about the contextual goal of good life chances (which the notion of recovery will easily relate to).

As a general principle, we believe services that take place in venues that are separate and distinct from the ordinary patterns of community life – for example hospitals, inpatient clinics, and other therapy-based accommodation services – should be used sparingly. While they can be a venue for intense therapeutic input, the longer a person remains in such settings, the more likely it is that distance is created between the person and the ordinary routines, roles, connections and venues of community life. This depletes the person's life chances.

For example, from the author's own experiences administering mental health services and associated reform in New Zealand, in-patient mental health services are not typically places where people recover, but instead are places where people can receive intense support during the most vulnerable moments of their illness, as a way of limiting further harm and only when effective community supports are not available. However, the longer a person remains in inpatient mental health care, the more likely it is the various aspects of their community life begin to dismantle.

For service venues like Margaret Tobin Centre, this means establishing clarity about the measurable therapeutic goal the Centre seeks to deliver to people living with 'dual diagnosis', over what timeline, and as part of what overall clinical and community pathway to recovery and good life chances.

For any such service, this raises imperatives for (i) best practice therapeutic inputs to minimise the length of inpatient stay necessary for success, (ii) a coherent, values driven client pathway covering all services and stakeholders, and (iii) a systematic investment in community capacity.

For service venues like James Nash House, the situation is somewhat more complex because of the forensic component and therefore the custodial features to the service. However, the fundamental imperatives remain the same, that is the need for best practice therapeutic inputs to minimise length of stay, how these are anchored within a values driven client pathway, and investment in community capacity particularly in terms of prevention and de-escalation. Such investment extends to the training of relevant professionals, which gives rise to the next question.

2.2 The level of training offered to general practitioners, psychologists, psychiatrists and other relevant professionals in the area of dual diagnosis and possible measures to enhance that training

Again, the anchor points for the effectiveness of this will be (i) harvesting what is known about best practice therapeutic investment, and (ii) understanding where the various professional inputs might best feature in an overall client pathway dedicated to advancing the person's life chances. Without such overall coherence, training will lose potency.

From the author's own experiences in mental health reform, there is significant merit in investing in training to community professionals. One such example, in Wellington New Zealand, involved the delivery of training resources to general practitioners to support people living with mental illness, as part of a project that saw hundreds of people successfully shift from specialist mental health services back to the care of their general practitioner.

However, training in itself will not guarantee the outcomes people might hope for. In the above example the training was one element of a program that operated a number of features. These features included an adjustment to financial mechanisms to make it as easy as possible for the person to visit their local general practice, a strengthening of the primary-specialist mental health interface to help provide responsive support should a person hit severe crisis, the provision of 'browse-anytime clinical information resources, and the introduction of a practice broker position.

Also in Wellington, and as part of the same overall mental health reform, a new consultancy service was developed involving professionals with specialist interest and expertise in dual diagnosis. Their role was not to provide direct therapeutic input to caseload, but instead to provide practice support to mental health service professionals and associated community stakeholders. In addition, a small service was established to provide roving casework support to people living with mental illness, including the dual diagnosis focus of the present enquiry, who also lived itinerant lifestyles.

These and other reform elements contributed to a dramatic reduction in the consumption of inpatient mental health beds.

Therefore, training is critical but must also operate in the context of other investments.

2.3 Information given to individuals and carers on how to manage a dual diagnosis

Information is essential to making an informed choice, and it is through informed choices that a person can build their chances of living a good life.

The author's Model of Citizenship Support², published in 2013, sets out the importance of information to help build a person's *Knowledge Capital* in terms of what the person knows and can do for her/himself.

This is one of four such *Capitals* in the Citizenship Model, the others being *Personal Capital*, *Material Capital* and *Social Capital*. We believe such a framework can form the basis for building a comprehensive information service that attends to matters such as the person's outlook on their life chances, information about how to manage the practical aspects of their mental and physical well-being, where to find assistance with planning and decision-making, where to access practical supports, and where to find places and people who are welcoming.

Our preference would be to provide a verbal briefing to Committee members on the detailed elements of the Citizenship Model, and how they might be used to build an information service to assist people living with dual diagnosis.

2.4 Supports to individuals and carers in managing and living with a dual diagnosis

Similar to the previous question, we believe the Citizenship Model can be used to build a framework of supports and we would prefer to provide a verbal briefing to Committee members on this.

2.5 Any other matters

We note the major disability policy reform underway through the implementation of the National Disability Insurance Scheme (NDIS). The Scheme is in its early stages and will have a number of policy and practice challenges to navigate over the next several years as it moves to full implementation. Such challenges are likely to include the extent of psychiatric disability necessary for a person to be eligible for the Scheme, and for what type of assistance.

Importantly, the Scheme should not be seen as a one-stop-shop for any and all life issues experienced by a person living with disability. If a person living with disability also happens to have a mental illness or an issue of substance misuse, then the primary recourse for assistance should be those mainstream resources available to *any* citizen needing assistance with such matters. This orientation to the mainstream

² *ibid.*

underpins not only the NDIS, but also Australia's National Disability Strategy and the UNCRPD.

As such, we recommend the Committee exercise caution before making any conclusion that the NDIS might be the primary agent of assistance for the mental health and substance use issues of persons living with dual diagnosis. A more sustainable solution will lie in how South Australia's mainstream health and community services sector can build its capacity to best respond.

As a local parallel example, we refer the Committee to the current work undertaken via the Attorney General's Department (AGD) to improve access to justice by people living with disability, many of whom will experience practical difficulties and attitudinal barriers because of communicative impairment and/or reduced capacity to understand information and make decisions. Rather than assume such challenges are for the disability sector to fund and resolve, the AGD is undertaking work to systematically strengthen the mainstream justice system's capacity to respond.

3.0 REQUEST TO MEET

We request the opportunity to meet with the committee to further discuss the points made in this brief submission, and we look forward to such an opportunity, hopeful that we might be of assistance to the Committee as it navigates this important topic.

Robbi Williams MA
CEO

30 September 2014