Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF GARY CROTON

I, Gary James Croton, Registered Nurse (Division 1), of PO Box 326, Albury, New South Wales, 2640, say as follows:

BACKGROUND

1 My name is Gary James Croton RN MHSc (AOD), and I am a Clinical Nurse Consultant at the Hume Border Victorian Dual Diagnosis Initiative at Albury Wodonga Health (**AWH**).

My role

2 In my role, I am responsible for assisting local Alcohol and Other Drug **(AOD)**, Clinical Mental Health (**CMH**) and Mental Health Community Support Services (**MHSCC**) sectors, services, and workers to develop their capacity to recognise and respond effectively to people experiencing co-occurring mental health-substance use concerns.

3 I carry out this role through the following:

(a) Primary consultations: limited primary consultations are provided with people with complex needs related to their co-occurring mental health-substance use issues. In most cases, these services are provided with the person's primary worker involved, with the secondary aim of developing that worker's 'dual diagnosis capability'.

(b) Secondary consultations: are provided with regional mental health and AOD workers. A secondary consultation involves a discussion, usually via telephone, between a clinician and the referrer about a specific client. The client is not present during the consultation. The aim of the consultation is to clarify pertinent issues and to provide advice about the client's ongoing management.

(c) Clinical Supervision is provided, on individual and group bases, with local mental health and AOD workers.

(d) Tertiary consultations: are conducted with diverse local, state, interstate, national and international stakeholders around mental health-substance use systems developments. I have served on the Hume Region Multiple and Complex Needs Initiative (**MACNI**) Regional Panel since its inception. I also provide secretariat services to the Victorian Dual Diagnosis Initiative Leadership Group (**VDDILG**) and the Victorian Dual Diagnosis Initiative Rural Forum (**VDDIRF**).

(e) Education and training: workshops are facilitated with local mental health and AOD workers, consumer and carer groups and other workers and sectors who provide services to people with mental health-substance use concerns. These workshops include Dual Diagnosis Foundations, Brief Interventions, Motivational Interviewing and a range of other mental health-substance use topics.

(f) Creation of resources around responses to people with mental health-substance use concerns for dissemination via email, websites, and social media.

Qualifications and experience

4 I am a Registered Nurse (Division 1), General and I hold a Master of Health Science (Alcohol and Other Drugs) obtained from Newcastle University in 2004.

5 I have worked continuously in mental health and alcohol and other drugs settings for 45 years in the following capacities:

Year	**Role**
1998 to current	Clinical Nurse Consultant for the Hume Border Victorian Dual Diagnosis Initiative at AWH
1993 to 1998	Community Psychiatric Nurse for Northeast Health Wangaratta
1992 to 1993	Psychiatric Nurse in London, United Kingdom
1982 to 1991	Deputy Charge Nurse at Mayday Hills Psychiatric Hospital
1982 to 1983	Deputy Charge Nurse at Royal Park Hospital
1981	Community Nurse from Larundel
1977 to 1980	Student Mental Health Nurse at Larundel Psychiatric Hospital
1975 to 1977	Ward Assistant at Bundoora Repatriation Hospital

6 I have worked continuously in a dedicated dual diagnosis capacity building role for 21 years. In November 1998, Community Psychiatry, Wangaratta District Base Hospital, initiated a cross-sectors, 'Dual Disorders' Project Role. I commenced working in this role which was a capacity building-direct service role with local mental health and AOD services. In this role, and at my instigation I also provided the secretariat to the then Substance Use Mental Health Network (**SUMHNet**), a state-wide coalition of consumers, carers and providers with an interest in dual diagnosis. In 2002, the Northeast Health Wangaratta Dual Disorders project was subsumed into the newly created Victorian Dual Diagnosis Initiative (**VDDI**). Il have been the service's sole worker in this region since then (2002). In 2012, auspice of the service was transferred to AWH, and AWH now assumes responsibility for all regional clinical mental health services.

7 In 2003, I was awarded a Victorian Travelling Fellowship to undertake a 6-week investigation of integrated treatment responses to co-occurring mental health-substance use in the UK, USA and New Zealand.

8 The following year, in 2004, I developed the 'Dual Diagnosis and other complex needs' website (www.dualdiagnosis.org.au), and I have been the website's sole administrator since then. I have authored a number of publications and developed tools to assist in the development of dual diagnosis capability.

9 I am a member of, and provide the secretariat to, both the VDDILG and VDDIRF. I have served on a range of committees, including Ministerial Advisory Committees, providing consultation around co-occurring mental health-substance use issues.

10 In 2008, I was awarded the Victorian State Nursing Excellence Award for Mental Health and Drugs Nursing.

11 **Attached** to this statement and marked **GJC-1** is a copy of my detailed curriculum vitae. My curriculum vitae highlights my memberships, achievements and publications within the mental health, alcohol and other drugs and dual diagnosis settings.

Authority to give this evidence

12 I give this evidence on behalf of the Albury Wodonga Health component of the VDDI, and am authorised by Albury Wodonga Health to give this evidence on its behalf.

13 The opinions and views expressed in my evidence are my own, and do not necessarily represent the opinions and views of either Albury Wodonga Health or the VDDI.

14 I give this evidence from facts which I believe to be true and correct and which are within my own knowledge, unless otherwise stated. Where I refer to a document, I have read that document before signing this statement.

HUME BORDER VICTORIAN DUAL DIAGNOSIS INITIATIVE

Background

15 The Hume Border VDDI, auspiced by Mental Health, Albury Wodonga Health, is a component of the state-wide VDDI and provides cross-sector, dual diagnosis capacity building services to stakeholder workers, services and sectors. The VDDI aims to build the capacity of services and workers to recognise and respond effectively to people with co-occurring mental health-substance use concerns.

16 The ‘clients’ of the Hume Border VDDI are the workers and the agencies who provide services to people experiencing co-occurring mental health-substance use issues. The VDDI’s nominated target sectors are AOD, CMH and MHCSS.

17 All AOD, mental health services, workers and stakeholders are eligible to access the services of the Hume Border VDDI through the varied approaches identified in sub-paragraphs 3(a) and 3(f) above. The Hume Border VDDI is a sole worker service that provides services to 3 sectors (being AOD, CMH and MHCSS), which are composed of perhaps 50 agencies and sub-agencies that employ several hundreds of workers.

18 At its inception in 2002, the VDDI, including the Hume Border VDDI, was jointly funded by a partnership of the (then) Victorian Mental Health Branch and the Victorian Drug Treatment Services. Since around 2004-2005, funding has come from the Department of Health and Human Services (or its equivalent) to the various auspicing clinical mental health services.

19 The VDDI was designed as a cross sector initiative with nominated target sectors of AOD, CMH and MHCSS. Most VDDI services, where possible, also provide education and consultation services to other sectors and agencies that frequently encounter people with mental health-substance use concerns e.g. Primary Care, Domestic Violence, and Housing services.

20 People who experience co-occurring mental health-substance use concerns have an increased risk of also experiencing a diverse range of other concerns, disorders and needs. These co-occurring concerns may include (among other things) varying combinations and severities of physical health disorders, learning disability, forensic involvement, physical disability, employment problems, homelessness or housing issues, family or relationship difficulties, domestic violence, social isolation, poverty and trauma (either physical, psychological or social).[1]

21 These people are often characterized by ‘complexity’ and tend to have ‘poorer outcomes and higher costs of care’.[2] Therefore, any initiative that aims for better outcomes for people with mental health-substance use must consider and address the pathways between the range of sectors and agencies that provide services to people with mental health-substance use.

22 An example of VDDI multi sector engagement is evidenced in the *2010 Hume Region, multi-sector No Wrong Door, Integrated Dual Diagnosis Protocol*, which is **attached** to this statement and marked **GJC-2**. The protocol, developed with lived experience

[1] APPG-CNDD. (2013). Complex Needs Fact Sheet. All Party Parliamentary Group on Complex Needs and Dual Diagnosis <https://www.turning-point.co.uk/appg.html>.

[2] Cline, C. M. (2009). Compass EZ TM A Self-assessment Tool for Behavioral Health Programs. ZiaPartners <http://www.ziapartners.com/tools/compass-ez/>.

expertise, was a collaboratively developed guidebook to its 33 signatory agencies and their workers in delivering a seamless, integrated 'No Wrong Door' service system to people with mental health-substance use concerns. The protocol includes secondary consultation principles and guidance and dispute resolution procedures. A planned next step was to have the protocol echoed in individual agency's policies and procedures, however, despite local enthusiasm and support, the initiative was overtaken by other systemic developments and priorities.

23 Information about the VDDI (generally) is set out in pages 28 to 31 in my submission to the Royal Commission dated 5 July 2019 (**Submissions**). **Attached** to this statement and marked **GJC-3** is a copy of my Submissions.

24 **Attached** also to this statement and marked **GJC-4** is a copy of the initial VDDI framework document, which specifies the intended purpose and function of the VDDI:

> '*The Dual Diagnosis initiative will provide training, tertiary consultation and secondary consultation to organisations delivering mental health or drug and alcohol services, and direct treatment to a small number of clients who have both a mental illness and problematic substance use.*
>
> *The initiative will focus on developing the capability of hospital and community based alcohol and drug, and mental health treatment services to improve the health outcomes of people with a dual diagnosis. The development of cooperative interservice arrangements and better treatment programs tailored to individual client needs will be central activities for the initiative.*
>
> *The initiative will be established through the provision of funding to 4 lead metropolitan agencies who will be major providers of both mental health and drug treatment services, to establish dual diagnosis teams. The initiative also will have a rural component which will connect specialist dual diagnosis workers in eight rural centres to the metropolitan teams.*
>
> *The establishment of the four metropolitan teams will ensure that there is an appropriate critical mass to lead the initiative and deliver on the overall objectives of the initiative, while the location of specialist dual diagnosis positions in the major rural centres will ensure that the initiative is accessible and able to effectively deliver good outcomes to rural communities.*
>
> *It is proposed that the positions located in the major rural centres will be linked to the four teams to ensure that training and appropriate professional development and supervision is available to workers.'*

25 Other publications that describe the role of the VDDI and services that it provides are as follows:

(a) The Statewide Dual Diagnosis Initiative Evaluation Final Report dated October 2004, co-authored by Bridget Roberts, Lynda Berends and Alison Ritter, which is **attached** to this statement and marked **GJC-5**.

(b) The Australian Healthcare Associates' 2011 evaluation of the VDDI.[3]

(c) The Victorian Mental Health Services Annual Report 2015-16.[4]

(d) The Victorian Health and Human Services' alcohol and other drugs program guidelines (part 2: program and service specifications).[5]

(e) The VDDI Role Description and Contacts, which is **attached** to this statement and marked **GJC-6**.

The Hume Border VDDI's treatment approach

26 The Hume Border VDDI has deployed various approaches to building regional, agency and worker dual diagnosis capability. These approaches have evolved over time as our understanding of the often-wicked nature of dual diagnosis problems has developed. [6]

27 An initial focus on direct service provision to people with complex problems as a demonstration of integrated treatment gave rise to recognition that good practice will not spread osmotically without a number of aligned supporting strategies. A focus on training and education has highlighted the costs and frustrations of the 'training trap'. Namely, that training alone will do little to change practice, unless supported by aligned organisational and systemic practices, values, priorities and handrails.

28 To sustainably influence complex behaviours such as the provision of healthcare services, I consider that it is necessary to iteratively deploy an array of, aligned and complementary, strategies around a collaboratively developed vision of how the system/s will look, feel and behave when providing effective responses to people with co-occurring mental health-substance use and other complex needs.[7] I echo the views of Drs Minkoff and Cline, the authors of 'Changing the world: the design and implementation of

[3] The Australian Healthcare Associates (2011) Evaluation of the Victorian Dual Diagnosis Initiative <https://www.ahaconsulting.com.au/projects/evaluation-of-the-victorian-dual-diagnosis-initiative/>.

[4] Victorian Health and Human Services (2016) Victoria's Mental Health Services Annual Report 2015-16 <file:///C:/Users/102215/Downloads/mental-health-services-annual-report-2015-16%20(1).pdf>.

[5] Victorian Health and Human Services (2018) Alcohol and other drugs program guidelines; Part 2: program and service specifications <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/alcohol-and-other-drugs-program-guidelines>.

[6] Croton, G (2019) Better Outcomes: Towards a Victorian Complexity-Capable Service System. Submission to Royal Commission into Victoria's Mental Health System <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/3115/7230/6421/Croton_Gary.pdf>.

[7] Croton, G. (2010) An Australian rural service systems' journey toward systemic mental health-substance use capability. Chapter in Developing Services in Mental Health-Substance Use (Book 2 in the 6-book Mental Health-Substance Use Book Series) Editor: David B Cooper. Radcliffe Publishing Ltd, Oxford, UK.

comprehensive continuous integrated systems of care for individuals with co-occurring disorders', who state that, an implication of the prevalence of people with co-occurring disorders is the: '*need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already'*.[8]

29 Just as necessary preconditions for an individual to successfully change long-standing, entrenched behaviours are a safe space and opportunities to reflect on the behaviours; necessary preconditions for workers and services to change long-standing, service-delivery behaviours are time, support, agreed and aligned organisational goals and stability in their working environments. In my view both mental health and AOD services are, too often, pressured, inadequately-resourced, environments where there are multiple, often-competing demands in a background of constant, sometimes poorly-aligned and short-term, systems reforms. These conditions are the antithesis of those needed to evolve into a flexible, responsive, therapeutic, person-centred, service system. The Hume Border's approach, in this context, has been to recognise that mental health-substance use capacity building is a long term endeavour, and that it is most effective to work from a strengths-focused, systems approach that prioritises the system's alignment with changed practices before deploying worker-focused change strategies.

Limitations of the Hume Border VDDI's treatment approach

30 There are some limitations of the Hume Border VDDI, including but not limited to the following:

(a) It being a sole worker service.

(b) There being as many as 50 cross-border, stakeholder, AOD, CMH and MHCSS services and sub-services, in which several hundred people are employed.

(c) The host of service delivery challenges and barriers associated with being a rural-regional service.

(d) It is a cross-border service.

CO-OCCURRING MENTAL ILLNESS AND PROBLEMATIC ALCOHOL AND OTHER DRUG USE

31 People with co-occurring mental illness and problematic alcohol and drug use commonly experience a diverse range of significant challenges. I have addressed the most salient

[8] Minkoff K, Cline C. Changing the world: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. Psychiatr Clin North Am. 2004 Dec;27(4):727-43 <http://kenminkoff.com/article2.html>.

challenges on page 10 of my Submissions, which are **attached** to this statement and marked **GJC-3**.

32 The Royal Commission has identified a diversity of challenges[9] that service organisations experience in supporting people with mental illness per se. These challenges also impact on people with co-occurring mental illness and problematic alcohol and other drug use. Specific challenges that service organisations experience in supporting people with co-occurring mental illness and problematic alcohol and other drug use include the following:

(a) Agencies and systems that are trained, structured, oriented and funded to respond only to single disorders. The service's funding agreements and/or suite of reportable outcome measures may not include any measure of whether, or how effectively, the service recognises and responds to people with co-occurring mental health-substance use concerns.

(b) Competing priorities: Mental health and substance treatment workers work in time and resource-poor, crisis-focused (VAGO, 2019), pressured environments which perforce tend towards minimum, non-integrated, treatment provision. These restrictions do not allow the time necessary for activities such as building and maintaining cross-sector relationships that build cross sector understanding, collaboration and consultations and navigable treatment pathways.

(c) Resources: Local managers, agencies, planning & funding bodies are besieged by wicked problems around funding, resource allocation, systemic priorities, misaligned structural arrangements and layers of workforce challenges. Directions are heavily contested and there is an inadequate evidence base to guide decision making. Recent data [10] has graphically demonstrated how under-resourced Victorian Mental Health services are to achieve against their tasks. In this context, in struggling to provide effective mental health services per se, it is understandable that the services have made little recent headway in building their capacity and routine practice to provide integrated treatment to people presenting with dual diagnosis and other complex needs.

(d) Recognising co-occurring disorders - often co-occurring disorders are not immediately apparent. Organisations attempting to implement routine screening

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9 State of Victoria, Royal Commission into Victoria's Mental Health System, Interim Report, Parl Paper No. 87 (2018–19) <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4215/8104/8017/Interim_Report__FINAL_.pdf>.

10 VAGO. (2019). Access to Mental Health Services Independent assurance report to Parliament 2018–19 . Melbourne: Victorian Auditor General. State of Victoria <https://www.audit.vic.gov.au/report/access-mental-health-services?section=>; Perkins, M. (2019, March 26). Nothing between GP and emergency': Victoria's mental health failure. Newspaper Article March 26 2019 [Accessed July 5, 2019]. The Age. <https://www.theage.com.au/politics/victoria/nothing-between-gp-and-emergency-victoria-s-mental-health-failure-20190227-p510ip.html?utm_source=Mental+Health+Vic+contact+list&utm_campaign=6da441a42a-EMAIL_CAMPAIGN_2018_02_05_COPY_01&utm_medium=email&utm_ter>.

procedures, face challenges in choosing appropriate screens, in the time taken to screen and document, in addressing worker's role validity and culture change.

(e) Clinicians trained and oriented to respond only to single disorders. Clinicians may lack skills, knowledge, self-efficacy and sense of role validity in deploying AOD or mental health treatment approaches.

(f) Aligning agency norms with changed practices: Workers, through workshop participation, may become enthused about providing more integrated treatment only to learn that their agency's tools, procedures, clinical leaders, culture and priorities do not support this practice development.

(g) Policy and planning bodies and service management may fall into the 'training trap'. Training alone, without attention to the web of other factors needed to change complicated behaviour such as mental health and substance use treatment provision, may have little impact and may even do harm.

(h) Training standards: To date there has seldom been agreed minimum standards and curriculum informing workplace training around clinicians capacity to respond effectively to people with complex needs. Tertiary education curricula is difficult to influence and institutions can be slow to build mental health and substance use treatment modalities into health undergraduate courses.

(i) There may be a lack of knowledge about the interplay of disorders and confusion over which disorder is 'primary' and 'secondary'. In my opinion, the best practice is to detect and to provide, or facilitate the provision of evidence based responses to all presenting disorders.

(j) Clinician's may be 'change-weary and change-wary'. Clinicians may perceive an implication that their current practice is 'wrong'. Clinicians may regard providing integrated assessment and treatment as added work rather than more effective work. Clinicians may be shut down both because of the demands of the work and because of continuous, sometimes poorly aligned, reforms.

(k) Complexity can lead to difficulties in engagement and treatment, clinician frustration and a tendency to stigmatise.

(l) Both mental health and substance use disorders are highly stigmatised (individually), and as a result, there can be 'compounded stigma' and discrimination that restricts service access and contributes to inadequate treatment.

(m) Both mental health and AOD treatment systems tend to focus scarce resources on treating people with the most severe disorders whereas the greatest potential gains and savings may be in the cohorts with less severe mental health and substance use disorders.

(n) Service inclusion criteria that, in practice, can function as exclusion criteria. Best practice complexity responses, such as developing active welcoming and flexible entry criteria, are increasingly less possible due to the weight of demand and related central system design and funding mechanisms. In practice taut, limited, service entry criteria function as exclusion criteria and inhibit services and workers from flexibly, promptly responding to the diverse needs of people with mental health-substance use and other complex needs.

(o) Stakeholders may lack familiarity with the prevalence, harms and potential for better outcomes associated with co-occurring disorders.

(p) Lack of understanding of other treatment system's philosophies, strengths and constraints.

(q) Ineffective mechanisms to achieve clinical care coordination across mental health and AOD services and sectors. This is exacerbated by the service demands in each sector. Workers tend to meet, most often, around people presenting with particularly complex needs. These can be situations in which both AOD and MH services struggle to be effective and there is potential for frustrations about perceived inadequacies in the opposite sector's responses.

33 Victoria's policies and approach to supporting people with both mental illness and problematic alcohol and drug use have changed over time. Of all of Australia's states and territories, Victoria has the most long standing and significant investment in achieving better outcomes for people with co-occurring mental illness and problematic alcohol and drug use.

34 I have addressed Victoria's policies and approach at pages 26 to 37 of my Submissions, which are **attached** to this statement and marked **GJC-3**.

35 Of those landmarks, I consider that the most significant events in contributing to systemic dual diagnosis capability to date have been:

(a) the creation of the VDDI;

(b) the ongoing learnings from Drs Minkoff and Cline around the Comprehensive, Continuous Model of Care (**CCISC**); and

(c) the impacts of the 2007 cross sector Victorian Dual Diagnosis Policy.[11]

36 **Attached** to this statement and marked **GJC-7** is a copy of a publication that I co-authored, titled *Victoria's strategies towards integrated service delivery for people with mental health-substance use concerns*, which reflects on what has been learned about

[11] DHS (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Health Services, Melbourne, State of Victoria <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

systems change and identifies developments that have been effective in influencing more integrated service delivery.

UNDERSTANDING THE ALCOHOL AND OTHER DRUG SYSTEM

37 In 2014, there was a process for recommissioning Victorian alcohol and other drug treatment services. That process included the following:

(a) March 2011: A Victorian Auditor General's Drug and Alcohol Services Report[12], which concluded that the AOD service system was fragmented with 'significant access barriers facing those who need the system'.

(b) June 2012: Plans to reform the alcohol and drug service system were announced.[13] A central feature of the reform was the creation of dedicated intake and assessment providers, which were responsible for the screening, initial comprehensive assessment and referral components of the treatment pathway.

(c) December 2014: A NDARC report[14] identified a range of unintended consequences of the reform.

(d) 2015: The Minister for Mental Health commissioned an independent review[15] to identify problems from the 2014 recommissioning. The review concluded that the recommissioning made it harder for vulnerable Victorians to navigate the system and access alcohol and drug treatment and support.

(e) 2016: A number of reforms were instituted, which included shifting responsibility from intake providers to treatment providers providing comprehensive assessment and treatment planning. The degree to which this occurs, across the state, is variable.

38 In 2020, concerns are still being voiced. Murray PHN's most recent update of its Needs Assessment[16] cites the following concerns:

(a) Difficulties in navigating the system (including central intake via contracted service providers).

(b) Reluctance to make referrals.

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12 Victorian Auditor General's Report (2011) Managing Drug and Alcohol Prevention and Treatment Services <https://www.parliament.vic.gov.au/papers/govpub/VPARL2010-14No14.pdf>.

13 DoH (2013). New directions for alcohol and drug treatment services A framework for reform. State of Victoria, Department of Health, 2013 <https://www2.health.vic.gov.au/about/publications/researchandreports/New-directions-for-alcohol-and-drug-treatment-services-A-framework-for-reform>.

14 Berends, L., Ritter, A. (2014). The Processes of Reform in Victoria's Alcohol and Other Drug Sector, 2011-2014. Sydney: National Drug and Alcohol Research Centre < https://www.vaada.org.au/wp-content/uploads/2018/06/The-Process-of-Reform-in-Victorias-Alcohol-and-Other-Drug-Sector-2011-2014.pdf>.

15 Aspex Consulting (2015) Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services <https://www2.health.vic.gov.au/about/publications/researchandreports/review-of-mental-health-community-support-services-and-drug-treatment-services>.

16 MurrayPHN, Needs Assessment Population Health November 2019 Update 2018-2022 <https://www.murrayphn.org.au/wp-content/uploads/2019/02/Murray-PHN-Needs-Assessment.pdf>.

(c) Assessment/intake is complex and disengages clients.

(d) Due to central intake, treating agencies often need to undertake an additional assessment.

(e) A sense that since central intake commenced, referrals have dropped.

(f) Limited outreach.

(g) Coordination of care is not funded.

(h) GPs are often the starting point for system entry, but engagement and relationships are less developed, where previously direct referral capacity from GP strengthened GP/AOD worker relationships.

39 One of the most significant, oft-documented, challenges for people experiencing co-occurring mental health-substance use concerns is that they tend to fall through the gaps, either not accessing services or not receiving services when they do present.

40 I consider that models which aspire to be a welcoming, (where possible) 1-stop-shop, single agency for a person's whole treatment and care journey, from first contact to discharge, are likely to be preferred by those people seeking services. These models, in my opinion, are the most effective and efficient way to engage and prevent people with mental health-substance use from falling through the gaps. These models are preferable to 'production-line' models, in which different agencies are given responsibility for different components of a person's treatment journey.

Key similarities and differences in the treatment approaches of the alcohol and other drug and mental health sector

41 There are a number of similarities and differences in the treatment approaches of AOD and mental health sector.

42 The similarities are as follows:

(a) The heart of both sectors are their workforces. Both workforces contain exceptional people motivated by a desire to contribute to happier lives for people experiencing challenging health concerns.

(b) Both sectors have developed their treatment approaches in the context of inadequate resources to meet the known disability and healthcare burden associated with either and both mental health and substance use concerns.

43 The differences are that:

(a) Clinical Mental Health services tend to run more on a predominantly medical model while AOD services (and many Mental Health Community Support Services) tend to run on a broader, more holistic, psychosocial model; and

(b) AOD services tend to focus more on welcoming and engagement and motivationally working with issues than do Clinical Mental Health services.

44 In respect to the treatment philosophy and mandates of AOD and mental health sectors, I also recognise the following:

(a) A not-insignificant percentage of the clients of the AOD system are forensic clients,[17] who access AOD treatment as a result of their contact with the criminal justice system. The majority of forensic clients are mandated to attend treatment as a condition of their order or diversion.

(b) Many components of the mental health system (eg. Primary Mental Health) have not been designed or delivered around compulsory treatment, and instead are predicated around voluntary engagement and client centred responses. I am aware that there have been tensions around the funding and priority of these components, resulting in a sense that they are less critical, less core, than legislated systemic responsibilities.

45 In light of the matters described above, I consider that it would be difficult to reconcile the AOD sector philosophy of voluntary engagement, treatment and self-help with the mental health system philosophy which includes a scheme for compulsory treatment, given that each system has developed and refined their treatment needs and preferences of predominantly different cohorts of people with mental health-substance use issues.

46 With that said, I consider that Victoria's AOD and mental health service can learn a lot from one another. Broadly speaking:

(a) the mental health sector can learn from the AOD sector how to respond to people with severe substance use disorders, including by perhaps using more engaging, holistic, psychosocial, motivational approaches; and

(b) the AOD sector can learn from the mental health sector how to respond to people with severe mental health concerns, including perhaps diagnostic approaches and responding to physiological needs.

[17] DHHS. (2018) Forensic Alcohol and Other Drugs Treatment Service Delivery Model Alcohol and Other Drugs Treatment and Services. Victorian Government <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/forensic-aod-services>.

47 While working with people with suicidal ideation is commonplace in AOD services, the AOD sector is not equipped, in resources or legislated powers, to meet the needs of people with immediate, acute suicidal risk. Mental health services have developed expertise in managing acute suicidality and can serve as a point of reference for AOD services around acute suicidality.

48 While acute inpatient mental health services have developed expertise in substance withdrawal this is incidental to their primary tasks and withdrawal, whether community or residential, is appropriately, primarily, the responsibility of AOD services. AOD services have developed expertise in withdrawal and can serve as a point of reference for mental health services around withdrawal.

49 *'How'* each system can learn from the other is perhaps an as important question as the '*what'*. There are a number of strategies to promote effective partnerships between mental health and AOD services (see paragraphs 73 to 79 below). These strategies, which aim to increase formal and informal contacts between AOD and mental health workers, have relevance to how cross sector learnings can occur. One clear goal here is for service systems to aspire to, support, develop and maintain robust, cross-sector, secondary consultation practices around people with mental health-substance use needs. Routine secondary consultation practices provided by AOD to mental health workers and vice versa is a critical step towards effective systemic responses to people with mental health-substance use. I consider that agreed, cross-sector, secondary consultation processes, which are articulated in both interagency protocols and individual agencies procedures, are a valuable step towards embedding this as routine practice.

50 Another related question is '*what can the services learn, collaboratively, together*?' Subsequent sections of this statement address systemic goals that include:

(a) integrated treatment when provided on a multi-agency basis;

(b) navigable cross sector treatment pathways; and

(c) The development of a No Wrong Door service system.

51 I note that solutions that work well in one region may not work in another. How each different and unique region (composed of different and unique services and workers) achieves these goals depends on the ongoing, combined, collaborative efforts of all workers, managers and lived experience leaders in the region learning together what works for them and their unique systems and sub-systems.

POTENTIAL REFORMS

52 Some submissions to the Royal Commission have argued for 'dual diagnosis specific' services as a best practice response for people with co-occurring mental health and

problematic alcohol and other drug use. I consider that attempts to design a third, dual diagnosis specific, treatment system:

(a) fail to recognise prevalence, namely that people with co-occurring mental health-substance use are the '*expectation not the exception'* in both mental health and AOD sectors (albeit different predominant cohorts with different treatment needs and preferences). Even where there is the will and funding available to successfully do this, what would the existing mental health and AOD services do once they had lost up to 90% of their current clients?;

(b) are potentially stigmatising ('*double-trouble*');

(c) would contribute to further systemic complexity and challenges in accessing and navigating the service systems, including for people seeking services, their significant others and the people working in the systems; and

(d) send a message to mental health and AOD workers that, rather than being 'core business',[18] responding to co-occurring substance use-mental health is the domain of specialists and specialist services.

53 I consider that it is more strategic, with limited resources and already complex service systems, to attempt to influence our existing AOD and mental health services to continue to develop their capability and orientation to provide welcoming integrated, holistic, 'dual diagnosis capable' services.

54 A best practice service response and consumer experience for adults and young people with co-occurring mental illness and problematic AOD is one in which any person, accessing any mental health or AOD service, is:

(a) welcomed in and warmly engaged with no matter where, in the service system, they initially present to; and

(b) met by a worker who:

(1) has a developed, sympathetic understanding of the prevalence, harms and potential for better outcomes associated with co-occurring mental health-substance use concerns and other complex needs;

(2) whose initial purpose is weighted more to engagement than assessment. This requires a worker with a developed understanding of trauma, who is oriented and supported to sensitively, flexibly, identify, not only what has brought the person to the door, but also to explore the person's strengths,

[18] DHS. (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Human Services, Melbourne, State of Victoria. Melbourne <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

their hopes and their individual vision of what their 'happiest, most hopeful, productive and meaningful life is'.[19] Identifying and amplifying the person's strengths should be a central function of the interaction;

(3) has specialist knowledge and skills in either mental health or substance use and a developed awareness of, and knowledge and skills in, recognising and responding to the 'other' issue. The worker involved will regard recognising and providing integrated treatment and care for mental health-substance use as core business;

(4) has the necessary skills, orientation and organisational supports to develop a safe relationship in which helpful, respectful conversations can occur, in which issues can be explored, the client's goals can be identified and a plan collaboratively developed to achieve those goals;

(5) has a developed understanding of stigma and its impacts on access to and quality of treatment received; and

(6) has a developed understanding of the broader service system and how to navigate it. If it is determined that the agency where the person has first presented is not the best placed agency to meet that person's needs, that person is nonetheless welcomed, engaged with and meaningfully assisted to access the needed services (i.e. a 'No Wrong Door' service system).

(c) Wherever possible, and depending on the person's preferences, the person involved will receive integrated, one stop shop, treatment of and care for their co-occurring mental health-substance use needs.

(d) Where integrated one stop shop treatment is beyond the agency's capacity (eg. a person accessing mental health services with co-occurring complex substance withdrawal needs or a person accessing AOD services with acute suicidality), then the person will be meaningfully supported to access needed services. If multiple agencies are then involved, the workers will endeavour to work with the person to 'develop a single integrated treatment plan that continues after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client'[20].

55 The role of families, carers and/or a consumer's broader personal support networks play an important role in this service response.

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[19] Minkoff, K, Cline, C. (2008) Integrated Longitudinal Strength Based Assessment (ILSA-Basic). ZiaPartners <http://www.ziapartners.com/tools/ilsa-basic>/.

[20] DHS. (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Human Services, Melbourne, State of Victoria. Melbourne <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

56 The significant others of people with co-occurring mental health and substance use concerns can experience a greater range of challenges and adverse experiences than the significant others of people with only one of the concerns. Often these challenges tend to parallel those of the person with the issues and may include the following:

(a) Compounded courtesy stigma: Which is the 'experience of stigma as a result of a relationship with, or proximity to, a stigmatised person'.[21] People with mental health-substance use concerns experience worse access to, and a lower standard of, treatment as a result of experiencing two of the most stigmatised healthcare concerns. Their significant others often experience parallel challenges including increased isolation and worse access to supports (especially in regional areas).

(b) Losses: There is evidence that people caring for a person with both mental health and substance use concerns experience greater financial losses and anticipatory grief than people caring for someone with only one of the concerns.

(c) Recovery directions: The significant others of people with co-occurring mental health and substance use concerns may experience dilemmas centred around 'primacy', namely what treatment would be helpful, where and how to access treatment, and the dilemmas of responsibility versus consequences.

(d) Information: One of the greatest challenges can be where and how to get reliable information. This could be about the concerns that the person they care for is experiencing but also could be about how to navigate complex health and social services.

57 As with people who experience only one of the concerns, the significant others of people with mental health-substance use have a critical role to play in the impacted person's recovery. The further development of routine family inclusive practice, as well as any specific strategies to address the range of challenges experienced by significant others of people with mental health-substance use, will contribute to their capacity to support the impacted person's recovery.

Examples of successful models of treatment for people with co-occurring mental illness and problematic alcohol and other drug use

58 There are multiple everyday examples of Victorian mental health and/ or AOD workers providing successful treatment for people with co-occurring mental illness and problematic alcohol and other drug use. Unfortunately these examples are often

[21] Adfam. (2012). Challenging Stigma - Tackling the Prejudice Experienced by the Families of Drug and Alcohol Users. London <https://adfam.org.uk/files/docs/adfam_challenging_stigma.pdf>.

dependent on the individual clinician involved and we are not yet at a stage where they can be considered routine practice.

59 An example is the Integrated Primary Mental Health Service (**IPMHS**) of Northeast Victoria, which was formed as a partnership between the then Division of General Practice and the local, state-funded, clinical mental health service (initially auspiced by Northeast Health Wangaratta and later Albury Wodonga Health).

60 Between 2003 and 2018, mental health clinicians were co-located in regional General Practices supporting GPs through direct mental health assessment and treatment with people with high prevalence mental health disorders. The model was an outstanding example of vertical and horizontal integration of mental health with primary health care. IPMHS had considerable rigor and accountability with team-based weekly clinical review, adherence to Commonwealth KPIs, psychiatrist oversight and access and external evaluation.

61 As the model developed, it became clear that the people who accessed the service frequently also experienced co-occurring substance use issues. Clinicians developed advanced capabilities in providing effective integrated mental health-substance use treatment and care. Discussions in clinical review were as much around substance use as mental health concerns. Client, GP and funder satisfaction with the service was regularly assessed and was consistently high.

Strategies required to address the discrimination and 'double stigma' mental health and alcohol and other drug clients experience

62 Over the past decade increasing effort and resources have been devoted to addressing the stigma and discrimination associated with mental health concerns.[22] Initiatives to address the stigma and discrimination associated with substance use concerns[23] are occurring but are more embryonic. There may be transferrable learnings from these initiatives that are useful in addressing the discrimination and 'double stigma' mental health and alcohol and other drug client's experience.

63 In March 2018, the Queensland Mental Health Commission (**QMHC**) proposed options for reform to reduce stigma and discrimination for people experiencing problematic alcohol and drug use. The QMHC identified 18 options for reform under six key domains comprising, human rights, social inclusion, engaging with a lived experience and their families, access to services, the justice system and economic participation. **Attached** to

[22] Sane Australia (No Date) StigmaWatch: Help tackle stigma in the media surrounding mental illness and suicide. Website [Accessed March 15, 2020] <https://www.sane.org/services/stigmawatch>.

[23] G Denham, AOD Media Watch (No Date) 31st October 2019: Is Victoria Police behind media push to close down Melbourne's injecting room? Website. [Accessed March 15, 2020]. <https://www.aodmediawatch.com.au/>; Mindframe (No Date) Mindframe guidelines. Website. [Accessed March 15, 2020]. <https://mindframe.org.au/alcohol-other-drugs/communicating-about-alcohol-other-drugs/mindframe-guidelines>.

this statement and marked **GJC-8** is a copy of the QMHC's paper titled "Changing attitudes, changing lives".

64 In 2016, a National Academies Press monograph on ending discrimination against people with mental health and substance use disorders, reviewed a range of approaches to reducing stigma. These included education, mental health literacy campaigns, peer services, protest and advocacy and legislative and policy change.[24]

EXPLORING INTEGRATION

65 A significant number of stakeholders have called for greater integrated care for people with co-occurring mental illness and problematic AOD use.

66 Integrated care, otherwise known as 'integrated treatment', as defined in Victorian policy means: [25]

> '*Integrated treatment may be provided by a clinician who treats both the client's substance use and mental health problems. Integrated treatment can also occur when clinicians from separate agencies agree on an individual treatment plan addressing both disorders and then provide treatment. This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client.'*

67 I consider that it is helpful to distinguish integrated treatment from three other, frequently conflated terms: integrated programs, integrated services and integrated systems. This conflation can impact on the clarity and direction of change initiatives:

(a) Integrated Programs: 'are implemented within an entire provider agency or institution to enable clinicians to provide integrated treatment'[26]. An example is a community mental health agency whose staff includes a portfolio holder with AOD expertise who provides consultation and support to their colleagues in delivering integrated treatment with an individual client.

(b) Services Integration: refers to 'any process by which mental health and substance use services are appropriately integrated or combined at either the level of direct contact with the individual client with co-occurring disorders or between providers or programs serving these individuals. Integrated services can be provided by an

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[24] Committee on the Science of Changing Behavioural Health Social Norms (2016). Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington (DC): National Academies Press (US) <https://www.ncbi.nlm.nih.gov/books/NBK384915/>.

[25] DHS. (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Human Services, Melbourne, State of Victoria. Melbourne <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

[26] CSAT. (2006). Definitions and Terms Relating to Co-Occurring Disorders. COCE Overview Paper 1. Rockville, MD.: Center for Substance Abuse Treatment. Substance Abuse and Mental Health Services Administration <http://drugslibrary.wordpress.stir.ac.uk/files/2017/07/DefinitionsandTerms-OP1.pdf>.

individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients'.[35]

(c) Systems Integration: describes the 'process by which individual systems or collaborating systems organize themselves to implement services integration to clients with co-occurring disorders and their families'.[35]

68 I'm aware that past submissions to the Royal Commission have called for devolving AOD services into the mental health system as an appropriate approach to achieve 'integrated treatment'. I disagree with these submissions because:

(a) It would neither be an efficient or an effective way to proceed.

(b) It fails to recognise the differing treatment approaches and expertise of AOD workers.

(c) It also fails to recognise the different predominant cohorts of people (and their different treatment needs and preferences) who currently receive services in the AOD system.

(d) It would result in many people who currently receive services in the AOD system experiencing further barriers to treatment access and being more likely to fall through the gaps with unwanted (and sometimes tragic) outcomes.

The ways in which integrated treatment can be achieved

69 The CCISC (referenced in sub-paragraph 35(b) above) is a successful evidence based system model for addressing individuals and families with mental health-substance use.[27] The CCISC has been trialled successfully in Victoria[28] but has not yet had systemic implementation.

70 With the Royal Commission's leadership, the Victorian healthcare system can produce better outcomes within our existing resources by directing system redesign. In my opinion, the only costs will be in the consultation, technical assistance, and training required to perform the redesign over a period of years.

71 There are three steps:

(a) **Step 1 -** The plan should involve the whole system not just mental health because people with dual diagnosis and other complex needs are everywhere. This means the mental health sector, the AOD sector, and all lived experience providers. It is not recommended that the AOD and mental health sectors be administratively

[27] Website CCISC Overview. <http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc/>.
[28] EACH Service Principles. Internal document. See **GJC-10**.

combined because evidence suggests that this would slow down the change and make it more costly. I consider that the leadership of each sector should be directed to work collaboratively to implement one integrated system vision for people with dual diagnosis and other complex needs, as described in 2 and 3 below.

(b) **Step 2 -** The essence of this vision is that all programs and all staff become dual diagnosis/complexity capable. Each program may have a different job, but each one is designed (within its existing resources) to provide the right services to the people with dual diagnosis and other complex needs who they already serve, so more people get what they need within a single door. It is not necessary for all staff to be dually credentialed. Each member of staff is helped to have competency to provide appropriately matched services to the people with dual diagnosis in his or her caseload, no matter what the staff member's primary discipline or training is. I recommend that the Royal Commission mandate that all sectors initiate a process by which all programs engage in an evidence based step by step process to become dual diagnosis capable.

(c) **Step 3 -** All programs within all sectors should be directed that every door is the right door for individuals and families with complex needs. Wherever people come into the system they should be welcomed and engaged as they are, and then helped over time to make connection to the best ongoing dual diagnosis capable services in their community to meet their needs. Administrative rules and barriers to entry should be reduced, and within each community, all types of services should be required to treat each other as priority partners for consultation, in-reach, and collaboration so more people can get what they need in the door that most closely matches their needs and preferences. As part of the process in step 2, leaders in all sectors should be directed to implement policies and procedures that reflect this goal, and to incorporate this expectation in the work of implementing universal dual diagnosis capability

72 Drs Minkoff and Covell, the authors of *Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?*[29], have recommended various policy steps (under the heading 'Recommendations') as being 'relatively simple, not terribly costly and highly productive in improving integrated mental health-substance use services in you system'. **Attached** to this statement and marked **GJC-9** is a copy of the paper.

[29] Minkoff, K., Covell, N (2019) Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now? National Association of State Mental Health Program Directors <https://www.nasmhpd.org/sites/default/files/TAC_Paper_8_508C.pdf>.

Supporting effective partnerships between services to achieve better integrated treatment and consumer experiences

73 The capacity of workers, agencies and systems to provide integrated treatment (when provided on a multi-agency basis) depends on the strength of the relationships between the individual services and the individual workers in those services.

74 Central policy and planning bodies can contribute to building effective partnerships between services by ensuring that there is in place a clear, agreed, coherent, aspirational, cross-sector, vision of how the services will look, feel, behave and interact when providing effective treatment with people with co-occurring mental health-substance use issues. The policy steps recommended by Minkoff and Covell (**attached** to this statement and marked **GJC-9**) should be considered in this process. A clear aspirational vision supports all stakeholders to align their efforts towards agreed directions. This was the Victorian experience for the several years following the release of the 2007 dual diagnosis policy.[30]

75 The vision must be coherent and supported by all subsequent policies and investments. It should include broad guidance about which components of the service system have broad treatment responsibility for the different cohorts of people with mental health-substance use and the goal of a 'No Wrong Door' service system. There should be a clear direction that the provision of integrated treatment and care with people with mental health-substance use is core business for all mental health and AOD services and workers.

76 The VDDI has devised and deployed diverse strategies to contribute to more navigable treatment pathways, improved cross-sector relationships and better integrated care and consumer experiences. A general principle is that maximising formal and informal contacts between AOD and mental health workers augurs towards enhanced capacity to provide integrated treatment. These strategies have included the following:

(a) The administration of the state-wide Reciprocal Rotations Project in 2006-2007, which involved staff from the mental health and alcohol and other drug sectors engaging in a three month work placement in the opposite sector and undertaking relevant formal education. The project was evaluated positively.

(b) Facilitating the development of interagency protocols that promote navigable treatment pathways and guide services in how they will interact.

[30] DHS (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Health Services, Melbourne, State of Victoria <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

(c) Developing secondary consultation policies to support workers in seeking, providing and maximising the benefits of secondary consultation as routine practice.

(d) The provision of joint and reciprocal education.

(e) 'Bus trips' in which new workers participate in a 1-day, cross-sector tour of key partner agencies where they meet other workers and are given a brief profile of each visited agency and how best to work with it.

(f) Randomised Coffee Trials[31] designed by the Hume Border VDDI, to pair AOD with Mental Health workers, providing small funding for coffee and encourage them to have a relaxed conversation.

77 There are different integrated services responses required depending on the severity and complexity of a client's support needs. People with co-occurring mental health-substance use are not homogenous. Rather, they experience diverse combinations and severities of the gamut of possible mental health concerns with the gamut of possible substance use concerns. This diversity leads to similar diversity in treatment needs and preferences. An array of services with flexible entry criteria, arranged around the needs and preferences of different cohorts, is required to meet these diverse needs. Each service with its particular job but with a developed recognition of the prevalence of people with co-occurring needs and an enhanced capacity to provide or facilitate integrated responses to those needs.

78 To stream clients for these responses:

(a) Several typologies have been proposed to guide services in who has primary treatment responsibility for the different predominant cohorts, such as the USA's four-quadrant model,[32] and its many adaptations,[33] and the 3-level schema proposed in the 2007, cross-sector, Victorian dual diagnosis policy[34] (see pages 7 and 46 of my Submissions **attached** and marked **GJC-3**).

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31 Webpage Randomised Coffee Trials - Hume-Border Region 2017- www.dualdiagnosis.org.au Accessed 18/03/2020 <http://www.dualdiagnosis.org.au/home/index.php/randomised-coffee-trials-hume-border-region-2017?highlight=WyJjb2ZmZWUiXQ==>.

32 McDonell M, K. A. (2012). Validation of the co-occurring disorder quadrant model. *J Psychoactive Drugs.*, 266-73 < https://www.ncbi.nlm.nih.gov/pubmed/23061327>.

33 Marel, C. M.-L. (2016). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). Sydney. Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, Uni NSW <https://extranet.who.int/ncdccs/Data/AUS_B9_Comorbidity-Guidelines-2016.pdf>; Drug and Alcohol Findings. (2015). The complexity and challenge of 'dual diagnosis'. Hot Topic Blog Series <https://findings.org.uk/PHP/dl.php?f=dual.hot>.

34 DHS. (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Human Services, Melbourne, State of Victoria. Melbourne <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

(b) Drs Minkoff and Covell,[35] recommend that systems need to 'review and adjust all access rules that create barriers for individuals with co-occurring conditions. Every door is the right door to get help, and the job of every program should be to bring you in quickly and help you get connected to what you need.' The value that 'all services are welcoming and accessible (every door is the right door)' is central to achieving better outcomes for people with mental health-substance use and other complex needs.

79 An upcoming, and yet to be published, USA document co-authored by Dr Minkoff (among others) proposes Crisis Hubs as places for people in crisis to go to, that are an alternative to Emergency Departments (ED) or forensic facilities. It is proposed that the Crisis Hubs are community facilities where the majority of people in behavioural health crisis are brought, which 'coordinate access to a complete continuum of services, and have dedicated resources that allow for high quality medical triage and ambulatory intervention, mental health and/or substance use disorder evaluation, observation, initiation of treatment and connection with community-based resources'. The document states that the avoidance of unnecessary ED visits should be measured as a system-wide quality metric. The proposed Crisis Hubs would be one element in an ideal mental health-substance use crisis system, which also includes aligned call centre helplines, crisis trained first responders, medical triage and screening, mobile crisis workers, crisis residential services, defined roles of hospitals in crisis services, continuity of transition from intensive community-based crisis interventions to routine care and transportation options. A goal for the whole system should be a seamless flow through the range of services as the person progresses and their needs change.

Streaming clients, including in times of acute need

80 The crisis services described in the upcoming USA document (described in the preceding paragraph) allow for a flexible range of possible assessment and streaming points depending on a client's presentations, acuity, specific circumstances, possibilities and needs.

81 Assessments could be conducted when a person:

(a) is seen in their own environment by mobile crisis workers as soon as possible, and no later than an hour after their first call. Mobile crisis workers provide crisis intervention, de-escalation where needed, supportive counselling, collaboration with significant others, and access to least restrictive transport options where

[35] Minkoff, K., Covell, N. (Aug. 2019) Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now? National Association of State Mental Health Program Directors <https://www.nasmhpd.org/sites/default/files/TAC_Paper_8_508C.pdf>.

indicated. Mobile crisis workers may work independently or with first responder services, where clinically indicated;

(b) attends, or is brought to, the local crisis hub where they are welcomed, positively engaged with and their immediate needs are assessed and addressed, treatment is initiated and they are seamlessly connected with a range of community-based resources;

(c) calls the call centre helplines that provide an initial triage service. Helplines can, depending on circumstances, activate the range of possible crisis responses including mobile crisis workers; or

(d) through initial contact with one of the above options, receives services from a crisis residential setting which has available '23-hour evaluation/extended observation beds'. This facility is able to 'provide evaluation, observation and intervention by a multidisciplinary team' for up to 23 hours, during the acute phase of a crisis.

82 The above continuum of possible 'streaming services' should be designed to have sufficient capacity to share information, to access and be guided by any advance directives, to provide guidance and consultation to the broader service system and to respond to the needs of significant others.

83 The physical environments required for assessment and streaming would depend on the particular function of the service and the possibilities afforded by the local environment in which they operate.

84 The upcoming USA document (referred to in paragraph 79 above) identifies the critical importance of the Crisis Hub *not* being in a hospital, and that having a separate service shifts the system's culture to a more '*efficient and effective conceptualisation of how to respond to people experiencing a … crisis'.*

85 Further, a multidisciplinary workforce in adequate numbers would be required to respond to the known levels of demand, disability and costs associated with mental health-substance use and other complex needs. Such workforce should function on an interdisciplinary, rather than a siloed, basis.

86 Ideally, the workforce would comprise of peer workers, nurses, social workers, psychologists, and other medically trained individuals who have developed expertise in mental health and in substance use assessment and treatment. By way of example, the role of peer workers should include engaging people, educating about treatment options and helping them to access needed services.

Successful models of system and service integration across mental health and alcohol and other drugs beyond Australia

87 I have observed successful models of systems or services integration across mental health and AOD in jurisdictions beyond Australia. Based on my understanding and experience:

(a) all western healthcare systems (driven by the prevalence, harms and potentials associated with mental health-substance use) are deploying strategies to evolve to become more effective in meeting the needs of people with mental health-substance use;

(b) given the wicked nature of many of the associated problems, there is no finite endpoint to this evolution - rather it is best viewed as an ongoing, continuous quality improvement, process of learning, trialling, evaluating and refining our approaches; and

(c) different systems experience different strengths and challenges around their responses to people with mental health-substance use, hence solutions devised by one system aren't necessarily transferrable to other systems. For example, strategies that are successful in metropolitan Melbourne may not be influential or practicable in rural and regional areas.

88 In my opinion, the values, principles and directions identified in the CCISC model[36] provide significant guidance to systems attempting to develop more effective responses to people with mental health-substance use. CCISC has been hugely influential in many of Victoria's developments and has had a similar influence in systems around the globe. In Melbourne, the Eastern Access Community Health (**EACH**) service has developed its service principles around the CCISC model. EACH used a series of 'Innovation Labs' to adapt the CCISC evidence-based principles of service delivery into the EACH service principles. **Attached** to this statement and marked **GJC-10** is a copy of the EACH Service Principles.

89 Following my Victorian Travelling Fellowship in 2003, I prepared a report that identifies the models and initiatives I observed while conducting a 6-week investigation of integrated responses to mental health-substance use in the UK, USA and New Zealand. **Attached** to this statement and marked **GJC-11** is a copy of my report.

[36] Website CCISC Overview. <http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc/>.

Achieving integration of state and federal services in Australia

90 Achieving better outcomes for people with mental health-substance use is a clear, current, ongoing and urgent priority at both state[37] and federal[38] levels. There is abundant state-federal agreement about the prevalence, costs and harms and priority of addressing the needs of people with mental health-substance use. However, Australia as a whole, has not yet seen an integrated, collaboratively developed, coherent, state and federal vision of how the mental health and AOD service systems will look, feel and behave when providing effective responses to people with mental health-substance use.

91 There is potential for the Royal Commission, perhaps in collaboration with the Federal Government Productivity Commission Mental Health Inquiry, to develop a single integrated systemic vision around how services will respond to people with mental health-substance use and other complex needs and to accompany this with a stepwise plan for all systems to achieve against that vision. This plan should involve the steps identified in sub-paragraphs 71(a) to 71(c) above.

WORKFORCE CAPABILITIES

92 Current Victorian policy[39] mandates that responding to co-occurring mental health-substance use is *core business* for all Victorian mental health and AOD workers. A principle in the *Mental Health Act 2014* (VIC) is that *'persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.'*

93 People with co-occurring mental health-substance use concerns are highly prevalent, the *expectation not the exception* in both mental health and AOD services. Accordingly, there is a frequent need for mental health services to access specialist alcohol and other drug expertise to support such clients, and vice versa. Despite this need, it is often the case that secondary consultation isn't sought. This is due to a variety of reasons including time

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[37] DHHS (2020) Mental Health Intensive Care Framework. Victorian Government, Melbourne <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-intensive-care-framework>; DHHS (2019.) Equally well in Victoria: Physical health framework for specialist mental health services. Victorian Government, Melbourne <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/equally-well-in-victoria-physical-health-framework-for-specialist-mental-health-services>; DHS. (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Human Services, Melbourne, State of Victoria. Melbourne <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

[38] DoH (2017) National Drug Strategy 2017–2026 Commonwealth of Australia <https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026>; DoH (2019) National Alcohol Strategy 2019–2028 Commonwealth of Australia <https://www.health.gov.au/resources/publications/national-alcohol-strategy-2019-2028>; DoH (2017) Fifth National Mental Health and Suicide Prevention Plan Commonwealth of Australia <http://www.coaghealthcouncil.gov.au/Publications/Reports>; DoH (2020) National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029 Commonwealth Australia <https://www.health.gov.au/resources/publications/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29>.

[39] DHS. (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Human Services, Melbourne, State of Victoria. Melbourne <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

and resource constraints and lack of knowledge about, and inadequately developed partnerships between, the sectors.

94 Given known prevalence rates, complexity of presentations and the potential for better outcomes, it is necessary to deploy a range of complementary strategies aimed at building the specialist AOD expertise within mental health services and vice versa. In my opinion, these strategies should include:

(a) attention to building a practice culture in which seeking and providing secondary consultation is a recognised, expected and a 'rewarded' component of routine practice. This may involve adjusting criteria in workers' recording of activity statistics, local development of cross sector protocols (that include dispute resolution mechanisms), development of complementary secondary consultation policies and procedures that support workers in seeking and providing secondary consultation. Any strategies which prompt more formal and informal contacts between mental health and AOD workers (rather than only meeting around challenging issues) will augur towards increased secondary consultation and navigable pathways between the services;

(b) depending on the particular 'job' of the AOD or mental health agency involved embedding dedicated positions with expertise in the 'other' speciality. The current VAADA 2020-2021 budget submission[40] calls for employing 'three specialist' dual diagnosis clinicians into each AOD region to build the capability of the sector to respond to the needs of service users experiencing acute co-occurring AOD and mental health concerns' and a similar initiative in each mental health region;

(c) dedicated psychiatrist or mental health nurse practitioner time being made available to AOD workers and services;

(d) dedicated addiction medicine or AOD nurse practitioner time being made available to mental health workers and services; and

(e) promoting the expectation that each mental health and AOD service and sub-service will appoint a senior 'dual diagnosis portfolio holder'. Persons appointed should have some expertise in both mental health and substance use and the seniority, standing capacity, and leadership skills to consider and develop the service's responses to people with mental health-substance use. Portfolio holders should be allocated time to meet and collaborate with local VDDI workers.

[40] VAADA (2020) VAADA 2020-2021 State Budget submission <https://www.vaada.org.au/wp-content/uploads/2020/03/SUB_VAADA-budget-submission-2020-21_12032020.>.

Skills and expertise required in the mental health and alcohol and other drug workforces

95 To be fully effective in responding to the various needs of people with mental health-substance use concerns, I consider that workers must aspire to be welcoming, flexible, inclusive, person-centred, strengths-oriented, significant others-focused, trauma-informed, recovery-focused, complexity-capable, resiliency-enhancing, and culturally-competent.

96 The level of skills and expertise required by both mental health and AOD workforces will vary depending on the service's specific 'job' within the system, as well as the needs and preferences of the predominant cohorts of people with mental health-substance use and other complex needs who access that service.

97 Current Victorian policy[41] guidance mandates the following:

(a) Responding to co-occurring mental health-substance use concerns is 'core business' for Victorian AOD and mental health workers.

(b) Staff in both mental health (clinical and PDRSS) and alcohol and other drug services are appropriately educated and are 'dual diagnosis capable'.

(c) Dual diagnosis capable means being able to screen for dual diagnosis; where indicated, conduct a more detailed assessment that enables the development of an integrated treatment and care plan; and be aware of and able to use agreed referral pathways within and between services in order to provide a seamless service for dual diagnosis clients.

(d) Advanced practitioners in both mental health and alcohol and other drug services have the necessary knowledge and skills to plan and deliver dual diagnosis treatment and care and provide supervision and support to other staff providing treatment and care to these clients.

98 Tools for workers to self-assess and identify steps to develop their level of skills and expertise include:

(a) CODECAT-EZ™ self-assessment tool[42] for behavioural health treatment and service provider staff;

[41] DHS. (2007). Dual diagnosis: key directions and priorities for service development. Victorian Government. Department of Human Services, Melbourne, State of Victoria. Melbourne <https://www2.health.vic.gov.au/about/publications/researchandreports/dual-diagnosis-key-directions>.

[42] Cline, C., Minkoff, K. (2019) CODECAT-EZ™ Self-assessment Tool for Behavioural Health Treatment and Service Provider Staff Working with Adults, Children, Youth and Families. ZiaPartners. <http://www.ziapartners.com/tools/codecat-ez/>

(b) Drs Minkoff and Cline's scope of practice guidelines for clinicians working with clients with co-occurring disorders[43];

(c) workforce-specific, clinician-level, dual diagnosis capability self-assessment 'Checklist' tools[44]; and

(d) Cross-sector, clinician-level, dual diagnosis capability, 'Checklist' self-assessment tool.[45]

Best practice and holistic support for consumers with co-occurring needs

99 People experiencing co-occurring mental health-substance use are not homogenous – rather they have diverse circumstances and combinations and severities of mental health and substance use concerns, which gives rise to considerable diversity in treatment needs and preferences.

100 To provide best practice holistic support for consumers with co-occurring needs, workforces deployed to address these treatment needs and preferences must be both multidisciplinary and function on an interdisciplinary team basis. Team based models provide considerably more rigor, accountability and creativity than do single provider models.

101 Members of the workforce need to have adequate qualification and skills. All workforces need to be trained to and oriented around the expectation of co-occurring mental health-substance use and have, as a core value, that responding to co-occurring mental health-substance use concerns is core business. Line management need to have developed expertise in the service's core business.

102 Mental health and AOD funding and governance should be independent and firewalled Funding should be activity based on top of a block-funded safety net to ensure equity in disadvantaged communities.

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[43] Minkoff K & Cline C.(2003), Scope of Practice Guidelines for Addiction Counselors Treating the Dually Diagnosed. Counselor. 4: 24 -27.; Minkoff K & Cline C. (2006) Scope of practice guidelines for rehabilitation professionals working with individuals with co-occurring mental health and substance disorders. Rehab Review. Summer, 22-25.; Minkoff K & Cline C. (N/D) Integrated Scope of Practice for Singly Trained Clinicians Working with Clients with Co-Occurring Disorders.

[44] Croton G. (2008) Checklist Clinician Dual Diagnosis Capability: Alcohol, Tobacco and Other Drug Worker <http://www.dualdiagnosis.org.au/home/index.php/capability-tools/checklists>; Croton G. (2008) Checklist Clinician Dual Diagnosis Capability: Clinical Mental Health Worker <http://www.dualdiagnosis.org.au/home/index.php/capability-tools/checklists>; Croton G. Rose, J. (2013) Checklist Clinician Dual Diagnosis Capability: Non-Clinical Mental Health Worker <http://www.dualdiagnosis.org.au/home/index.php/capability-tools/checklists>.

[45] Croton, G. (2018) CLINICIAN - Dual Diagnosis Capability Checklist <http://www.dualdiagnosis.org.au/home/images/Capability_Tools/Checklists/CLINICIAN_Dual_Diagnosis_Capability_Checklist.pdf>.

103 Both AOD and mental health services should be primarily community focused, and both sectors should be oriented towards vertical and horizontal integration with primary care.[46]

Constraints of cross-disciplinary and consumer-focused practice

104 There are a host of factors that constrain cross-disciplinary and consumer-focused practice. One of the most pertinent to mental health-substance use is that inadequate resources influence systems towards specialisation. Service systems often attempt to deal with overwhelming demand by defining increasingly narrow, inflexible criteria for receiving a service. Service inclusion criteria tend to function more as service exclusion criteria and are used as tools in a gatekeeping culture that has arisen from inadequate resources.

105 Inadequate resources also influence systems towards 'production line service models', where one agency is responsible for intake and another agency is responsible for treatment. Such models can work where there is great cohesion and collaboration between the agencies but they can also, too easily, become barriers to access and unwelcoming to the people receiving services. People seeking services are forced to tell their stories multiple times and to attempt to build relationships with multiple different people. Accordingly, in that context, people with mental health-substance use tend to fall through the gaps and fail to access treatment. Often, at the time of needing treatment, people are considerably disempowered and ill-equipped to navigate complicated and unwelcoming service systems.

106 The service systems do not have in place clear, agreed, coherent, current, cross-sector guidance around how they should respond to people with mental health-substance use and other complex needs. Without this central guidance workers, services and sectors are forced, in high pressure environments, to operate from their own best understandings about what constitutes optimal treatment.

107 I consider that these issues can be addressed by the following:

(a) Adjusting mental health and AOD funding to align with the known costs and burdens and potential cost savings.

(b) Developing a single integrated systemic vision around how services will respond to people with mental health-substance use and other complex needs accompanied with a stepwise plan for mental health and substance use and other systems to achieve against that vision.

[46] Thomas, P. et al. (2008) Combined horizontal and vertical integration of care: a goal of practice-based commissioning Qual Prim Care <https://www.ncbi.nlm.nih.gov/pubmed/19094418>.

Implementation of new roles to help workforces to work in an integrated way

108 I consider that peer workers are a critical yet under developed resource in services that assist people with mental health-substance use. Peer workers have critical expertise in welcoming and facilitating authentic connections, in inspiring hope, in 'offering help and support as an equal, within a defined role and in developing positive relationships that demonstrate the power and possibility of change'.[47]

109 It is exciting to observe that the rapidly developing AOD and Mental Health Lived Experience workforces are less silo bound than our current mental health and AOD systems, and that there is an overt recognition that many consumers and carers have experiences of seeking support from both mental health and AOD services.

110 As identified paragraph 94(e) above, it is recommended that each Mental Health and AOD service and sub-service appoint a senior 'dual diagnosis portfolio holder' with expertise in both mental health and substance use, and the seniority, standing capacity, and leadership skills to consider and develop the service's responses to people with mental health-substance use. Portfolio holders should be allocated time to meet and collaborate with local VDDI workers.

111 Consideration should be given to creating specific positions in each service to embed the expertise of the 'other' speciality (eg. psychiatrist or mental health nurse practitioner time being made available to AOD workers and services or addiction medicine or AOD nurse practitioner time being made available to mental health workers and services).

Joint mental health and alcohol and other drug workforce training and development

112 There is scope and opportunities for joint mental health and AOD workforce training and development in Victoria. While there can be sector-different learning needs, there are also many topics and foci of common interest (for instance, the development of trauma informed systems) and significant strengths in joint mental health and alcohol and other drug workforce training and development. The provision of joint education allows workers to build cross sector relationships which contribute to navigable treatment pathways and enhanced capacity to provide integrated treatment. It allows workers from each sector to learn more about the strengths and challenges of the other sector and how best to work with the other sector.

113 In Table 1 below, I have set out some current examples of joint mental health and alcohol and other drug (and other) workforces training and development:

[47] SHARC Webpage Accessed 22/03/2020 Self Help Addiction Resource Centre <https://www.sharc.org.au/>.

Mildura VDDI Professional Development Program. *Dual Diagnosis: The Journey, Not the destination* (**attached** to this statement and marked **GJC-12**) • A systematic 2019 professional development program for Mildura services, which supports an integrated care system approach with people with a dual diagnosis and complex care needs. • The participating agencies included Mildura Base Hospital MH, Mallee Family Care Community Managed Mental Health, Headspace Mildura, Sunraysia Community Health Drug Treatment Services, Mallee District Aboriginal Services Emotional Health & Wellbeing, Mallee Accommodation and Support Program. • 5 sessions x 1.5 hours delivery of MH-AOD-Complex Needs education, services development program. • Sessions included 1. Dual Diagnosis Intro/ local AOD landscape 2. Substance Induced Psychosis & Anti-psychotics 3. Depression & Anxiety 4. Personality disorders/ Trauma. 5. Large complex case study. • All sessions included a dual diagnosis case plan and service information session. • The final session was a complex case plan that included a scenario that included 10 participating agencies. • Compiled participant evaluations available.
2020 VDDI 2-day Dual Diagnosis Foundations Workshop • PHN requested and funded workshop with content and facilitation by rural VDDI worker • Attended by workers from a range of services & sectors including AOD counselling, AOD resi rehab, Domestic Violence, MHCSS, NDIS, Clinical Mental Health, Tertiary undergraduates. • One of the aims of the workshop was that participants would consider and document their next steps in developing their own dual diagnosis capability and would also reflect on next steps in developing their agency's dual diagnosis capability. • Participants were tasked with estimating the prevalence of people with co-occurring mental health-substance use in their sectors/services. Estimations were all higher than 50% - Domestic violence workers estimated that 80% of their referrals experienced co-occurring mental health-substance use concerns; that responding to these co-occurring concerns was perhaps the largest challenge in their work. • Compiled participant evaluations available.

Table 1: Examples of joint mental health and alcohol and other drug (and other) workforces training and development.

114 There are many ways in which joint training approaches across a whole system can be implemented. As with all training initiatives, it is critical that attention is devoted to aligning the systems and agencies with the desired changed practices before training is deployed.

115 While I do not support simply merging AOD into mental health services, I do support the sectors being braided together at policy and planning, training and systems development levels and I consider that the new Victorian Collaborative Centre for Mental Health and Wellbeing announced by the Royal Commission[48] could have its remit broadened to the Victorian Collaborative Centre for Mental Health, Substance Use and Wellbeing. The current collaborations between the Victorian Mental Health Workforce Reference Group and the Victorian AOD Workforce Reference Group has potential to, where relevant, initiate joint training approaches across the whole system.

116 The Mental Health Professional Online Development (**MHPOD**) Learning Portal is a free national eLearning platform aimed at building knowledge and understanding of mental health and mental health service delivery amongst Australia's broader mental health and social services workforce. Originally launched in 2010, MHPOD has recently undergone a significant technical and visual upgrade with the new MHPOD now available (via https://elearning.mhpod.gov.au).

117 A particular strength of the recent MHPOD changes is that the resource is now available to workers other than in mental health, including AOD workers. I consider that the importance of online learning is likely to grow in the current COVID-19 pandemic, and it is recommended that resources be allocated to support the further development of this platform. This should include a range of modules around co-occurring mental health-substance use concerns such as:

- Dual Diagnosis Overview
- Screening for AOD and MH concerns
- Integrated MH-AOD assessment
- AOD and MH treatment systems
- AOD treatment approaches overview
- Brief Interventions
- Motivational Interviewing
- Relapse Prevention
- Withdrawal
- Pharmacotherapies (Alcohol, Opiate, Nicotine)
- Amphetamine Type Substances-MH
- Alcohol-MH
- Cannabis-MH
- Prescription Drugs-MH
- Smoking-MH
- Substance Use and MH Stigma and Discrimination
- Personality- Substance Use
- Psychosis -Substance Use
- Anxiety, Depression-Substance Use

[48] State of Victoria, Royal Commission into Victoria's Mental Health System, Interim Report, Parl Paper No. 87 (2018–19) <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4215/8104/8017/Interim_Report__FINAL_.pdf >.

INTERSECTION BETWEEN PHYSICAL AND MENTAL HEALTH

118 I consider that there are reforms that could be made to improve diagnosis, treatment and support for people that have co-existing mental and physical illnesses.

119 Reforms to improve diagnosis, treatment and support for people that have co-existing mental and physical illnesses must be a high priority given the associated prevalence, systemic barriers and the gravity of the associated unwanted outcomes. There are transferrable learnings from the experiences of the VDDI that may be useful in implementing these reforms.

120 In my opinion, the domains identified in the DHHS publication *Equally well in Victoria: Physical health framework for specialist mental health services*[49] would be an ideal starting place. Two of these domains are:

(a) Support to quit or reduce smoking; and

(b) Reducing alcohol and substance use.

121 Workforce Considerations, for all domains in the abovementioned publication, include the goal to 'Develop Motivational Interviewing skills'. I strongly support this and recommend that an ongoing process to develop skills in (and a mental health sector culture aligned with the spirit of) Motivational Interviewing[50] be included in the Royal Commission's final recommendations. Motivational Interviewing is often identified as one of the most useful possible responses to people with mental health-substance use concerns.

122 The related *Equally Well 2019 Book of Proceedings*[51], which was published recently, profiles a range of systems-leading Victorian initiatives to improve diagnosis, treatment and support for people that have co-existing mental and physical illnesses.

JUSTICE AND FORENSIC

123 People with co-occurring mental health-substance use concerns are at increased risk of forensic involvement.[52] In my opinion, it appears likely that the prevalence of people with

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49 DHHS (2019) Equally well in Victoria: Physical health framework for specialist mental health services Victorian Government, Melbourne <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/equally-well-in-victoria-physical-health-framework-for-specialist-mental-health-services>.

50 Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd edition). Guilford Press.

51 Maylea C, Roberts R, Peters D, editors. (2020) Equally Well in Action: Implementing strategies to improve the physical health of people living with mental illness. Proceedings of the First National Equally Well Symposium, Charles Sturt University <https://www.equallywell.org.au/symposium-proceedings/?ct=t(EMAIL_CAMPAIGN_11_20_2018_10_42_COPY_01)>.

52 Butler, T. et al. Co-occurring mental illness and substance use disorder among Australian prisoners. Drug Alcohol Rev. 2011; 30(2): 188-94 <https://www.ncbi.nlm.nih.gov/pubmed/21355926>; Wallace, C., Mullen, P., Burgess, P. (2004). Criminal offending in Schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. Am J Psychiatry 161:4 <https://www.ncbi.nlm.nih.gov/pubmed/?term=Wallace%2C+C.%2C+Mullen%2C+P.%2C+Burgess%2C+P.+(2004).+Criminal+offending+in+Schizophrenia+over+a+25-year>.

methamphetamine related presentations contributes to the numbers of people with mental health-substance use concerns who also have forensic involvement.

124 There are outstanding agencies and workers involved in the intersection of mental health, alcohol and other drug and justice.[53] At the same time, there is a huge lack of continuity of care between the criminal justice, mental health and AOD systems and potential for better outcomes and cost savings in addressing these service system gaps. I support the views of Dr Jesse Young, who noted that:[54]

> '*Improving the health and social outcomes for justice-involved people with co-occurring mental health and substance use issues requires that community-based mental health and AOD services best placed to achieve this are well funded, appropriately trained, and better integrated with each other and with the criminal justice system. Whole of government support and coordination is needed if true continuity of care and improved health and well being of marginalised Victorians with co-occurring mental health and substance use issues is to be achieved.'*

125 As always, there are aspects of the current system that are doing well to assist people with co-occurring mental health-substance use concerns that become justice-involved, as well as other areas that can be improved to improve the care for these people.

126 Victoria's Multiple and Complex Needs Initiative (**MACNI**) is doing well to support people 16 years and older, who have been identified as having multiple and complex needs. This includes people with combinations of mental illness, substance use issues, intellectual impairment, acquired brain injury and forensic issues. I consider that MACNI has made a clear contribution to better outcomes for some people with co-occurring mental health-substance use and forensic involvement. However it is only able to provide its services to a small fraction of the numbers of people who experience complex needs.

127 I support the recommendations for improvement made in the joint VAADA-Melbourne University submission[55] to the Mental Health Royal Commission: Inequalities and inequities experienced by people with mental health and substance use issues involved in the criminal justice system.

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[53] ACSO Webpage https://www.acso.org.au/offender-rehabilitation Accessed 22/03/2020 <https://www.acso.org.au/offender-rehabilitation>.

[54] VAADA-Melbourne University (2019) Inequalities and inequities experienced by people with mental health and substance use issues involved in the criminal justice system. Submission to the Victorian Mental Health Royal Commission <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4815/6643/1257/Victorian_Alcohol_and_Drug_Association_02.pdf>.

[55] VAADA-Melbourne University (2019) Inequalities and inequities experienced by people with mental health and substance use issues involved in the criminal justice system. Submission to the Victorian Mental Health Royal Commission <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4815/6643/1257/Victorian_Alcohol_and_Drug_Association_02.pdf>.

COVID-19

Emerging changes in mental health service delivery as a consequence of COVID-19

128 I have consulted with mental health and AOD clinicians around Victoria to attempt to identify significant emerging changes in mental health service delivery as a consequence of COVID-19. The following paragraphs are based on my own knowledge and also information provided to me by these clinicians.

129 The most significant change identified has been the transition, wherever possible, from acute inpatient care to treatment in community settings. The past several months have brought extraordinarily rapid service development to allow people, who previously would have been treated in acute inpatient units, to be treated with intensive mental health community care.

130 This change has involved:

(a) The reconfiguration of care and preferred treatment approaches including consideration of changes in the allocation of workforce and other resources with possibilities of staff redeployment and bed closures.

(b) An increased recognition that, for predominantly community based treatment to work, it has to be genuinely strengths-based. For some considerable time mental health services have aspired to strengths-based approaches however actual service delivery has, essentially, been pathology-focused around a dominant medical model.

(c) A greater focus on working in partnerships with consumers and their significant others, peer workers, GPs, AOD services and relevant NGOs and NDIS providers to create a recovery plan for intensive mental health community care.

(d) Increased reliance on significant others to monitor the mental health of affected family member/s. This has contributed to a greater recognition and appreciation of the vital role played by significant others in supporting people with mental health issues.

(e) Community teams being more assertive in contacting consumers and spending more time speaking to people over the phone and via telehealth. It is possible that consumers having more regular, albeit briefer, contact with clinicians may be a more effective model than having less frequent, though longer, in-person contacts.

131 To be safe and effective in providing community care, service providers have had to rapidly develop our capacity to work in telehealth modalities. Services have had to build capacity to provide accurate, therapeutic, assessments, including risk assessments via

telehealth. Workers and services have rapidly developed our familiarity with, and skills in, using a range of telehealth platforms and approaches. Assessments have had to broaden to include more psychosocial dimensions around the person's responses to the strains and changes associated with COVID-19. By now, most initial assessments include an exploration of the person's access to, comfort with and capacity to utilise telehealth options. Working to increase a client's access to telehealth has now become a routine part of practice.

132 Services and clinicians have been challenged to identify and deploy effective therapeutic interventions via telehealth, and to develop strategies to meet the needs of significant others whilst working in telehealth modalities. A current challenge is how we can develop our recognition of domestic violence, especially given reports of increased domestic violence linked with COVID-19 isolation. There are reports that client worker encounters tend to be superficial in the initial stages of moving to telehealth. But now, as workers and clients have become familiar with telehealth, therapeutic encounters have again tended to have more depth.

133 Many mental health and AOD clients have now indicated a strong preference for telehealth support in their own homes rather than having to attend centres. This is important, but it is too early to know if this is a universal preference.

134 Rural and regional services have reported a more 'level playing field' with their metropolitan counterparts now that most planning meetings are conducted on-line. While all Victorian services have become interested in potential savings and efficiencies associated with conducting more client-facing work online, the potential savings are greatest in rural services. Rural services have always had to contend with the time and costs associated with providing services in geographically dispersed areas, whilst operating on the same funding formulas as metropolitan services.

135 Acute mental health inpatient care is also in rapid change as a result of the social distancing necessitated by COVID-19. Inpatient units have had to impose restrictions in order to function safely in COVID-19 environments. Measures to minimise the risk of transmission have included reviewing compliance procedures for locked bed based acute units and in some cases transitioning to a locked unit, restricting weekend or other leave from the acute unit and imposing restrictions on visitors. One service now requires visitors to provide their mobile number upon arrival so that visitors can be sent a text message after one hour indicating they should end their visit. It has been reported that, to reduce risks of contamination, some inpatient units have evolved an internal 'pod' structure – units within units – with reported positive client feedback around it being a more predictable environment.

136 There are reports that social distancing has meant acute inpatient staff are spending more time away from central staff workstations interacting with clients, with positive patient and staff feedback. In some units, temporary restrictions on leave is reported to have led to a decrease in substance use, including tobacco use, and a greater uptake of nicotine replacement therapies. Reduced substance use is perceived to have contributed to a safer environment with the reduction of flash points over substance use and the need for staff to police leave provisions.

137 Reported changes, particularly related to co-occurring mental health and substance use concerns, include:

(a) Reduced access to face to face AOD services has increased the demand for mental health services to provide integrated MH-AOD treatment and support.

(b) Increased use of alcohol in the general community, which includes increased use amongst people who receive mental health services. Additionally, changes in substance use patterns, as a result of disrupted supply chains, may have prompted an increase in alcohol consumption amongst some people with mental health-substance use. These factors have increased the demand for mental health services to develop their recognition of, and responses to, people with co-occurring alcohol use issues. One service reports that these factors have brought to the fore the need for more supported pathways into AOD residential facilities for people with serious mental illness. They contend that, to successfully access residential rehabilitation AOD services, some people with serious mental illness require more support than the self-directed, self-motivated approach required of people in traditional AOD models.

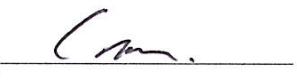
138 Whole of community crises tend to have the most impact on the most disadvantaged members of our society. People who are already experiencing severe disadvantage as a result of their co-occurring mental health-substance use and other complex needs may well be disproportionally impacted by COVID-19, including by being more at risk of contracting the disease. Foremost amongst these groups are likely to be people experiencing homelessness as a result of their multiple concerns.

139 I am optimistic that many of the changes that have arisen from COVID-19 are positive and will be of enduring benefit to consumers and significant others. Since deinstitutionalisation there has been widespread agreement that mental health services should be delivered predominantly in the community. This recognition has sat uneasily with the tendency, as demand has grown, for scarce resources to be increasingly devoted to inpatient services at the expense of services in the community.

140 Increased community acceptance of, and skills in engaging in, telehealth offers particular advantages to regional and remote communities and suggests further developments that

could build on recent gains. The Victorian public mental health services psychiatry workforce is heavily concentrated in metropolitan areas. As telehealth continues to evolve into an accepted, routine means of service delivery we should see the development of mechanisms by which communities, clients and clinicians in rural and regional remote areas can benefit from more equitable access to psychiatrists.

141 It appears that, as a consequence of COVID-19, mental health services are, at last, evolving to be truly community-based. The Royal Commission has an unprecedented opportunity to support and strengthen that evolution by reconfiguring mental health services governance and funding to be independent and predominantly community-based. My view is that this is a necessary precondition to developing mental health services that are truly effective in meeting the range, depth and quantum of the mental health treatment needs of the Victorian community.

sign here ► 

print name Gary James Croton

date 21 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-1

This is the attachment marked '**GJC-1**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

CURRICULUM VITAE

GARY JAMES CROTON

RN (MH) MHSc (AOD)

Clinical Nurse Consultant, Victorian Dual Diagnosis Initiative (Auspice: Albury Wodonga Health)

DOB: 29/09/56

CITIZENSHIP: Australian

QUALIFICATIONS

Registered Nurse (Mental Health) - Larundel Hospital - 1980

Master Health Science (Alcohol and Other Drug) - Newcastle University - 2004

APPOINTMENTS

1998 - Current	Clinical Nurse Consultant- Hume Border Victorian Dual Diagnosis Initiative- Albury Wodonga Health
1993 - 1998	Community Psychiatric Nurse, Northeast Health Wangaratta
1992 - 1993	Psychiatric Nurse- London, United Kingdom
1982 - 1991	Deputy Charge Nurse -Mayday Hills Psychiatric Hospital, Beechworth
1982 - 1983	Deputy Charge Nurse - Royal Park Hospital
1981	Community Nurse- Larundel
1977 -1980	Student Mental Health Nurse -Larundel Psychiatric Hospital
1975 - 1977	Ward Assistant - Bundoora Repatriation Hospital

PUBLICATIONS

- Croton, G. (2004). Co-occurring mental health and substance use disorders: an investigation of service system modifications and initiatives designed to provide an integrated treatment response. State of Victoria: Victorian Travelling Fellowship.
- Croton, G. (2005) Co-occurring substance use disorders: implications for psychiatric disability services and workers. New Paradigm VICSERV
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- Croton, G. (2010) An Australian rural service systems' journey toward systemic mental health-substance use capability. Chapter in Developing Services in Mental Health-Substance Use (Book 2 in the 6-book Mental Health-Substance Use Book Series) Editor: David B Cooper. Radcliffe Publishing Ltd, Oxford, UK
- Fahy P, Croton G, Voogt S. (2010) Embedding routine alcohol screening and brief interventions in a rural general hospital. Drug and Alcohol Review. June 2010
- Croton G., Foster. G. (2019). Victoria's strategies towards integrated service delivery for people with mental health-substance use concerns. New Paradigm

PROFESSIONAL ACTIVITIES

Since 1998 I have contributed to a number of committees at state and regional levels. At state level these have included Ministerial Advisory Groups and Mental Health Workforce Reference Groups. I have been a member of the VDDI Leadership Group from 2007 to current and the VDDI Rural Forum from 2003 to current. At regional levels I have been a member of the Hume Region MACNI panel since its inception. I developed and administer the www.dualdiagnosis.org.au website and I have created a range of tools to assist workers and services in developing their level of dual diagnosis capability. I have been a peer reviewer for a number of journals including the Medical Journal of Australia and the Mental Health & Substance Use: Dual Diagnosis' journal. In 2003/04 I was awarded a Victorian Travelling Fellowship to investigate integrated treatment response to co-occurring mental health and substance use disorders. Over a 6-week period I conducted interviews with key informants in 22 site visits in the UK, USA and New Zealand. In 2008 I was the recipient of the Victorian DHS State Nursing Excellence Award in the category of Mental Health and Drugs Nursing.

Royal Commission into
Victoria's Mental Health System

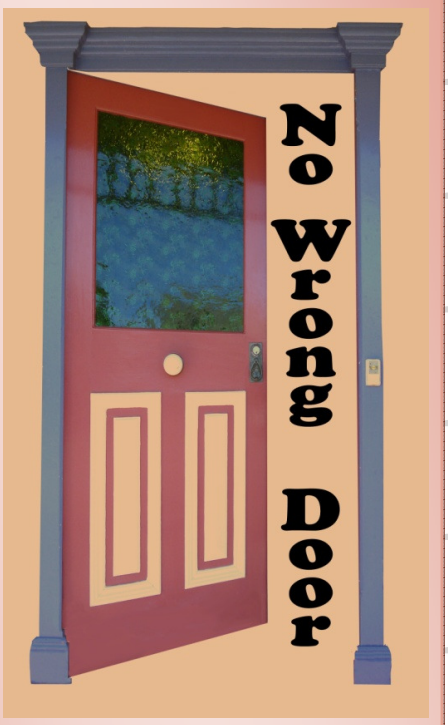
ATTACHMENT GJC-2

This is the attachment marked '**GJC-2**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

No Wrong Door 2

Integrated Dual Diagnosis Protocol 2010

Hume Region



www.nowrongdoor.org.au

Working collaboratively towards a No Wrong Door service system in the Hume Region

An initiative of Ovens & King Community Health Service in collaboration with regional partners.

OVENS & KING
Community Health Service

No Wrong Door2 – Integrated Dual Diagnosis Protocol, 2010.

Published by: Ovens & King Community Health Service, 2010

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Available for download on: www.nowrongdoor.org.au

Table of Contents

Acknowledgements

No Wrong Door Integrated Dual Diagnosis Protocol, 2010 adheres to the Melbourne Charter for promoting mental health & preventing mental and behaviour disorders.

This document has been developed in consultation with partner agencies and their workers within the Hume Health region. It has evolved through significant consultation with regional consumer & carer groups and organisations whom refer to or work within mental health & drug and alcohol services. A total of 14 consumer & carer consultation sessions occurred across the Hume Region with 43 people participating and 307 surveys were distributed with 45 returns. In addition to the consumer & carer consultations, a further 15 consultations were conducted with member organisations and their staff, with a total of 152 participants. The 80 organisations on the email distribution list all received the health professional's survey, with 33 returns.

This project builds upon the Central Hume Primary Care Partnership, Paving the Way Inter-agency Protocol, launched in November 2006.

This document is a guidebook to agencies and their staff in relation to how to deliver a No Wrong Door service and how to work with neighbouring agencies within a seamless and integrated service system.

I would like to extend particular thanks to all NWD participating agencies, Kaylene Sealey - NWD2 Consumer Consultant, Department of Health and Ageing, Department of Health - Victoria, East & West Dual Diagnosis Groups and members, Darren Bate – Gateway Community Health, Gary Croton – Northeast Health Wangaratta, Donald Currie – Ovens & King Community Health Service and Gail Ward – Victorian Alcohol and Drug Association.

Renee Williams

Project Manager & Author

OVENS & KING
Community Health Service

Background & Introduction

Background…

… "from little things big things grow" …

Dual Diagnosis is the co-occurrence of both mental illness and substance misuse. Individuals presenting to agencies with dual diagnosis are the expectation, not the exception. Individuals experiencing dual diagnosis problems and their families may have multiple and complex needs that require a high level of responsiveness and a strong need for collaboration across all services, levels of care and throughout all phases of clinical care including early intervention, engagement, screening, assessment, treatment, rehabilitation, discharge planning and aftercare. People with dual diagnosis are the core business of mental health and alcohol and other drug services. Effective services for these people based on their individual needs, rely on the provision of comprehensive, holistic, person (and their family) centred interventions. (Queensland Government, September 2008).

In 2005 – 2006, services in the Central Hume Primary Care Partnership region identified the need for the development of guidelines for practice between all local agencies who deliver mental health and/or drug & alcohol services to the community. Over the years, various protocols had been developed between one agency and another, but none identified key elements across all agencies in the one protocol document. Consequently there were many formal documents between services, which created a mesh of protocols that were inconsistent from agency to agency.

Ovens & King Community Health Service initiated "Paving the Way – No Wrong Door project" in 2005 in response to the challenges of building sustainable relationships across the service sector. This initial project provided an endorsed platform upon which eleven participating organisations committed to embed a cultural shift through ongoing staff support, regular interagency forums and opportunities for layers of professional development. (Paving the Way, No Wrong Door Interagence Protocol., 2006)

This protocol aimed to clarify roles and responsibilities within the referral processes and pathways because it was recognised that while most people had great intentions to work collaboratively, the road was neither clearly defined, nor without potholes.

No Wrong Door (NWD) is based on the principle that every door in the health care system should be the 'right' door. Each provider within the system has a responsibility to address the range of client needs wherever and whenever a client presents for care. This approach provides people with, or links them to appropriate services regardless of where or how they enter the system.

Following the launch of the No Wrong Door protocol in 2006, considerable interest grew from other agencies and other areas of the region. Due to the interest raised from the initial project, 2007 saw many varied agencies come together as a working group to build a larger project brief and investigate funding options and opportunities to enable the expansion of No Wrong Door across the Hume Region.

Supported by this working group, Ovens & King Community Health Service successfully submitted a project application to Department of Health & Ageing, under the "Improved Services for People with Drug & Alcohol Problems and Mental Illness measure—Capacity Building Grants". The three year funding (2008-2010) received will enable project expansion and development of a protocol for the entire Hume health region, (incorporating all health and welfare agencies) in the No Wrong Door 2 project.

The protocol acknowledges that Mental Health & Alcohol, Tobacco and Other Drug problems impact not only on the consumer presenting, but also on their family members, carers and dependent children. Workers will remain cognisant of the support needs of carers, families and dependents and will actively work to engage services relevant to their needs also.

How to use this manual….

This manual has been designed to be a document that will guide practice. It is available for download from the No Wrong Door website (www.nowrongdoor.org.au) and compliments the staff induction training which is also available on the website.

This manual focuses on care provided by:

- Mental health services
- Alcohol, tobacco & other drug services
- Psychiatric disability & support services
- Primary care (Divisions of General Practice)
- Community health services
- Disability services
- Youth & Family services
- Department of Education
- Housing services
- Other health & welfare targeted services

It is endorsed by Department of Health, State and Regional office as well as Department of Health & Ageing.

This manual is an agreed set of protocols in which signatory agencies will work together in relation to provision of an integrated service approach for people with dual diagnosis. It governs the following areas:

- Providing a No Wrong Door service system
- Entry & Referral
- Intake and Initial Needs Identification
- Assessment & Screening
- Care Coordination
- Crisis Management
- Communication & Consent
- Discharge (preparation, transition and actual)
- Secondary consultation

It also outlines how the service system in the Hume Region commits to:

- Workforce Capacity building, education & training
- Dispute resolution processes
- Consumer & carer engagement

The manual is chaptered under the above headings. Each area provides specific definitions and then recommendations (key agency & personnel requirements) for agencies to adopt. To ease adoption of these recommendations, a related policy template follows each chapter. Agencies can choose to adopt the entire policy or can integrate the wording within their own agency's individual template.

The appendices are examples of readily available tools for agency use.

The No Wrong Door 2 Protocol – Introduction...

The No Wrong Door2 protocol document operates on the premise that all member agency staff are familiar with both state and federal policy documents relating to Dual Diagnosis / Co-morbidities.

Department of Human Services, Dual Diagnosis Key Directions and Priorities for Service Development Document, 2007.

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 services
2. Staff in mental health and alcohol and other drug services are '*dual diagnosis capable*', that is, have the knowledge and skills necessary to identify and respond appropriately to dual diagnosis clients and Advance practitioners are able to provide integrated assessment, treatment and recovery.
3. Specialist mental health and alcohol and other drug services establish effective partnerships and agreed mechanisms that support integrated assessment, treatment and recovery.

   Develop and maintain collaborative service relationships that result in a 'no wrong door' outcome for dual diagnosis clients seeking help from either service, by agreeing on regularly monitored, as part of quality assurance, referral pathways within and between services. Establish functional relationships with other service sectors that provide acute physical health care, housing, education and employment.
4. Outcomes and service responsiveness for dual diagnosis clients are monitored and regularly reviewed.

   Systematic collection of dual diagnosis service use and client outcome data is essential to service planning, development and evaluation at both local and central levels.
5. Consumers and carers are involved in the planning and evaluation of service responses.

   The involvement of clients, families and carers in the planning, review and ongoing development of services is a requirement of quality service provision.

Key Directions document and No Wrong Door: Partnerships between specialist mental health and alcohol and other drug services, that deliver operationally useful relationships at the local level, underpin continuity of care and integrated treatment and recovery. This requires the development of mechanisms for clear communication between sectors. Shared understandings about the needs of the target group, how best to address them and the roles that services in each sector will play, are essential requirements underpinning effective collaboration and protocol development. (Dual diagnosis, key directions and priorities for service development, 2007).

The Melbourne Charter for Promoting Mental Health and Preventing Mental & Behavioural Disorders, 2009.

The Melbourne Charter asserts that mental health and wellbeing are:

- an indivisible part of general health;
- essential for the wellbeing and optimal functioning of individuals, families, communities and societies;
- a fundamental right of every human being, without discrimination.

The No Wrong Door 2 Protocol – Introduction...

The Melbourne Charter affirms that mental health and wellbeing are:

- of universal relevance;
- most threatened by poor and unequal living conditions, conflict and violence; and
- a key indicator of a nation's social and economic development.

The Melbourne Charter believes that mental health and wellbeing are:

- everybody's concern and responsibility;
- best achieved in equitable, just and non-violent societies; and
- advanced through respectful, participatory means where culture and cultural heritage and diversity
- is acknowledged and valued.

The Melbourne Charter identifies principles and actions that governments, communities, organisations and individuals can take to influence the interconnecting social, economic, cultural, environmental and personal factors that influence mental health and wellbeing.[1]

Because Mental Health Matters, Victorian Mental Health Reform Strategy & Implementation Plan: 2009-2019:

The No Wrong Door protocol compliments the reform package via strengthening planning, governance and shared responsibility for service delivery and the following key areas:
:

- Reform Area 2: Early in life – Improved early identification and mental health outcomes for children and young people with a mental illness
- Reform Area 3: Pathways to care – Right time – Right place and No Wrong Door service delivery
- Reform Area 4: Specialist Care – Dual Diagnosis capability
- Reform Area 6: Reducing Inequality – Dual Diagnosis service provision
- Reform Area 7: Workforce & Innovation – Building system capacity & supporting innovative projects.
- Reform Area 8: Partnerships and accountability – No Wrong Door multi-agency protocol document.

Department of Health & Ageing: National Comorbidity Initiative

The Initiative aims to improve service co-ordination and treatment outcomes for people with coexisting mental health and substance use disorders and focuses on the following priority areas.

- raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models;
- providing support to general practitioners (GPs) and other health workers to improve treatment outcomes;
- facilitating and improving access to resources and information for consumers; and
- Improving data systems and collection methods within the mental health and alcohol and other

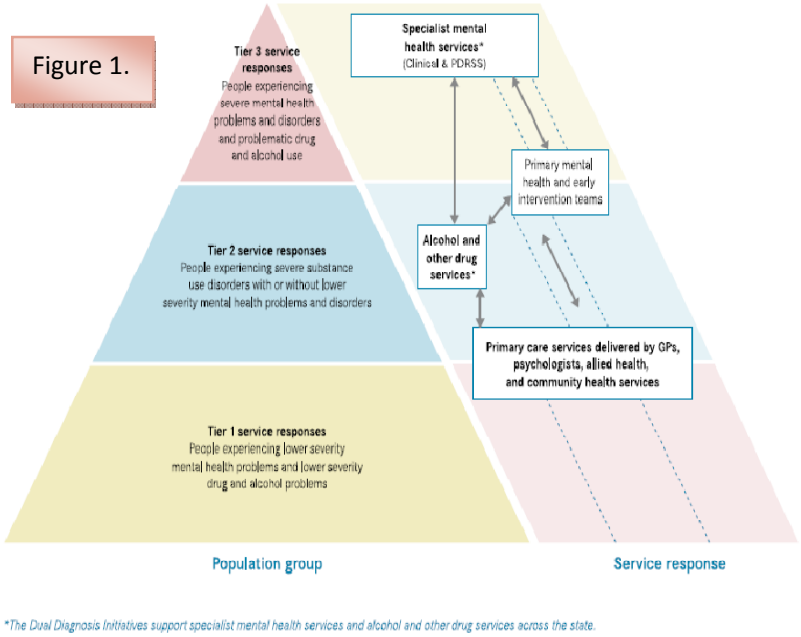
[1] The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders, 2009. VicHealth.

Systematic Response to Dual Diagnosis...

A Three level Schema to guide responses to Mental Health & Alcohol and other Drug issues

Figure 1 represents a 3 level schema for service response to mental health and drug & alcohol presentations. The schema is provided to promote clearer understanding about response expectations of the service system, whilst being mindful of integrated care and shared care roles between services. (Dual Diagnosis, Key directions and priorities for service development, 2007)

Figure 1.



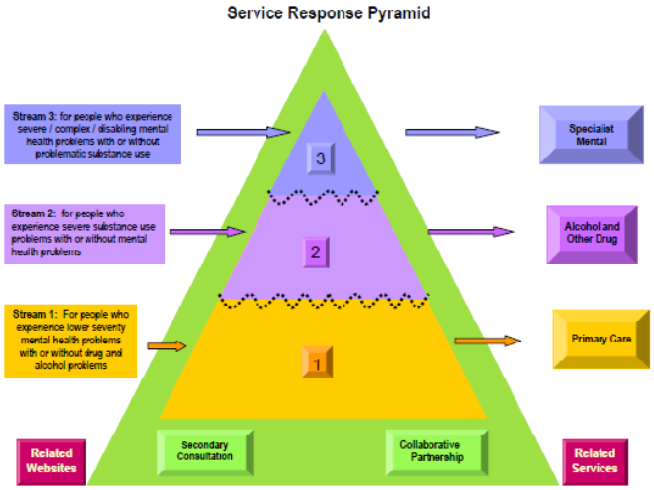


Figure 2.

Figure 2 represents the overlay of the 3 level schema to the No Wrong Door protocol , the Hume Region Service Pathways tool and associated website: www.nowrongdoor.org.au .

Systematic Response to Dual Diagnosis...continued

Stream 1: For people who experience difficulty navigating stressful life circumstances or with symptoms of Depression and / or Anxiety: eg: through bereavement, trauma, relationship difficulties, questioning identity and; with or without concurrent problematic substance use.

A large group of people in the community with the most common problems present different challenges for service delivery. This group requires highly accessible interventions that focus particularly on anxiety, depression, and/or problematic alcohol, nicotine and cannabis use.

Primary care services (Community Health / General Practice etc) are assisted by both Primary Mental Health and Early Intervention Teams from the specialist Mental Health Sector and Drug and Alcohol Services to provide professional development as well as secondary and tertiary consultation.

Stream 2: For people who experience severe substance use problems with or without mental health problems of lesser severity and complexity

The main service response will be provided by staff with high level drug & alcohol skills and training who are also *dual diagnosis capable.* People treated by this sector experience a significant incidence of relapse (in both mental health problems and drug & alcohol use) and services incorporate some long term psychosocial interventions in order to assist people overcome addictions.

People in this group may have significant mental health problems associated with their drug and alcohol use. These can be managed effectively with consultation from, and in some instances transfer to, specialist mental health services. Short term shared care arrangements may be put in place to respond to crises. Poly substance use increases the complexity of presentations. Part of the function of clinicians in Drug and Alcohol Services is to provide support through co-consultation, secondary consultation and training and education to the Stream 1 services.

Stream 3: For people who experience severe mental health problems with or without problematic substance use

People with serious and complex problems, which include a severe mental illness with or without problematic substance use, require an integrated response that takes account of all aspects of their illness.

Services should bring together the best in well researched models of primary care, psychiatry, rehabilitation and addiction medicine. A blend of integrated / collaborative treatment will frequently be necessary to ensure the most effective possible response to people with multiple complex needs. (Dual Diagnosis, Key directions and priorities for service development, 2007)

A No Wrong Door Service System

What is a No Wrong Door Service System?

No Wrong Door (NWD) is based on the principle that every door in the health care system should be the 'right' door. People are welcomed and treated with a non-judgemental approach. Each provider within the system has a responsibility to address the range of client needs wherever and whenever a client presents for care. This approach provides people with, or links them to appropriate services regardless of where they enter the system. NWD acknowledges that it is the responsibility of the engaged health service to navigate and negotiate the web of health providers on behalf of the client and ensure seamless service delivery between agency to agency. NWD supports enhanced dual diagnosis capability and integrated assessment and care.

Dual Diagnosis: The term dual diagnosis is used to describe when someone has co-occurring mental health and a substance use disorders.

Dual Diagnosis and No Wrong Door: Mental health and Alcohol and Other Drug services implement a 'no wrong door' approach for people who present with co-occurring conditions; all are eligible recipients of coordinated service delivery using an integrated approach with triage (intake), assessment, care coordination and treatment. The presence of either a Mental Health or Alcohol and Other Drug condition does not constitute criteria for service exclusion.

Service Coordination: stems from the Better Access to Services Policy and Operational Framework (DHS, 2001). Service Coordination is a statewide approach to align practices, processes, protocols and systems through functional integration. Achieving functional integration enables organisations to remain independent of each other as entities and still work in a cohesive and coordinated way so that consumers experience a seamless and integrated response. (Department of Human Services, 2009). No Wrong Door compliments and builds upon the Service Coordination principles; whereby service coordination places consumers, and their families, at the centre of service delivery (client & family centred service), to ensure that they have access to services they collectively need, opportunities for early intervention and improved health outcomes.

Integrated care entails the coordination of interactions and relationships within and across services in order to secure the best possible service system response for a person with a dual diagnosis, and does not imply the structural realignment of service systems. At the service level, a core feature of integrated care is the provision of mental health and substance use services in a single setting wherever possible, and if not possible, then linkage with services via agreed clinical pathways should occur. At the systems level, integrated care entails a focus on the provision of holistic and coordinated care, liaison and advice, and the development of clinical pathways between and across a range of agencies. As such, this is a prerequisite for the delivery of effective treatment for people with dual diagnosis.

What is a No Wrong Door Service System...continued?

Key Agency Recommendations:

- Signage to articulate that agency complies with a No Wrong Door philosophy and process.
- Agency policy, procedure and strategic plan provides direction in relation to provision of No Wrong Door service delivery and responding to dual diagnosis
- Quality Improvement Activity annually conducted: Dual Diagnosis Agency capability audit / checklist [2].
- Agency support ongoing staff education and development (articulated in strategic plan)
- Staff orientation manual links to No Wrong Door protocol and website to ensure participation in NWD induction training.
- Staff appraisal systems link to No Wrong Door protocol compliance and Dual Diagnosis capability (Staff complete Dual Diagnosis clinician checklist annually[3]).
- The Hume Region key consultative groups[4] will support the roll out of this initiative by providing opportunity to further develop staff and organisation capacity to better respond to this target group.

Vignette:

Ben is a 28-year-old separated father of two young children living in the rural township of Anytown. He is currently employed in a local factory. Ben has a past history with Anytown Community Health Service, and has been seen by the Victims Assistance & Counselling Program and generalist counselling team in the past. This is his 3rd presentation in two years. Ben is experiencing anxiety with depressive symptoms and has been drinking quite heavily over the past three months. He has comes in to Anytown Community Health Service for help.

No Wrong Door:

When Ben arrives at Anytown Community Health Service, and notices signage that states that the agency operates under a No Wrong Door philosophy. He will expect to be welcomed to the service without prejudice or judgement regardless of his presentation. Ben is shown to a comfortable and safe waiting room and is seen by a member of the team relatively soon.

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[2] Checklist: Dual Diagnosis Capability: Agency / Service Level. Croton, G. 2009
[3] Checklist: Dual Diagnosis Capability: Clinical Mental Health & Alcohol & Other Drug Clinicians. Croton, G. 2009
[4] Eastern Hume Dual Diagnosis Group, West Hume Dual Diagnosis Group, Dual Diagnosis Hume Education Collaborative

0.0 POLICY TITLE: No Wrong Door Service System

An integrated approach to health care.

OVERVIEW:

Introduction: All clients presenting to services are welcomed. A no wrong door approach provides people with, or links them to, appropriate service regardless of where they enter the system of care. Services must be accessible from multiple points of entry and be perceived as welcoming, caring and accepting by the consumer. This principle commits all services to respond to the individual's stated and assessed needs through either direct service or linkage to appropriate programs, as opposed to sending a person from one agency (or department) to another. It is premise on the principle that every door in the health care system should be the right door.[5] The experience for clients should be one of being welcomed, feeling hopeful, and being heard.

Anytown Health Service: operates under the principle that every door in the health care system should be the "right" door. Each team within the organisation has a responsibility to address the range of client needs wherever and whenever a client presents for care. When clients present to a team that is not qualified to provide a specific assessment or treatment, this team should facilitate referral and connect the client to the appropriate, team or other facility. Follow-up by staff will ensure that clients receive appropriate and timely care.

Anytown AOD / MH Team: operates under a "no wrong door" philosophy. It formally recognises that individuals with a dual diagnosis may enter a range of community service sites; that they are a high priority for engagement and that proactive efforts are necessary to welcome them into treatment. Each individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services.[6]

Dual Diagnosis: The term **dual diagnosis** is used to describe the co-morbid condition of a person considered to be living with a mental illness and a substance abuse problem.

[5] (QLD health policy, 2008).
[6] (Croton, G, 2006. CSAT 2000a).

PROCEDURE

2.1 Anytown Health Service will welcome all clients who enter the service and will identify all client needs and address these needs in an integrated fashion.

2.2 Anytown Health Service will provide a seamless service internally and externally with multi-providers.

2.3 Anytown Health Service will ensure all staff have access to service pathways and up to date service information to enable accurate, timely and responsive referral and linkages to other agencies
www.connectingcare.com
www.nowrongdoor.com

2.4 Anytown Health Service acknowledges its responsibility to navigate and negotiate the health sector services on behalf of the client and ensure seamless service delivery from agency to agency.

2.5 Anytown Health Service will work actively towards developing processes and practices which enhance the uptake of functional integration internally, between programs and externally, with other health providers. Functional integration enables Anytown Health Service to remain independent, but work in a cohesive and coordinated way for the benefit of the client.

2.6 New and current staff are required to participate in No Wrong Door training, which will be linked to staff appraisal systems and orientation & induction programs.

2.7 Anytown Health Service will conduct an annual service audit in relation to its compliance and uptake of No Wrong Door practices.

2.8 Anytown Health Service will practice culturally and linguistically diverse friendly practices

Entry & Referral

Entry & Referral (Initial Contact) - Walking in the door...

Entry: is the point a consumer or carer makes his or her first contact with the service system.

Entry into the service system should be one of a No Wrong Door experience. It is based on the principle that every door in the health care system should be the 'right' door. People are welcomed and treated with a non-judgemental approach. Each provider within the system has a responsibility to address the range of client needs wherever and whenever a client presents for care.[7]

Referral:

Referral describes the transmission of personal and / or health information relating to an individual, from one service provider to another service provider. This is conducted with the individual's consent and for the purpose of further assessment, care or treatment. Referral may be made from any part of service delivery. [8] For those under 18 years, consent can be provided by a parent or guardian.

Self Referral: is where a consumer takes responsibility for contacting another service provider to make a referral on their own behalf.

Supported referral: is where a carer / friend / relative refers a consumer and acts on their behalf (with consent).

Assisted active referral: service providers within the service system make a referral on behalf of a consumer.

Key Agency Recommendations:

- Reception (counter) staff are trained in No Wrong Door service delivery & philosophy
- There is clear expectation that the agency will help whether they are the correct agency or not
- The environment should provide safety and be welcoming
- Health information should be readily available for consumers to access freely
- Where possible, a private place or personal space away from the waiting room should be provided for consumers who may be in crisis or feel unsafe.
- Attention and support should be given to any accompanying children, family or carers.

[7] Sealey. K, 2009
[8] Good Practice Guide, 2009

Entry & Referral (Initial Contact) - Walking in the door…continued

Assisted active referral includes:

- initial verbal contact with the receiving agency,
- discussion about referral requirements
- anticipated appointment time (waiting list considerations)
- appropriate documentation forwarded (SCTT[9] or VSRF [10] from GPs)
- feedback to referring agency

Managing Waiting Lists:

For self referrals, the intake worker at the receiving agency is responsible for monitoring and supporting clients placed on any internal waiting list.

For assisted active referrals, the referring agency is responsible for monitoring and supporting the client until the receiving agency is able to transfer care. The referring agency should ascertain length of waiting time and ensure strategies are employed to monitor the client whilst they are waiting to be seen.

Vignette:

Referral & Entry:

Ben is a self-referral who attends the reception counter at Anytown Community Health Service. The reception staff is able to quickly identify that Ben is upset and intoxicated by asking a couple of key questions. The staff believes that Ben needs to talk to someone today. The reception staff contacts the intake worker, who can either:

1. Provide Ben with reassurance and basic information with an alternative appointment for tomorrow when Bens level of intoxication has reduced. Ben would also be provided with name and contact number of an identified support person should he need assistance during this time.

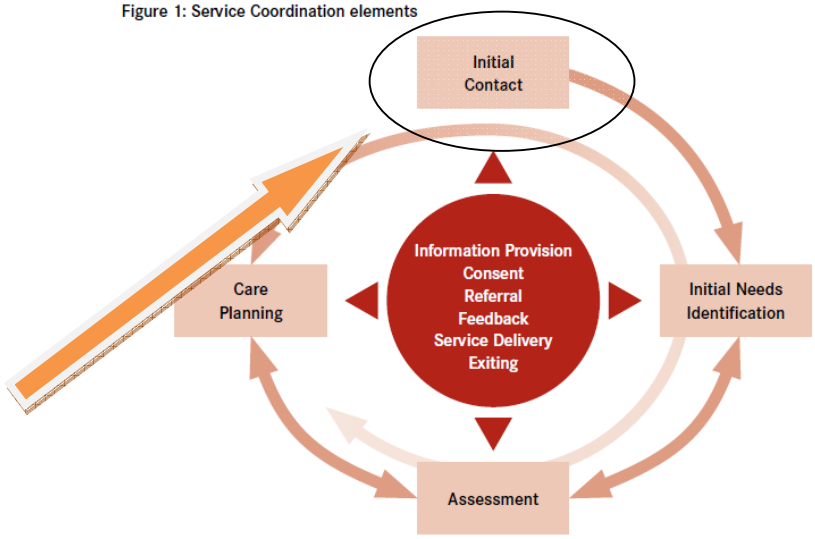
OR

2. Provide a basic entry assessment, if the level of intoxication is low. The intake worker will be able to determine all of Ben's concerns and prioritise his needs. Ben is provided with relative information about the service, his rights and responsibilities and options.

[9] Service Coordination Tool Template – Appendices
[10] Victorian Statewide Referral Form

0.0 POLICY TITLE: Initial Contact - Entry & Referral

Figure 1: Service Coordination elements



1. OVERVIEW:

Entry: is the point a consumer or carer makes his or her first contact with Anytown Health Service.

Entry should be one of a No Wrong Door experience.

Referral (in and out):

Describes the transmission of personal and / or health information relating to an individual, from one service provider to another service provider. This is conducted with the individual's consent and for the purpose of further assessment, care or treatment. Referral may be made from any part of service delivery.[11]

- ***Self Referral:*** is where a consumer takes responsibility for contacting another service provider to make a referral on their own behalf.
-
- ***Supported referral:*** is where a carer / friend / relative refers a consumer and acts on their behalf (with consent).
-
- ***Assisted active referral:*** service providers within the service system make a referral on behalf of a consumer.

[11] Good Practice Guide, 2009

2. PROCEDURE

2.1 Anytown Health Service will welcome all clients who enter the service and will identify all client needs and address these needs in an integrated fashion.

2.2 Anytown Health Service will provide a seamless service internally and externally with multi-providers.

2.3 Anytown Health Service reception (counter) staff are trained in No Wrong Door service delivery & philosophy

2.4 Anytown Health Service will endeavour to ensure that the waiting room environment should provide safety and be welcoming

2.5 Health information will be readily available for consumers to access freely, both in the waiting area and as a result of consultations with staff.

2.6 Where possible, a private place or personal space away from the waiting room will be provided for consumers who may be in crisis or feel unsafe.

2.7 The intake worker will provide intake and initial needs identification for consumers who attend Anytown Health Service.

2.8 Assisted active referral includes:

- initial verbal contact with the receiving agency,
- discussion about referral requirements
- anticipated appointment time (waiting list considerations)
- appropriate documentation forwarded (SCTT[12] or VSRF [13] from GPs)
- feedback to referring agency

[12] Service Coordination Tool Template:
- Appendix 1. consumer consent
- Appendix 2 consumer information
- Appendix 3 summary and referral
- Appendix 4 confidential referral cover sheet & acknowledgement

[13] Victorian Statewide Referral Form (situated on GP computer packages)

Intake & Initial Needs Identification

Intake & Initial Needs Identification - Starting the ball rolling…

Intake is also commonly known as "triage". Intake is the initial meeting with the client (via phone or face to face) during which the worker gathers sufficient information to address the client's immediate needs to encourage his/her engagement and retention in services. Intake provides initial & brief screening and assessment for the purpose of appropriate triage internally and/or referral externally. Relative data should also be collect about any dependent children, carers and family members and their immediate needs.

The process prioritises referrals based on presenting issues, risk assessment and recommended response time. The key outcome of intake is that clients and the broader community are able to access timely and efficient services whether internally or externally based on their presenting problems and accompanying risk factors.

An assessment should also include the impact (psychologically, physically and protective factors) of the presenting mental health issues or substance use issues have on any dependent children, carer and family members. This will ensure appropriate associated services can be engaged simultaneously to assist where required, and therefore maximising emotional wellbeing and support for all those involved.

Role of the worker:

- ✓ Respond to clients and the broader community in a timely and efficient manner.
- ✓ Develop equitable intake process for clients (dual diagnosis friendly)
- ✓ Determine the need for counselling or service provision based on the client's level of priority for service utilising the Counselling priority tool. [14]
- ✓ Provide appropriate support to clients whilst on waiting lists.
- ✓ Provide the gateway for agency contact and referral pathways
- ✓ Client registration and health record maintenance (SCTT)

[14] Department of Health, Victoria. Community health priority tools, 2009.

Intake - Starting the ball rolling...continued

Key Agency Recommendations:

- Intake staff are trained in basic level dual diagnosis screening & assessment and use supported, evidence based tools to perform this task. Service Coordination Tools such as:[15]
  - Health Behaviours (asks about alcohol and smoking)
  - Psychosocial Profile (screens for anxiety & depression) using the K10
  - Initial Needs Identification (INI) broad shallow screening for underlying & presenting issue.
- Alternate tools may be used by specialist services (eg: Mental Health Triage tool).
- In addition to these tools:
  - Child/ren & family name, and date of birth
  - Parental Status, current active caring role, client of partner pregnancy
  - Legal custody / contact matters
  - Risk concerns
- It is recognised that specialist mental health services use agency specific intake documentation that relates more uniquely to the intake information required.
- Substance use will not be used as a reason for exclusion from a service
- Clients are supported through the referral process. This includes support whilst held on waiting lists until fully engaged with the connecting agency / program. (eg: phone support, emergency contact numbers given, crisis management plan).
- Referral pathway options are accessible from the Intake Workers desktop: www.connectingcare.com or www.nowrongdoor.org.au

Vignette:

Intake & Initial needs identification

The Intake worker welcomes Ben and conducts a basic assessment and initial needs identification using PCP SCTT tools. Utilising the priority tools, it was ascertained that Ben was a priority 3, placed on the waiting list and advised that the Drug & Alcohol team would be in contact in the near future. Ben will be supported by the Intake Worker via phone contact whilst on the waiting list.

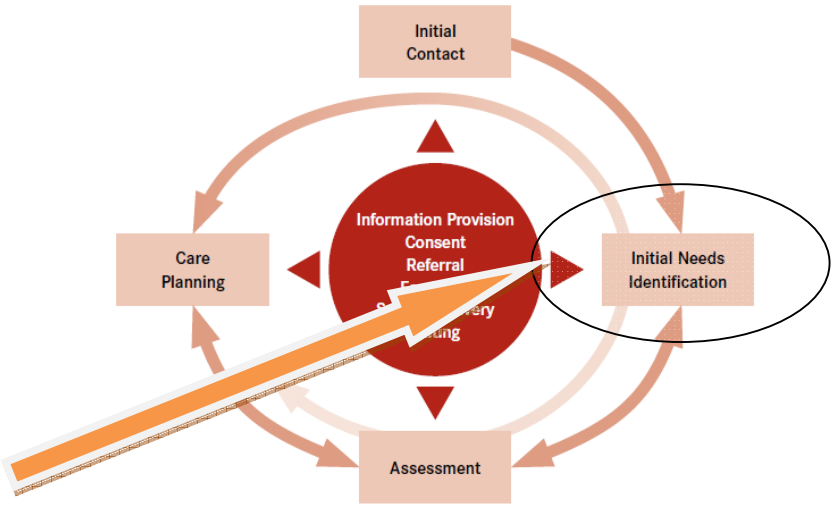
Ben is given the following documents:

Consumer consent, service information, privacy document and directline number

[15] Victorian SCTT 09

0.0 POLICY TITLE: Intake and Initial Needs Identification

Figure 1: Service Coordination elements



1. OVERVIEW:

Intake is the initial meeting with the client (via phone or face to face) during which the worker gathers sufficient information to address the client's immediate needs to encourage his/her engagement and retention in services. Intake provides initial & brief screening and assessment for the purpose of appropriate triage internally and/or referral externally. Relative data should also be collect about any dependent children, carers and family members and their immediate needs.

The process prioritises referrals based on presenting issues, risk assessment and recommended response time. The key outcome of intake is that clients and the broader community are able to access timely and efficient services whether internally or externally based on their presenting problems and accompanying risk factors.

Role of the worker:

- ✓ Respond to clients and the broader community in a timely and efficient manner;
- ✓ Develop and maintain equitable intake process for clients (dual diagnosis friendly);
- ✓ Ensure appropriate systems are in place to support clients whilst on waiting lists.
- ✓ Provide the gateway for agency contact and referral pathways;
- ✓ Client registration and health record maintenance

PROCEDURE

2.1 Anytown Health Service's Intake is staffed 5 days a week – Monday to Friday (not including public holidays).

- Intake staff are available to see clients between the hours of 10am – 4pm. (special consideration will be made for people needing urgent assistance).

2.2 Referrals are received via the following avenues:

Self Referral: is where a consumer takes responsibility for contacting another service provider to make a referral on their own behalf.

Supported referral: is where a carer / friend / relative refers a consumer and acts on their behalf (with consent).

Assisted active referral: service providers within the service system make a referral on behalf of a consumer.

2.3 All referrals will be actioned by the Intake Worker within 2 working days.[16]

2.4 Anytown Health Service's Intake staff are trained in basic level dual diagnosis screening & assessment and use supported, evidence based tools to perform this task. Service Coordination Tools:[17]

2.5 Substance use will not be used as a reason for exclusion from a service. However clients who are significantly alcohol or drug affected will be individually assessed for appropriateness of service access and treatment. These clients will be provided with alternate appointment arrangements.

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[16] Towards a Demand Management Framework for Community Health Services, Primary Health Branch. Department of Health, Victoria.

[17] Victorian SCTT 09:

- Appendix 5: Health Behaviours
- Appendix 6: Psychosocial profile
- Appendix 7: Needs for Assistance

2.6 Appropriate support and care will be provided to any dependent children, family members or carers.

2.7 Clients are supported through the referral process. This includes support whilst held on waiting lists until fully engaged with the connecting agency / program. (eg: phone support, emergency contact numbers given, crisis management plan).

Managing Waiting Lists:

- For self referrals, the intake worker at the receiving agency is responsible for monitoring and supporting clients placed on any internal waiting list.
- For assisted active referrals, the referring agency is responsible for monitoring and supporting the client until the receiving agency is able to transfer care. The referring agency should ascertain length of waiting time and ensure strategies are employed to monitor the client whilst they are waiting to be seen.

2.8 Referral pathway options are accessible from the Intake Workers desktop:
www.connectingcare.com www.nowrongdoor.org.au

Assessment & Screening

Assessment & Screening – Identifying needs…

Assessment:

Assessment is a time intensive process that is used to:

- Screen for alcohol and other drug use and mental health issues.
- Confirm whether the condition or disorder is present
- Assess its severity, impact and the client's / carers perceptions, attitudes and beliefs about the condition or disorder (this includes impact on any dependent children, carers and family members)
- Formulate and develop integrated treatment planning around the disorder (in dual diagnosis, around both diseases).

Screening:

Screening is a component of an assessment. A screen is a brief method of determining whether a particular condition (such as domestic violence) or disorder (such as substance use or mental health) may or may not be present. A positive screen will usually trigger a more detailed assessment of the indicated condition. Services screen all people on their initial presentation for mental health and alcohol and other drug issues.[18] In addition to this, services will screen for any cumulative harm of any dependent children, carers and family members.

Recording:

Detection of alcohol & other drug problems or/+ mental health problems are recorded with equal prominence in the persons treatment plan and other relevant information systems.

[18] Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol & Other Drug and Mental Health Services. Croton, G. (2007) Victorian Dual Diagnosis Initiative Advisory Group, Victoria.

Assessment & Screening – Identifying needs...continued

Key Agency & Personnel Recommendations:

- For Alcohol & Other Drug service staff, PDRSS, generalist workers a full Psycheck tool[19] should be used as an addition to the core agency assessment tool
- For mental health service staff, an ASSIST [20] screen will be conducted at the time of (or as close to the time) a full psychiatric assessment occurs
- For all Alcohol & Other Drug and Mental Health Services, a comprehensive risk assessment should also be conducted if risk issues are elicited.
- Screening of cumulative harm for dependent children
- Screening tools are linked to appropriate and relevant brief interventions that the clinician will instigate early in the treatment process.
- Where agencies have developed partnerships and collaborative working arrangements, an integrated assessment tool which incorporates both a comprehensive mental health and drug and alcohol assessment is the preferred option. Documentation can then be shared and progressed in an integrated fashion. [21]

Vignette:

Assessment:

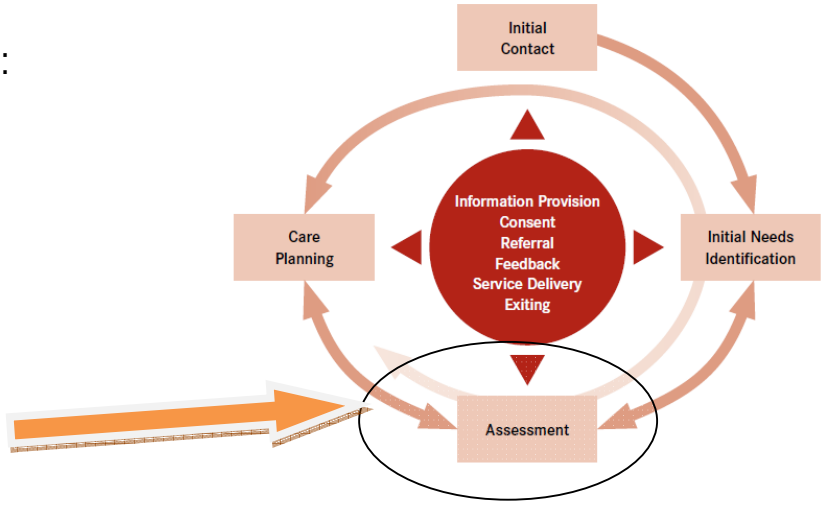
The Alcohol and Other Drug worker contacted Ben within the week of entry to the service. An appointment is made at the earliest opportunity

During Ben's appointment, a comprehensive integrated Dual Diagnosis assessment is completed. The key identified issue is excessive substance use, the Alcohol and other drug worker will expand the assessment to include a more comprehensive Substance Use screening tool. IN addition to this, the alcohol and other drug worker will make an appropriate referral to engage other practitioners to work collaboratively in the management of other identified issues.

[19] Psycheck – responding to mental health issues within alcohol and drug treatment. Department of Health and Ageing, 2007.
[20] Alcohol, Smoking and Substance Use Involvement Screening Test
[21] Appendix 8: Sample Integrated Mental Health and Alcohol and Drug Comprehensive Assessment form

0.0 POLICY TITLE: Assessment & Screening

Figure 1: Service Coordination elements



1. OVERVIEW:

Assessment:

Assessment is a time intensive process that is used to:

- Screen for alcohol and other drug use and mental health issues.
- Confirm whether the condition or disorder is present
- Assess its severity, impact and the client's / carers perceptions, attitudes and beliefs about the condition or disorder (this includes impact on any dependent children, carers and family members)
- Formulate and develop integrated treatment planning around all disorders.

Screening:

Screening is a component of an assessment. A screen is a brief method of determining whether a particular condition (such as domestic violence) or a disorder (such as substance use or mental health) may or may not be present. A positive screen will usually trigger a more detailed assessment of the indicated condition. Services screen all people on their initial presentation for mental health and alcohol and other drug issues.[22]

Recording:

Detection of alcohol & other drug problems &/or mental health problems is recorded and addressed in the persons treatment plan and other relevant information systems.

[22] Working with dual diagnosis: Guidelines for alcohol and other drugs workers

Staff involved:

Assessments must only be carried out by staff who have been trained in alcohol & other drug assessment and mental health assessments.

PROCEDURE

2.1 Anytown Health Service's counselling and support team are trained in providing integrated Dual Diagnosis assessment and screening.

2.2 Anytown Health Service's counselling and support team will provide a timely and comprehensive dual diagnosis assessment.

2.3 Assessment and screening will involve input from other key providers involved in the client's care, as well as any carers or significant others.

2.4 The assessment and screening tools endorsed by Health Service and regional Dual Diagnosis Reference Groups are:

- For Alcohol & Other Drug service staff, PDRSS, generalist workers a full Psycheck tool[23] should be used as an addition to the core agency assessment tool
- For mental health service staff, an ASSIST [24] screen will be conducted at the time of (or as close to the time) a full psychiatric assessment occurs
- Screen for cumulative harm for dependent children and assess the need for immediate support, psycho-education, health and development needs and family life.
- For both sectors, a comprehensive risk assessment should also be conducted if risk issues are elicited.
- Screening tools are linked to appropriate and relevant brief interventions that the clinician will instigate early in the treatment process.

[23] Psycheck – responding to mental health issues within alcohol and drug treatment. Department of Health and Ageing, 2007.
[24] Alcohol, Smoking and Substance Use Involvement Screening Test (ASSIST)

Care Coordination

Care Coordination – planning care

Care Coordination: (aka: care planning, case management)

Care planning involves the gathering and interpretation of comprehensive assessment information, and creating strategies with the consumer and the carer about their ongoing care and support.

Coordinated Care Planning is particularly important in facilitating appropriate care for consumers with multiple or complex needs, such as those with a co-morbidities and chronic conditions.

A care coordination document may also be known as an Individual Service Plan, Individual Treatment Plan, Care Plan etc.

Coordinated Care Planning supports the consumer to identify goals and agreed priorities, and consequent strategies, actions and services to achieve those goals. This involves discussion with the consumer to define their goals and establish how the goals can be met. It involves balancing relative and competing needs, and assisting consumers to make decisions that are appropriate to their needs, wishes, values and circumstances. This may involve linking the consumer to a range of services, identifying how self-management support, education and health promotion will be provided, and establishing effective communication between all the participants in care, including the consumer and their general practitioner. Advance directives should be clearly documented in the Consumer Recovery Plan.

Integrated Treatment:

Can be defined as one clinician, or agency providing treatment for both a client's substance use and mental health disorders. Integrated treatment also occurs 'when clinicians from separate agencies collaborate to develop a single treatment plan addressing both sets of conditions and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client' (CSAT, 2005), that is, develop an integrated treatment plan.[25]

[25] Working with dual diagnosis: Guidelines for alcohol and other drugs workers. Victorian dual Diagnosis Initiative & Turning Point Alcohol and Drug Centre, 2009.

Advance Directives:

Each consumer knows best about the lived experience of their 'illness' and that decisions made by others on their behalf will never adequately substitute for the decisions people make for themselves about their own lives. Self-determination is crucial to anybody's ongoing wellbeing. Advance directives provide a more formal means than currently exists, for the declaration of the treatment preferences and carrying out instructions of service users as well as developing a family care plan that outlines the actions to be taken for children in the event of relapse or ill health of a parent.

Advance Directives are one important way that health services can be better informed not only about the wishes and preferences of each person, but also consumers in general. It is critical that the service system can demonstrate an understanding of the perspective of people with an illness relating to decision-making processes and the experience of being a recipient of health services, particularly if under involuntary means either by forensic order or Mental Health Act status. Advance Directives are one way that consumers can seek to maintain authority over their own lives in a way that will in both the long and the short term keep them well. [26]

Key Agency Recommendations:

- The one plan principle: Other key health providers (& identified carers or significant others) should provide input into the development of the Care Coordination Plan. Each agency's roles and responsibilities need to be clearly articulated. With client consent, a copy of the completed Care Coordination Plan must be forwarded to the other key health providers within 2 weeks of original assessment. [27]
- The client should be encouraged to complete an Advance Directives Plan[28] which should sit as an attachment to the Care Coordination Plan. This should include a family care plan related to any dependent children, carers and other family members.
- One agency to be identified as the nominated key worker (consumer preference where possible).

[26] Mental Health Legal Centre – Advance Directives: http://www.communitylaw.org.au/mentalhealth/cb_pages/living_wills.php
[27] Appendix 9: Integrated Care Coordination Document template
[28] Appendix 10: Advance Directives Plan template

Care Coordination – planning care… continued

The client should retain a copy of both the Care Coordination Plan and the Advance Directives Plan.

- The client (and their family, carer & dependent children) should be offered relevant psycho-education and written information about the illness. Information about options for dependent children, home help, accommodation etc should also be considered.

- Each client's case will be reviewed every at least every xx months as a minimum. This review should include consultation and input with other key health providers, family and carers involved in the client's case.
- Review consultation outcomes must be documented on Review Form. The outcomes and subsequent updated Care Coordination Plan must be forwarded to the other key providers. A review should include consideration about how the plan has impacted (positively and / or negatively) on the client's carer, family and any dependent children.

- The Care Coordination Document should include plans for Discharge – including the transitional discharge process

- The Care Coordination may be updated earlier if the client's case issues have altered. If this occurs, the updated Care Coordination Document must be provided to other key health providers involved.

- Joint agency crisis management planning should occur if the client is likely to present at risk or in crisis.

- There is no one prescribed template for a Care Coordination Plan, however the following core items should be included in any document:
  - Demographic data
  - Participants involved in the development of the plan
  - Advance directives
  - Consumer & family stated agreed issues and goals
  - Agreed actions and responsibilities
  - Crisis management plan
  - Planned review date
  - Consumer acknowledgement / authorisation / consent of the plan
  - Author and date

Care Coordination – planning care… continued

Vignette:

Care Coordination:

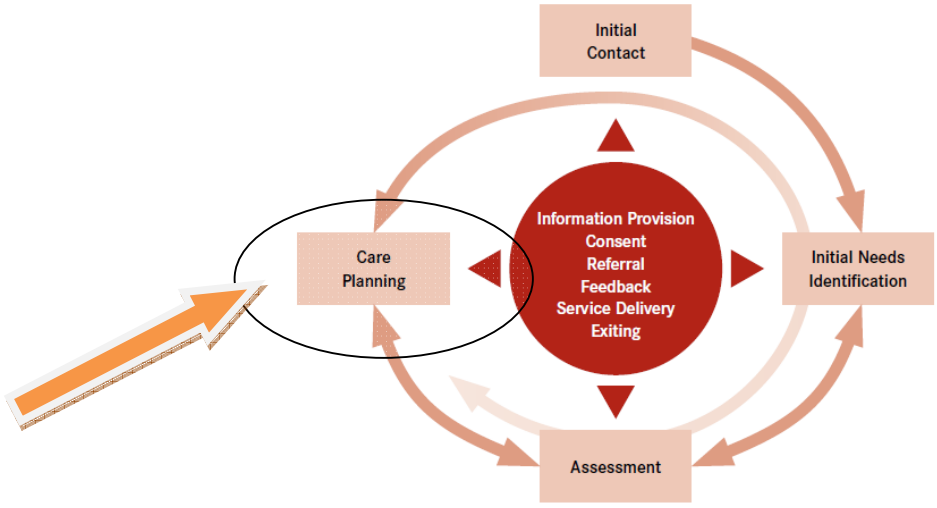
Ben is allocated a worker who will coordinate a plan for Bens care in consultation with Ben, other health providers, any significant others and Ben's GP. Ben's goals will be identified and roles and responsibilities of each health care provider are clearly articulated in the document.

Ben will be provided an opportunity to develop his Advance Directives on the consumer recovery plan which will be attached to the Care Coordination document.

Copy of the care coordination plan is forwarded to other key providers and GP, with Ben's consent.

0.0 POLICY TITLE: Care Coordination (Care Planning/Case Management)

Figure 1: Service Coordination elements



1. OVERVIEW:

Care planning involves the gathering and interpretation of comprehensive assessment information, and creating strategies with the consumer and the carer about their ongoing care and support.

Coordinated Care Planning is particularly important in facilitating appropriate care for consumers with multiple or complex needs, such as those with co-morbidities and chronic conditions.

Coordinated Care Planning supports the consumer to identify goals and agree on strategies, actions and services to achieve those goals. This involves discussion with the consumer to define their goals and establish how the goals can be met. It involves balancing relative and competing needs, and assisting consumers to make decisions that are appropriate to their needs, wishes, values and circumstances. This may involve linking the consumer to a range of services, identifying how self-management support, education and health promotion will be provided, and establishing effective communication between all the participants in care, including the consumer and their general practitioner. Client driven Advance directives should be clearly documented in the Care Coordination Plan.

Advance Directives: Each consumer knows best about the lived experience of their 'illness' and that decisions made by others on their behalf will never adequately substitute for the decisions people make for themselves about their own lives. Self-determination is crucial to anybody's ongoing wellbeing. Advance directives provide a more formal means than currently exists, for the declaration of the treatment preferences and carrying out instructions of service users. This should also include a family care plan related to any dependent children, carers and other family members.

Advance Directives are one important way that health services can be better informed not only about the wishes and preferences of each person, but also consumers in general. It is critical that the service system can demonstrate an understanding of the perspective of people with an illness relating to decision-making processes and the experience of being a recipient of health services, particularly if under involuntary means either by forensic order or Mental Health Act status.

Advance Directives are one way that consumers can seek to maintain authority over their own lives in a way that will in both the long and the short term keep them well. [29]

Care Coordination: operates on the One Plan principle, whereby all key stakeholders contribute to the one plan. This plan is reviewed regularly as agreed by the consumer and stakeholders. The plan will identify who the key contact (Care Coordinator) will be and what are the roles and responsibilities of all key stakeholders.

[29] Mental Health Legal Centre – Advance Directives: http://www.communitylaw.org.au/mentalhealth/cb_pages/living_wills.php

PROCEDURE

2.1 Anytown Health Service staff will facilitate a "one plan" approach to Care Coordination.

2.2 Anytown Health Service staff will consult other key health providers (& identified carers or significant others) when developing a Care Coordination Plan, ensuring each agency's roles and responsibilities are clearly articulated.

2.3 With client consent, a copy of the completed Care Coordination Plan will be forwarded to the nominated key health providers within 2 weeks of original assessment.

2.4 The client will be encouraged to complete an Advance Directive Plan which will be attached to the Care Coordination Plan.

An advance directive plan gives a client the chance to sit down when well, work out what needs to be done and what works best for them should they become unwell. This information can be made available to the hospital or clinic if they are admitted and it informs them of the client's wishes. Advance directives can also name those who are Power(s) of Attorney and ensure they are notified to commence their work on the client's behalf. This should include a family care plan related to any dependent children, carers and other family members.

2.5 The Care Coordination Plan will have a nominated Care Coordinator (Key Worker / and agency). (Consumer preference where possible).

2.6 The client will be offered a copy of both the Care Coordination Plan and the Consumer Recovery Plan.

2.7 The client and their carer, family and dependent children, will be regularly offered relevant psycho-education and written information about the presenting issues / illness and treatment. Information about options for dependent children, home help, accommodation etc should also be considered.

2.8 Each client's case will be reviewed regularly. Each program will have differing requirements as to frequency of review based on acuity. Anytown Health Service – counselling and support team will conduct monthly multidisciplinary clinical review meetings to enable problematic cases to be discussed and reviewed.

Review should include consultation and input with other key health providers involved in the client's case. Review consultation outcomes will be documented in the client's progress notes. The outcomes and subsequent updated Care Coordination Plan will be forwarded to the other key providers. A review should include consideration about how the plan has impacted (positively and / or negatively) on the client's carer, family and any dependent children.

2.7 The Care Coordination Plan will include plans for Discharge – including the transitional discharge process

2.8 The Care Coordination Plan may be updated earlier if the client's case issues have altered. If this occurs, the updated Care Coordination Document will be provided to other key health providers involved.

2.9 For clients who are likely to present at risk or have a past history, a joint agency crisis management plan will be developed.

2.10 There is no one prescribed template for a Care Coordination Plan, however the following core elements will be accepted as a Care Coordination document, by Anytown Health Service staff:

- Demographic data
- Participants involved in the development of the plan
- Advance directives including the family care plan
- Consumer stated agreed issues and goals
- Agreed actions and responsibilities
- Crisis management plan
- Planned review date
- Consumer acknowledgement / authorisation / consent of the plan
- Author and date

Crisis Management

Crisis Management – when the wheels start to wobble…

Crisis is seen as a brief "non-illness" response to severe stress. Crisis Management / Intervention is a technique to assist people who are under severe stress. It involves counselling and structured problem solving. Crisis management is the entire process of working through the crisis to the point of resolution (of the crisis, not the problem). It usually includes not only the individual in crisis but also the members of the person's social / family network.

Key Agency Recommendations:

- Agency staff should have appropriate training in crisis management. This training should be updated regularly and linked to staff appraisals, reviews and education needs assessments.
- Clients are active participants in the development of their crisis management plan.
- Crisis management plans should be developed with and included in the Care coordination document.
- The client and key agencies are provided with a copy of the crisis management plan
- Plans should be time limited and connected to identified stressors and palliative measures and techniques
- Agency contact details and service pathway options are accessible from staff desktops
    - www.connectingcare.com
    - www.nowrongdoor.org.au

Vignette:

Crisis Management:

Ben contributed to the development of his own crisis management plan, which has been incorporated into his Care Coordination Document. The plan includes:

- Precipitants to the re-emerging crisis
- Early Warning Signs
- What modifying factors work at making it better?
- What modifying factors make the problem worse?
- Current problem solving strategies
- Support people and contact numbers
- 24 hour help line numbers
- Plan for reducing the impact of re-occurring problems.

0.0 POLICY TITLE: Crisis Management: (When the wheels start to wobble)

1. OVERVIEW:

Crisis is seen as a brief "non-illness" response to severe stress. Crisis Management / Intervention is a technique to assist people who are under severe stress. It involves counselling and structured problem solving. Crisis management is the entire process of working through the crisis to the point of resolution (of the crisis, not the problem). It usually includes not only the individual in crisis but also the members of the person's social / family network. An emergency is a life-threatening situation demanding an immediate response. A crisis is often not immediately life-threatening and the timing of the response should be such as to include all participants in the crisis and existing or potential personal supports.

Developmental crises: These are the transitions between the stages of life that we all go through. These major times of transition are often marked by "rites of passage" at clearly defined moments (e.g., those surrounding being born, becoming adult, getting married, becoming an elder, or dying). They are crises because they can be periods of severe and prolonged stress.

Situational crises: Sometimes called "accidental crises", these are more culture- and situation-specific (e.g., loss of job, income and/or home, accident or burglary, or loss through separation or divorce).

Complex crises: These are not part of our everyday experience or shared accumulated knowledge, so we find them harder to cope with. They include:

- ***Severe trauma***, such as violent personal assault, natural or man-made disasters, often directly involving and affecting both individuals and their immediate and extended support network, observers and helpers.
- ***Crises associated with severe mental illness***, which can increase both the number of crises a person experiences and sensitivity to a crisis. Reciprocally, the stress of crises can precipitate episodes of mental illness in those who are already vulnerable. Post-traumatic stress syndromes similar to those resulting from a disaster have been reported in some individuals after emergency treatment of acute episodes of mental illness. [30]

[30] http://www.mja.com.au/public/issues/xmas/rosenmh/rosen.html

PROCEDURE

2.1 Anytown Health Service **is not** a Crisis service however, we do acknowledge that clients will present in crisis from time to time, thus Counselling and Support Team staff, Reception staff and Intake staff will be appropriately trained in crisis management.

Or

Anytown Health Service **provides** Crisis response, assessment and management to clients who present in crisis, thus staff (including reception staff) will be appropriately trained in crisis management.

2.2 Agency contact details and service pathway options are accessible from staff desktops

- www.connectingcare.com
- www.nowrongdoor.org.au

2.3 Crisis Management training will be offered and updated regularly and linked to staff appraisals, reviews and educational needs assessments.

2.4 Clients (and their families / social support network) will be active participants in the development of their crisis management plan.

2.5 Crisis management plans should be developed with and included in the Care coordination document.

2.6 Identified key agencies are consulted and included in the crisis management plan

2.7 The client and key agencies will be provided with a copy of the crisis management plan

2.8 Plans should be time limited and connected to identified stressors and therapeutic measures and techniques

2.9 If acute inpatient psychiatric care is needed, Anytown Health Service staff will liaise with the local mental health receiving Intake service to make the transition easier and to ensure consistency of the clinical management plan agreed with the individual and family.

Interventions

Interventions – therapeutic approaches…

Approaches:

Bio-psychosocial approach: Integrated service provision involves a bio-psychosocial approach comprising an array of physical, psychological and social approaches in the process of engagement, assessment, treatment and care.

These interventions are outlined in an integrated and comprehensive care coordination plan based on an assessment of individual needs and preferences, matched to appropriate levels of care, and coordinated within a broad range of provider networks and social services.

A harm minimisation approach: is used and promoted in the treatment of people with dual diagnosis. This approach recognises that people with substance use problems have a wide range of treatment goals that range from the reduction of harms related to use through to abstinence, and that interventions need to be realistic and achievable.

A holistic, recovery-based approach: is used in the provision of assessment, treatment and care, involving direct service provision for mental health and alcohol and other drug problems and effective linkage with the broader social service network to meet the range of complex needs experienced by people with dual diagnosis. [31]

A strength based approach: A strength based approach, places emphasis on growth and change, collaborative relationships, and the centre of change located in the client. The strengths approach attempts to understand client in terms of their strengths. This involves systematically examining survival skills, abilities, knowledge, resources and desires that can be used in some way to help meet client goals[32]. Strengths based practice assists people to recognise and mobilise their strengths and resources toward solutions to life difficulties. It also enable the client to direct the process of intervention as much as possible.

Interventions:

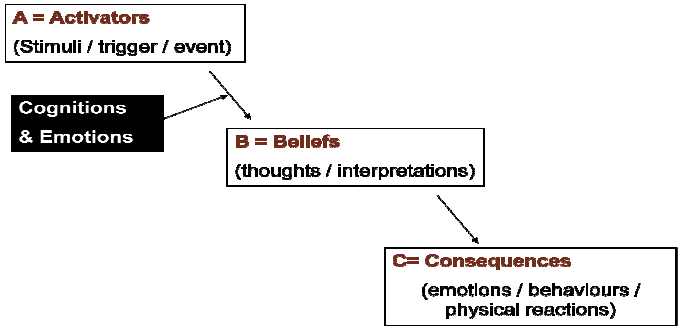
Brief Interventions: Where mental health or / alcohol & other drug problems are detected services will provide brief interventions. Types of brief interventions include:

- Psycho-education
- Identifying unhelpful thoughts
- Managing unhelpful thoughts
- Relapse prevention

[31] Qld Health Policy: Service delivery for people with dual diagnosis (co-occuring mental health and alcohol and other drug problems).
[32] Saleebey, 1996)

Interventions – therapeutic approaches... continued

Cognitive Behavioural Therapy: Cognitive behavioural approaches are relatively short-term focused interventions that target unpleasant thoughts, feelings and behaviours.



Motivational Interviewing: Motivational interviewing is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. Compared with nondirective counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal.[33]

Stages of change: The Stages of Change model is useful for identifying appropriate interventions to foster positive behaviour change by identifying where a person is in the change process, interventions can be tailored to the person's "readiness" to change. [34]

STAGE	CHARACTERISTICS	STRATEGIES
Precontemplation	The person is not even considering changing. They may be "in denial" about their health problem, or not consider it serious. They may have tried unsuccessfully to change so many times that they have given up.	Educate on risks versus benefits and positive outcomes related to change
Contemplation	The person is ambivalent about changing. During this stage, the person weighs benefits versus costs or barriers (e.g., time, expense, bother, fear).	Identify barriers and misconceptions Address concerns Identify support systems
Preparation	The person is prepared to experiment with small changes.	Develop realistic goals and timeline for change Provide positive reinforcement
Action	The person takes definitive action to change behaviour.	Provide positive reinforcement
Maintenance and Relapse Prevention	The person strives to maintain the new behaviour over the long term.	Provide encouragement and support

[33] http://www.motivationalinterview.org

[34] James Prochaska and Carlo Diclemente (1982)

Communication & Consent

Communication & Consent – sharing information…

Informed Consent:

Informed consent, in a health care setting, is the procedure whereby patients (clients) consent to, or refuse, an intervention based on information provided by a health care professional regarding the nature and potential risks (consequence and likelihood) of the proposed intervention (Coy, 1989). The Victorian Charter of Human Rights requires that consent for medical treatment be free, full and informed and states:

> *"…consent must be voluntary and the person concerned must have been given sufficient information for an informed decision to be made. This would include information such as the nature of the person's condition and the treatment options available, including explanations of possible risks, side effects and benefits of the treatment.*[35]

Key Agency Recommendations:

- The Victorian Primary Care Partnership Service Coordination Tool, "Consumer Consent to Share Information" template is the tool of choice for consent.[36] It complies with current State and Commonwealth legislative requirements. The template should:
  - ✓ be completed to obtain consumer consent to share information but does not need to be sent to the service provider with a referral, unless it is requested.
  - ✓ indicate on the Summary and Referral Information template whether consent to share information has been obtained from the consumer or authorised representative.
  - ✓ consent to share information must be obtained if the consumer has the capacity to give consent.

- If the consumer does not have the capacity (i.e. they are unable to understand the nature of what they are consenting to, or the consequences), consent must be sought from the consumer's authorised representative (see definition page v). If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out in Health Principle 2.2 of the *Health*

[35] VHA Informed Consent for Intervention: Discussion Paper March 2009
[36] Appendix 1: SCTT Consumer Consent Tool.

Communication & Consent – sharing information continued…

Records Act 2001. This includes where the sharing of information is by a health service provider and is reasonably necessary for the provision of a health service or where there is a statutory requirement. For further circumstances for disclosure see www.health.vic.gov.au/hsc/infosheets/disclosure.pdf

- If the consumer refuses consent to share information, a referral can proceed. However, the service provider to which the consumer is referred will need to obtain the information they need from the consumer.

- The Consumer Consent to Share Information template and the brochure *Your information—it's private* in the 57 languages (including Easy Speak) can be downloaded at: www.health.vic.gov.au/pcps/coordination .

Vignette:

Consent:

Ben is offered a consent form from the first point of intake in relation to who will be involved in his care and who can be contacted. Ben is regularly reminded about the consent form's details and offered opportunity to amend this at any given time should circumstances change.

0.0 POLICY TITLE: Informed Consent

1. OVERVIEW:

PURPOSE

The purpose of this policy is to guide staff in ensuring that consumers are given the opportunity to provide informed consent to their treatment and care.

DEFINITIONS

'***Consumer'*** refers to anyone who either directly or indirectly utilises the service, and anyone who may use the service in the future;

Informed consent**:** Informed consent is more than simply asking a patient to sign a written consent form. It is a process of communication between a patient and physician that results in the client's authorisation or agreement to undergo a specific intervention which may include sharing information across agencies.

2. PROCEDURE

2.1.1 Management and staff are committed to actively engage consumers in all aspects of their health care and ensure they provide informed consent to their care.

Consent to share information:

2.1.2 The Victorian Primary Care Partnership Service Coordination Tool, "Consumer Consent to Share Information" template is the tool of choice for consent.[37] It complies with current State and Commonwealth legislative requirements. The template should:

- be completed to obtain consumer consent to share information but does not need to be sent to the service provider with a referral, unless it is requested.
- indicate on the Summary and Referral Information template whether consent to share information has been obtained from the consumer or authorised representative.
- consent to share information must be obtained if the consumer has the capacity to give consent.
- Consent forms should be provided in the natural language of the consumer.[38]

[37] Appendix 1: SCTT Consumer Consent Tool.
[38] CALD sensitive versions: www.health.vic.gov.au/pcps/coordination .

2.1.3 If the consumer refuses consent to share information, a referral can proceed. However, the service provider to which the consumer is referred will need to obtain the information they need from the consumer.

Informed consent:

In the communications process, the clinician providing or performing the treatment and/or procedure (not a delegated representative), should disclose and discuss with the client:

- diagnosis, if known
- nature and purpose of a proposed treatment or management plan
- any risks and benefits of a proposed treatment
- alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance)
- risks and benefits of the alternative treatment or procedure
- risks and benefits of not receiving or undergoing a treatment or procedure
- the possibility of interagency communication requiring the sharing of a clients information

In turn, the client should have an opportunity to ask questions in order to elicit a better understanding of the treatment or procedure, so that he or she can make an informed decision to proceed or to refuse a particular course of intervention.

2.1.4 If the consumer does not have the capacity (i.e. they are unable to understand the nature of what they are consenting to, or the consequences), consent must be sought from the consumer's authorised representative. If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out in Health Principle 2.2 of the *Health Records Act 2001.* This includes where the sharing of information is by a health service provider and is reasonably necessary for the provision of a health service or where there is a statutory requirement.

Discharge: Transitional & Actual

Discharge – moving out or over…

Discharge Planning:

Discharge planning is the process of moving the patient from one level of care to another. The process should start on after entry, at assessment of the client into a service. The process should incorporate the multidisciplinary (cross sector) approach and involve all the appropriate health team professionals and offer holistic care.[39] For a variety of reasons, there will always be some clients who will self select to remove their care from an agency without adequate planning, this component of the protocol relates to clients who are actively involved in care and consent to discharge.

Phases in discharge planning :

Discharge planning is a progressive process that can be seen to involve a series of phases.

(a) Preparation phase

- Incorporates the pre-discharge and discharge process as part of the existing internal case review process
- Early consultations with the client occurs in relation to discharge expectations
- Early consultations with other key providers occurs in relation to discharge expectations and considerations.

(b) Implementation/transition phase

Transitional discharge is a "staged" process in which care is increasingly transferred to another provider (or to self care) while involvement from the current provider is diminished over time. In effect, the transition period is seen as a “practice” for discharge.

- Transition varies in the nature and length of the transition period according to the history and care needs of the client
- People, who have received extensive care from the specialist service system, may require a transition for up to 12 months (or more).
- For this group, it is expected that a number of planned contacts from the exiting agency will occur with the client and the receiving agency, including a review session at the end of the transition phase

[39] Discharge planning and the development of protocols between adult Area Mental Health Services and general practitioners (May 2005)

Discharge – moving out or over...continued

- Review sessions, will allow for decisions to be made to proceed to completed discharge or extend the transition phase, implement shared-care treatment arrangements or re-engage the client back into service

(c) Full discharge

The ability to assume full independent care or care is transferred to another provider with the exiting provider ceasing contact.

Key Agency Recommendations:

- Engage in collaborative discharge planning at an early stage of treatment with the person, their carer/s, GP and external stakeholders involved in the person's treatment and care.
- Develop an integrated discharge plan in consultation with the client, carer, GP and other key providers.
- Provide written and verbal treatment-related information for the person being discharged and their carers.
- Provide written and verbal treatment-related information for GPs and other service providers involved in the person's care.
- The discharge process will include a period of preparation, transition and then actual discharge
- There is no one template for a discharge plan / report, however there are some key requirements that should be included:
    - Demographic data
    - the consumer's bio-psychosocial history summary, including diagnoses, any risk issues and the current extent of recovery
    - past and current treatments and their responses
    - treatment goals and a recovery plan, together with management recommendations
    - early warning signs of relapse and risks, such as frequent missed appointments or the re-emergence of symptoms

Discharge – moving out or over...continued

- strategies for managing early warning signs, including whom to contact if a relapse is suspected
- alert information and medico-legal considerations
- the consumer's involvement with other agencies or service providers
- a brief statement of the consumer's and carer/s' knowledge of the condition and their involvement
- contact details of key workers and where appropriate, carer/s
- information about how to refer in situations of crisis or to obtain a second opinion.

Vignette:

Discharge:

Ben attends an appointment with the clinician 6 weeks prior to discharge to discuss creation and implementation of a transitional discharge plan.

Discussion will involve the anticipated number of appointments until actual discharge, frequency of appointments, other services to be involved post discharge and what interventions will be instigated to prepare for this process.

Ben, his clinician and all key stakeholders are involved in a case conference and as a group, they develop the discharge plan.

Ben consents for the discharge plan to be provided to his GP and key service providers that will be involved in his care.

Ben is provided with a "trial" discharge opportunity before actual discharge is instigated.

A discharge notification form will be forward to other key services after formal discharge is complete

0.0 POLICY TITLE: Discharge (Moving over or out)

1. OVERVIEW:

Discharge planning is the process of moving the client from one level of care to another. The process should start after entry, and at assessment of the client into a service. The process should incorporate the multidisciplinary (cross sector) approach and involve all the appropriate health team professionals and offer holistic care.[40] For a variety of reasons, there will always be some clients who will self select to remove their care from an agency without adequate planning, this component of the protocol relates to clients who are actively involved in their discharge.

Phases in discharge planning :

Discharge planning is a progressive process that can be seen to involve a series of phases.

(a) Preparation phase

Incorporates the transition discharge and actual discharge planning processes as part of the existing internal case review process

Early consultations with the client occurs in relation to discharge expectations

Early consultations with other key providers occurs in relation to discharge expectations and considerations.

(b) Implementation/transition phase

Transitional discharge is a "staged" process in which care is increasingly transferred to another provider (or to self care) while involvement from the current provider is diminished over time. In effect, the transition period is seen as a “practice” for discharge.

Transition varies in the nature and length of the transition period according to the history and care needs of the client

People, who have received extensive care from the specialist service system, may require a transition for up to 12 months (or more).

For this group, it is expected that a number of planned contacts from the exiting agency will occur with the client and the receiving agency, including a review session at the end of the transition phase

Review sessions, will allow for decisions to be made to proceed to:

- completed discharge or extend the transitional phase,

- implement shared-care treatment arrangements

- re-engage the client back into service

[40] Discharge planning and the development of protocols between adult Area Mental Health Services and general practitioners (May 2005**)**

(c) Full discharge

The ability to assume full independent care or care is transferred to another provider with the exiting provider ceasing contact.

PROCEDURE

2.1 Anytown Health Service staff will engage in collaborative discharge planning at an early stage of treatment with the person, their carer/s, GP and external stakeholder..

2.2 Written and verbal treatment-related information will be provided for the person being discharged and their carers.

2.4 Written treatment-related information will be provided for GPs and other service providers involved in the person's care.

2.5 The discharge process will include a period of preparation, transition and then actual discharge (as described above).

2.6 Each program will have its own preferred template for discharge. However there are some key requirements that a template should include:

- Demographic data
- the consumer's bio-psychosocial history summary, including diagnoses, any risk issues and the current extent of recovery
- past and current treatments and their responses
- treatment goals and a recovery plan, together with management recommendations
- early warning signs of relapse and risks, such as frequent missed appointments or the re-emergence of symptoms
- strategies for managing early warning signs, including whom to contact if a relapse is suspected
- alert information and medico-legal considerations
- the consumer's involvement with other agencies or service providers
- a brief statement of the consumer's and carer/s' knowledge of the condition and their involvement
- contact details of key workers and where appropriate, carer/s
- information about how to refer in situations of crisis or to obtain a second opinion.

Secondary Consultation

Secondary consultation – seeking and receiving advice...

Secondary Consultation:

The usual intention in seeking Secondary Consultation (SC) is to gain another clinician's perspective on a client's presenting issues and the most effective possible responses. Often SC may not involve the provision of any advice, simply a chance to review an issue or a consumer's presentation with another professional. While SC is usually focused around immediate problem solving SC also alleviates professional isolation and assists in clinician education and skills development.

In rural areas SC is particular valued for its utility in enhancing agencies and worker's capacity to provide the most effective possible response to a wide range of presenting disorders.

Disclaimer:

There have been concerns about accountability for advice offered in SC and there appears to be little guidance available in the Australian literature. Ambiguity around responsibility for SC may affect the effectiveness of treatment and clinician's willingness to provide.

This document is a general guide only and represents a local No Wrong Door attempt to clarify and resolve some of these concerns.

Please note, neither the authors of this document nor any of the signatory agencies will not be liable for any damages arising out of or in anyway related to these guidelines. We recommend that each agency seek consultation from its legal representative to ensure this is reflective of the agency's standards.

Definitions:

SC is the provision of clinical advice and support by health professionals to other health professionals at their request.

In SC, the consultant does not actually see or make contact with the client.

Consultant: is the professional providing the SC

Consultee: Is the professional seeking the SC and is the health professional primarily responsible for the care of the patient

Consent: As a general principle a health care worker is under a duty not disclose information which he or she has gained in his or her professional capacity, unless the patient consents.

In non urgent situations, the SCTT Consumer Consent Form (Appendix 1) should be completed before secondary consultation is sought. This will highlight who the consultee can communicate with and what can be communicated.

In urgent situations, safety considerations may outweigh consent. Please ensure this is clearly documented in clinical notes.

Secondary Consultation continued – giving & receiving advice…

Consultant:

Liability: Consultants should bring the same attention, care and rigour to the provision of SC as they would do to the provision of a direct service. A consultant will owe a duty of care to the consultee seeking the advice if he or she knows, or ought to know that the consultee may rely on that advice. Consultants must understand that having no direct patient contact will not necessarily absolve them from a duty of care towards the client. The consultant will not be held liable if the consultee chooses not to rely on the management advice given during SC.

Expertise: If SC is sought and the consultant judges that, in this instance, they do not have the expertise or experience to provide useful SC then this should be fed back to the consultee and other options for obtaining useful SC should be jointly explored.

Urgency: Where a consultant considers that a more intensive and assertive response is required the consultant shall, as a priority, discuss this with the consultee and obtain agreement about future management. If a consultee states that they are reluctant to follow the advice provided around crisis management / safety issues then it is incumbent upon consultant to advise the consultee that this will be referred to the Consultee's manager.

Documentation: Making accurate records is essential as it may provide crucial evidence in the event that litigation ensures. Therefore, any discussion which takes place between the consultee and the consultant should always be carefully documented. The consultant should record the information which is provided by the consultee and on which the consultant relies in formulating their advice. The key considerations in documentation are the purpose of the SC and the extent to which the consultant believes their advice will be relied on in the further management of the client. The greater influence the secondary consultation is expected to have on patient management, the more stringent records need to be maintained. Each agency will have a policy pertaining to how documentation occurs. It is recommended that agencies seek legal advice around minimum information to be recorded.

Please refer to appendix 11 for a template that can be used for secondary consultation.

Consultee:

Liability: SC will often represent one component of the information gathering process that builds towards an assessment and treatment planning. Consultee's are at liberty to accept or reject advice received from the consultant. The consultee considers the recommendations of the consultant and will decide whether or not to follow them, based on their more extensive knowledge of the client. If the consultee chooses not rely on the management advice given, then the consultee will be held liable for any damage caused to the client.

Follow up: The consultee, being the health provider with the direct relationship with the client, will have a duty to follow up.

Documentation: Any discussion that takes place between the consultee and the consultant should always be carefully documented. The consultee should always include the discussion, or elements of the decision making process and consultant's recommendations in the patient record. The consultee should record the name and agency of the consultant.

Please refer to appendix 11 for a template that can be used for secondary consultation.

Workforce: Education & Training

Workforce – Capacity Building, Education & Training…

Building workforce capacity:

For agencies to improve their effectiveness in response to people with co-existing substance use disorders, a key action is to provide evidence based education and training programs to enhance the existing skills, knowledge, abilities and general work practice.[41]

Not only should training focus on skills enhancement, but in improving attitudes of workers towards clients with co-existing mental health and substance use problems. Training should focus on the needs from basic clinicians / staff to Advance clinicians.

Training should include both management and staff and be ongoing, since one off training is insufficient for appropriate transfer of sustainable learning and practice change.

Agency Portfolio Holders – Advanced Clinicians:

The Department of Human Service, Dual Diagnosis Key Directions and priorities for service development Document recommends that each agency develop a leadership position that will champion agency change and uptake of dual diagnosis. This key role, "Portfolio Holder" should be one of a specialist dual diagnosis capable clinician. At the Advanced level, dual diagnosis capable means being able to assess and effectively treat dual diagnosis clients in an integrated manner within service and practice guidelines. The position of Portfolio holder for an organisation will require the clinician to be at and Advanced dual diagnosis capable leaven to provide leadership, supervision, secondary consultation, training and advice to agency staff.

Supervision:

Integrating dual diagnosis treatment and care will have implications for the provision of supervision. Team, clinical and professional supervision must take account of the expectation for integrated treatment and secondary consultation responsibilities across services. Services will need to develop and revise local arrangements that take account of changed practices and models of care. Ideally, staff should have access to clinical supervision with an Advance practitioner.

[41] AIHW, 2005; Croton, 2004

Workforce - Education & Training...continued

Key basic training units / modules recommended:

- Attitudes, knowledge, confidence and beliefs about working with people with a Dual Diagnosis
- Epidemiology
- Identification, Screening, Assessment, brief interventions and relapse prevention.
- Referral protocols and pathways.

Dual Diagnosis Committees:

There are three key committees in the Hume region whom have a focus on dual diagnosis support, education and training.

Eastern Hume Dual Diagnosis Reference Group: a reference group covering the **East** of the Hume (Wodonga, Wangaratta, Benalla and surrounding towns) for mental health, alcohol & other drug service, Psychiatric Disability Rehabilitation Services to plan a subregional consistent approach to agency response to dual diagnosis. This reference group also hosts the:

- Eastern Hume Dual Diagnosis Portfolio Holders Group
- Eastern Hume Dual Diagnosis Supervision Group

Western Hume Dual Diagnosis Reference Group: a reference group covering the **West** of the Hume (Shepparton, Seymour, Broadford and surrounding towns) for mental health, alcohol & other drug service, Psychiatric Disability Rehabilitation Services to plan a subregional consistent approach to agency response to dual diagnosis.

Dual Diagnosis Hume Education Collaborative (DDxHEC): The Dual Diagnosis Hume Education Collaborative is a partnership of regional education providers. It has been formed to deliver strategic dual diagnosis training that is equitable and tailored to meet the needs of member agencies in the Hume region. The Department of Human Services Regional office has endorsed the DDxHEC group to oversee the coordination and distribution of Postgraduate study scholarship funds to the sector.

Further information about these groups and current training opportunities can be found by accessing the No Wrong Door Website: www.nowrongdoor.org.au

Consumer & Carer Engagement

Consumer and Carer Engagement...

Engagement in No Wrong Door Protocol and Policy Development:

The No Wrong Door project employs a consumer / carer consultant. This has enabled extensive consultation to occur with regional consumer and carer groups and individuals in the development of this protocol document. The outcomes of the consultations formed the basis of the protocol "themes" and it's content. In addition, advice was received in relation to the sample templates for agencies to adopt.

Consumer & Carer Engagement in Agency Service Development:

Client involvement in service planning and evaluation is seen as essential quality practice in both sectors. Ensuring that services are client centred, built upon a sound therapeutic alliance and sharing the evidence about the merits and effectiveness of different treatments promotes compliance with treatment and maximises the opportunity for positive outcomes.[42] Each client will have active involvement in the development and delivery of any therapeutic management plan.

Agencies should have a well defined consumer and carer engagement policy relating to service development, review and implementation.[43]

Consumer & Carer Engagement in Service receipt:

Consumer participation in service receipt is about supporting and encouraging consumers to become empowered to be active participants in their health care. This includes involving consumers in needs identification, recovery planning, therapeutic interventions, monitoring and review of the care that they receive.

Carer participation in service receipt is about being recognised, respected and supported as a carer in providing care to the identified client. Families and carers will be engaged early as possible (with consent) in needs identification, recovery planning, therapeutic interventions, monitoring and review of the care that they receive.

Agencies should have a well defined consumer and carer engagement policy relating to services clients and families receive. [44] This policy should include identification of the needs of any dependent children, and how these needs will be addressed.

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[42] Department of Human Services, Dual Diagnosis – key directions and priorities for service development - draft document (270306) Version 1, 27.03.2006
[43] Appendix 12: Template - Consumer and Carer Participation Policy for Service Development
[44] Appendix 13: Template - Consumer and Carer Participation Policy for Service Receipt

Dispute Resolution

Dispute Resolution / Trouble Shooting...

It is acknowledged that within the context of collaborative working relationships every effort is made to communicate and resolve differences directly between staff who are engaged in the work with a client.

There may, however, be times when despite best intentions, a mutually agreeable outcome is not able to be reached.

No Wrong Door agencies commit to:

- Respectful, tolerant and open communication
- Rapid and constructive resolution of conflict
- Focus on the centrality of the client's best interest in all dispute resolution

The following is a guide to support the process.

Issue	Intent	Practice
Grievance Process	To resolve differences rapidly, constructively and respectfully	If the grievance is in relation to a clinical matter, a case conference will be called with all relevant services. If the matter is not able to be resolved at case conference it will be referred to the managers of each service.
Protocol Issue	To update protocol to ensure relevance and reflection to the changing health system	If the complaint is deemed a 'process' issue then the signatory agencies to this protocol will be requested to attend an earlier review meeting to address the issue/s identified
Consumer or Carer issue	Provide an opportunity for consumers and carer to provide feedback and enable complaints / concerns to be addressed	Each organisation should have a clearly articulated complaints procedure. Information about how to access this process should be readily available to consumers and carers. IE: signage, suggestions box, satisfaction surveys, website comments etc.

Appendices

Appendices:

Title:	Number:
Victorian Service Coordination Tools – List of Templates	1
Integrated Comprehensive Dual Diagnosis Assessment Tool – sample template	2
Advance Directives Plan	3
Secondary Consultation Record Sheet	4
Consumer & Carer Participation for Service Development Policy Sample Template	5
Consumer & Carer Participation for Service Receipt Policy Sample Template	6
The Melbourne Charter	7
No Wrong Door Protocol – Signatory Pages.	8

Appendix - 01: Service Coordination Tool Templates:

The No Wrong Door Integrated Dual Diagnosis Protocol supports the use of the Victorian Statewide Service Coordination Tools. The templates referred to in this document are:

- The core templates: Confidential Referral Cover Sheet, Consumer Information template and Summary and Referral Information templates.
  These core templates are used to send a referral after the consumer has provided consent to share information.

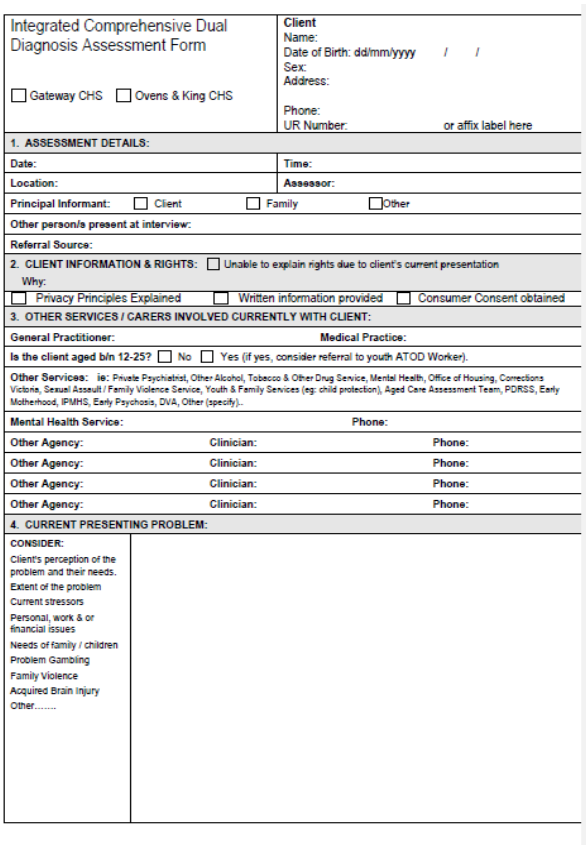
- Optional templates or profiles support the recording of further information on areas relevant to the consumer's circumstances and presenting needs. These templates or profiles referred to in this document are: Health Behaviours, Psychosocial and Need for Assistance.

These tools can be downloaded from the following website:

http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm

Service Coordination Tool Name:	Its use:
Confidential Referral Cover Sheet	Used for referral as a fax / email cover sheet. Also enables referral acknowledgement.
Consumer Information	Used to provide update information relating to client: demographics, contact details, general practitioner, pension /entitlements and insurance status.
Summary and Referral Information & Vic Statewide Referral Tool:	Used to provide information about the presenting issues, reason for referral, alerts, current services, referral action plan. ***Please note:*** GPs use the Victorian Statewide Referral Tool
Consumer Consent:	Used to record consumer consent for the service provider to share information.* It is a requirement to obtain consent to share information, if the consumer has the capacity. This template does not need to be sent to the service provider with a referral, unless it is requested.
Profile: Health Behaviours:	Contains information about nutritional risk, smoking, oral health, alcohol use, gambling, physical activity and physical fitness
Profile: Psychosocial:	Contains information about personal and social support, mental health and wellbeing
Profile: Need for Assistance:	Contains information about functional needs such as domestic, personal, mobility, transport, cognition, behaviour and communication
Care Coordination Plan:	With consultation from all key stakeholders, this document records a coordinated care plan for consumers with complex and/or multiple needs.

Appendix - 02: Integrated Dual Diagnosis Assessment Tool - Sample template



Integrated Comprehensive Dual Diagnosis Assessment Form

☐ Gateway CHS ☐ Ovens & King CHS

Client
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
Address:
Phone:
UR Number: or affix label here

1. ASSESSMENT DETAILS:

Date:	**Time:**
Location:	**Assessor:**

Principal Informant: ☐ Client ☐ Family ☐ Other

Other person/s present at interview:

Referral Source:

2. CLIENT INFORMATION & RIGHTS: ☐ Unable to explain rights due to client's current presentation
Why:
☐ Privacy Principles Explained ☐ Written information provided ☐ Consumer Consent obtained

3. OTHER SERVICES / CARERS INVOLVED CURRENTLY WITH CLIENT:

General Practitioner: **Medical Practice:**

Is the client aged b/n 12-25? ☐ No ☐ Yes (if yes, consider referral to youth ATOD Worker).

Other Services: ie: Private Psychiatrist, Other Alcohol, Tobacco & Other Drug Service, Mental Health, Office of Housing, Corrections Victoria, Sexual Assault / Family Violence Service, Youth & Family Services (eg: child protection), Aged Care Assessment Team, PDRSS, Early Motherhood, IPMHS, Early Psychosis, DVA, Other (specify)..

Mental Health Service: **Phone:**

Other Agency:	**Clinician:**	**Phone:**
Other Agency:	**Clinician:**	**Phone:**
Other Agency:	**Clinician:**	**Phone:**
Other Agency:	**Clinician:**	**Phone:**

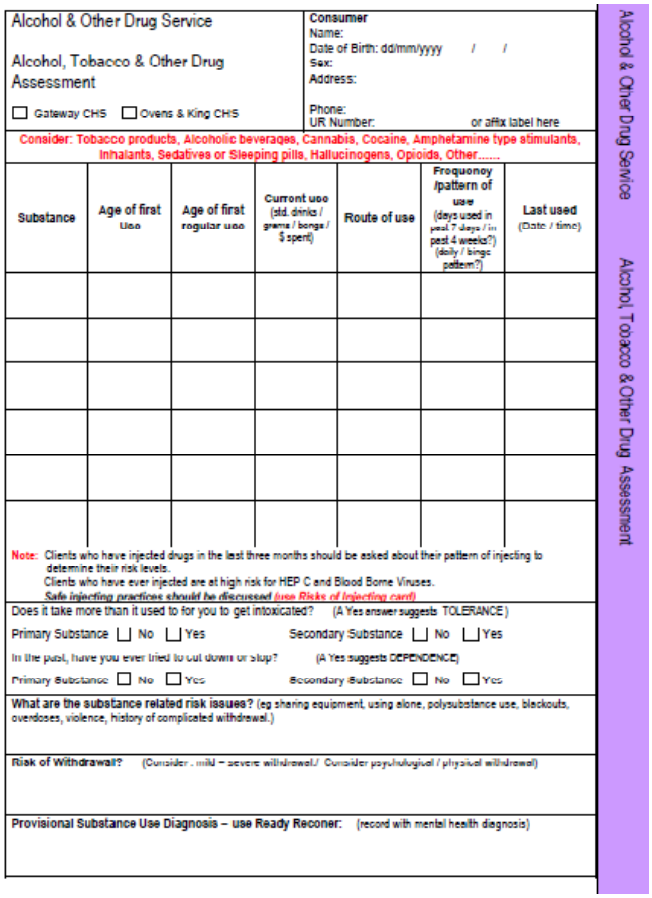
4. CURRENT PRESENTING PROBLEM:

CONSIDER:
Client's perception of the problem and their needs.
Extent of the problem
Current stressors
Personal, work & or financial issues
Needs of family / children
Problem Gambling
Family Violence
Acquired Brain injury
Other.....

Comprehensive Dual Diagnosis Assessment Tool

8 page sample tool downloadable from:

www.nowrongdoor.org.au



Alcohol & Other Drug Service

Alcohol, Tobacco & Other Drug Assessment

☐ Gateway CHS ☐ Ovens & King CHS

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
Address:
Phone:
UR Number: or affix label here

Consider: Tobacco products, Alcoholic beverages, Cannabis, Cocaine, Amphetamine type stimulants, Inhalants, Sedatives or Sleeping pills, Hallucinogens, Opioids, Other.....

Substance	Age of first use	Age of first regular use	Current use (std. drinks / grams / bongs / $ spent)	Route of use	Frequency /pattern of use (days used in past 7 days / in past 4 weeks?) (daily / binge pattern?)	Last used (Date / time)

Note: Clients who have injected drugs in the last three months should be asked about their pattern of injecting to determine their risk levels.
Clients who have ever injected are at high risk for HEP C and Blood Borne Viruses.
Safe injecting practices should be discussed (use Risks of Injecting card)

Does it take more than it used to for you to get intoxicated? (A Yes answer suggests TOLERANCE)
Primary Substance ☐ No ☐ Yes Secondary Substance ☐ No ☐ Yes

In the past, have you ever tried to cut down or stop? (A Yes suggests DEPENDENCE)
Primary Substance ☐ No ☐ Yes Secondary Substance ☐ No ☐ Yes

What are the substance related risk issues? (eg sharing equipment, using alone, polysubstance use, blackouts, overdoses, violence, history of complicated withdrawal.)

Risk of Withdrawal? (Consider : mild – severe withdrawal./ Consider psychological / physical withdrawal)

Provisional Substance Use Diagnosis – use Ready Reconer: (record with mental health diagnosis)

Alcohol & Other Drug Assessment Tool

2 page sample tool downloadable from:

www.nowrongdoor.org.au

Appendix - 03: Advance Directives Plan:

An advance directive is a document prepared by a consumer to be read and used in case of a mental health crisis. Typically advance directives contain special information outlining a person's unique circumstance, personal preferences regarding treatment choices and information about practical life management arrangements. An advance directive outlines the steps that must be taken to provide optimal support and care for a person with a mental illness during a time of crisis in order to limit or prevent the damage from that crisis. Advance directives are not legally enforceable in Victoria; however they can make a significant contribution to the wellbeing of people living with psychiatric disability.

More information can be found at:

http://www.communitylaw.org.au/mentalhealth/cb_pages/advance_directives.php

The Advance Directive should include:

- Name of person, DOB, Phone numbers, Address
- Who to notify in the event of hospitalisation
- GP / Psychiatrist / Key mental health worker
- Information about any Financial & Medical Power of Attorney
- Information about any Guardianship
- Who is the Primary Advocate / supporter / carer / attorney / guardian
- What has the client found helpful in relation to their medication / care & treatment
- What are the things that have not helped in the past
- Other health issues that may need to be highlighted or included
- What requests the client has in relation to care of housing, children, keys, pets, garden and employment.
- What other things does the client want people who are caring for them to know.

Each page should be numbered, signed, dated and witnessed.

The end of the document should have a signatory area for both the client and the witness to sign.

The witness should include their Full name, profession and telephone numbers. This page should be dated also.

Appendix - 04: Secondary Consultation Record Sheet Template.

Refer to the Secondary Consultation Guideline for related principles and recommendations.

Documentation of secondary consultation provision and receipt should reflect each agency's individual policy guidelines

Consultee / Their agency			
Consultant / Their agency			
Client name (if relevant/known)			
Client address (if relevant/known)			
UR (if relevant)		**DOB (if known)**	
Situation/ demographics / issues / concerns			
Outcomes / recommendations			

Consultant name:	**Signature**	**Date**

Appendix - 05: Consumer & Carer Participation for Service Development Policy

0.0 POLICY TITLE: Consumer and Carer Participation Policy for Service Development

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2. OVERVIEW:

PURPOSE

The purpose of this policy is to ensure that Anytown Community Health Service is guided in developing consumer, carer and community participation for improved outcomes for consumers.

DEFINITIONS

'Consumer' refers to anyone who either directly or indirectly utilises the service, and anyone who may use the service in the future;

'Carer' refers to anyone who is directly involved in the care of a consumer. This may include family, community and professional carers.

Consumer and carer participation is about supporting empowerment in health care for improved health and well-being. It may include involving consumers and carers in decision making, planning, implementation, monitoring, evaluation and review of a service.

Consumer and Carer participation may apply to consumers who are involved in any strategic organisational situation. This may include:

- Involving consumers and carers in the development, planning, implementation, evaluation and review of a service
- Seeking consumer and carer feedback to sanction plans or decisions made.

PROCEDURE

2. 1 Anytown Community Health Service will:

2.1.1 Work towards incorporating the principles of consumer participation in the service vision, mission and philosophical statement.

2.1.2 Recruit a consumer and / or carer representative as a board member.

2.1.3 Support and resource the consumer and carer representatives to build their capacity to adequately represent their constituency through:

- Development of a clearly delineated job description
- Provision of education, training and professional development
- Linkages to support networks
- Provision of peer supervision and mentorships
- Adequate remuneration for the roles they undertake
- Access to appraisal and review systems
- The establishment of consumer and carer focus groups

2.1.4 Support mechanisms which provide opportunities for consumer and carer consultation with their constituency via development of consumer and carer focus groups:

- Consumer and carer focus group will be overseen by a Terms of Reference.
- The consumer and carer focus groups will have access to communication channels with the Board via the employed consumer and carer representatives.
- The consumer representative will oversee the compliments / complaints / suggestions processes with direct recommendations to the Board for consideration
- The consumer representative will develop / source service related consumer and carer resources / brochures
- The consumer representative will ensure that their constituency remains updated to their progress and planning via a communication strategy that they develop.

2.1.5 Develop documentation informing stakeholders of the consumer participation incorporated into the service and any implications in regards to service delivery.

3.1 RESPONSIBILITY

3.1.1 The Committee of Management is responsible for ensuring governance processes are established for the support of consumer and carer participation.

3.1.2 The Director / CEO is responsible for developing strategies to enable consumer and carer participation and for processes to be applied throughout the service via appropriate structures, policies, processes and resources.

3.1.3 All staff of the service will be aware of the consumer and carer participation policy and processes and will contribute to activities to implement the policy.

3.1.4 The consumer and carer participation policy will be incorporated into staff induction training.

Appendix - 06: Consumer & Carer Participation in Service Receipt Policy

0.0 POLICY TITLE: Consumer and Carer Participation for Service Receipt

1. OVERVIEW:

PURPOSE

The purpose of this policy is to ensure that consumers and their carers are engaged and involved in all aspects of their care.

DEFINITIONS

'Consumer' refers to anyone who either directly or indirectly utilises the service, and anyone who may use the service in the future;

'Carer' refers to anyone who is directly involved in the care of a consumer; this may include family, community and professional carers.

Consumer participation in service receipt is about supporting and encouraging consumers to become empowered to be active participants in their health care. This includes involving consumers in needs identification, recovery planning, therapeutic interventions, monitoring and review of the care that they receive.

Carer participation in service receipt is about being recognised, respected and supported as a carer in providing care to the identified client. Families and carers will be engaged early as possible (with consent) in needs identification, recovery planning, therapeutic interventions, monitoring and review of the care that the client receives. This should include consideration of the needs of any dependent children, and how these needs may be addressed.

2. PROCEDURE

2.1.1 Management and staff are committed to actively engage consumers and carers in all aspects of their health care.

2.1.2 Consumer and carer comments and feedback about the care they have received will be sought, at least annually. These comments will be collected, collated and made available to focus groups for comment and recommendation. Then recorded and reviewed for organisational planning processes;

2.1.3 Consumers and carers will have access to agency Consumer and Carer representatives for advocacy, information provision and support.

2.1.4 Staff will be trained in consumer and carer engagement health care principles including Advance Directives.

2.1.5 Staff will work towards incorporating the principles of consumer engagement in all aspects of their health care

2.1.6 Upon entry to the service and throughout treatment, consumers and carers will receive information regarding the following:

- their Rights and Responsibilities
- confidentiality and the release of information
- consent for the release of information
- the service that Anytown CHS offers
- educational information relating to their illness / issues
- information about support whilst on waiting list.

2.1.7 Staff will ensure consumers and their carers are engaged and involved in all stages of the consumer's care, from entry to exit. This would include identification of the needs of any dependent children, and how these needs will be addressed.

2.1.8 Consumers will authorise (sign off) their Individual Treatment Plan (Care Coordination Plan).

2.1.9 Consumers will articulate clearly via consent on the treatment plan, who will and will not be involved in their care.

2.1.10 The consumer and their key stakeholders (other services and identified carers) will be provided a copy of their Care Coordination Plan.

2.1.11 Whereby, in the event that a consumer refuses to be actively involved in their treatment plan development and does not wish for a copy to be provided to them, then this must be documented clearly in the consumer's progress notes.

2.1.12 Consumer consent should reflect:

- who can be contacted
- what information can be provided
- who will be ACTIVE participants in the consumer's care.

2.1.13 The treatment plan should include or have attached to it the clients written Advance Directives.

2.1.14 Each consumer (and carer where possible) should be offered a service satisfaction survey to complete both during their treatment and at the conclusion of their treatment.

3.2 RESPONSIBILITY

3.2.1 The Committee of Management is responsible for ensuring that the staff are aware of the consumer and carer service receipt policy

3.2.2 The consumer and carer organisation representatives (or any formal consumer and carer consultative group) are responsible for the receipt, collation and feedback of the service satisfaction survey and compliments / complaints contributions and providing a report to the board with action recommendations.

3.2.3 The key worker / care coordinator is responsible for ensuring the consumer and their carer have had active involvement in all aspects of care and that this engagement continues to be offered throughout the course of treatment with the service.

4.1 RELATED POLICIES/ DOCUMENTS:

This policy links with the following documents:

- Consumer and carer participation in service delivery policy
- Consumer and carer rights and responsibility charter
- Consent for treatment policy
- Confidentiality and release of information charter
- Satisfaction, feedback, complaints and compliments charter.

Appendix - 07: The Melbourne Charter, 2009.

THE MELBOURNE CHARTER

for Promoting Mental Health and Preventing Mental and Behavioural Disorders

The Melbourne Charter asserts that mental health and wellbeing are:	The Melbourne Charter affirms that mental health and wellbeing are:	The Melbourne Charter believes that mental health and wellbeing are:
• an indivisible part of general health; • essential for the wellbeing and optimal functioning of individuals, families, communities and societies; and • a fundamental right of every human being, without discrimination.	• of universal relevance; • most threatened by poor and unequal living conditions, conflict and violence; and • a key indicator of a nation's social and economic development.	• everybody's concern and responsibility; • best achieved in equitable, just and non-violent societies; and • advanced through respectful, participatory means where culture and cultural heritage and diversity is acknowledged and valued.

The Melbourne Charter identifies principles and actions that governments, communities, organisations and individuals can take to influence the interconnecting social, economic, cultural, environmental and personal factors that influence mental health and wellbeing.

MENTAL HEALTH

Mental health is a state of complete physical, mental, spiritual and social wellbeing in which each person is able to realise one's abilities, can cope with the normal stresses of life, and make a unique contribution to one's community.

Mental illnesses such as anxiety disorders, depression and schizophrenic disorders are real and potentially disabling conditions, affecting over 450 million individuals, families and carers worldwide.

Poor mental health, loss of wellbeing, and illness have economic and social consequences for societies, communities, families and individuals. Mental health promotion is a strategic and sustainable approach to eliminating or minimising those factors which give rise to distress and loss of wellbeing and introducing and maximising those which create the circumstances in which all can flourish. It is also important in the process of recovery from illness or episodes of illness.

Principles for promoting mental health and preventing mental illness

Mental health and wellbeing are determined by multiple and interacting social, environmental, psychological and biological factors, just as health and illness in general are determined.

The critical social, environmental and economic determinants of mental wellbeing and of mental illness are common across nations. Individual and family-related and community protective and risk factors can be biological, emotional, cognitive, cultural, behavioural, interpersonal and environmental.

The presence of multiple risk factors, the lack of protective factors and the interplay of these culminate in greater likelihood of poor mental health and wellbeing and the development of mental illness (see boxes overleaf).

Mental health promotion aims to improve social, spiritual and emotional wellbeing by creating: supportive living conditions and environments that foster connectedness between people; strength in recovery from illness; and competence and resilience in individuals and communities. Prevention strategies are a core component of mental health promotion.

Population-based approaches for promoting mental health and wellbeing and preventing mental illness work by:

- utilising principles of public participation, engagement and empowerment
- redressing inequities and discriminatory practices that exclude the most socially disadvantaged or people at risk such as indigenous people, people with mental illness, children and young people, people with disabilities, elderly people and those in prison
- action in everyday contexts such as in schools, workplaces, sports clubs, community-based activities, government services and the natural environment
- providing access to quality care and recovery-focused services for those who are experiencing poor mental health or mental illness
- combining advocacy, communication, policy and legislation, together with community participation and evidence-building strategies
- joining up policies and practices across sectors including education, housing, mental health services, employment and industry, transport, arts, sports, urban planning and justice; and are
- accompanied by person-centered responses to mental distress and loss of wellbeing which foster hope, offer choices, support people to lead their own recoveries and ensure a quick return to active citizenship.

VicHealth

THE CLIFFORD BEERS FOUNDATION

THE CARTER CENTER

Waging Peace. Fighting Disease. Building Hope.

The Melbourne Charter is the outcome of a worldwide discussion that was initiated by the organisers and participants of the Global Consortium for the Advancement of Promotion and Prevention in Mental Health (GCAPPH) conference entitled From Margins to Mainstream: 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders, in Melbourne, Australia, September 2008. The Charter reflects the input and support of organisations from all over the world. It articulates some common principles and recommendations that should be part of our future action in mental health promotion and mental illness prevention. The Charter provides a framework which recognises the influence of social and economic determinants on mental health and mental illness and identifies the contribution that diverse sectors (including but not exclusive to health) make to influencing those conditions that create or ameliorate positive mental health.

ACTIONS

Decision-makers

The Melbourne Charter calls on national governments to acknowledge the factors that influence their people's mental health and wellbeing and:

- take responsibility for ensuring that those factors that protect mental health and wellbeing are accessible to all and those that place people at risk of poor health or illness are reduced or eliminated
- actively engage with those who are most adversely affected and socially excluded, such as people experiencing and affected by mental illness, people with disabilities, young people, people forcibly displaced, women subject to violence, and prisoners
- protect indigenous cultures
- promote equal opportunity and freedom from discrimination
- ensure policy is informed by best available and appropriate evidence and adequately funded
- invest in training personnel in publicly funded agencies to promote mental health
- facilitate partnerships across public agencies that influence mental health
- adequately fund and deliver accessible, high quality and recovery-focused mental health services; and
- ensure the private sector complies with local, national and international regulations and agreements that promote and protect mental health.

People working to promote mental health and wellbeing

The Melbourne Charter calls on those working to improve the mental health and wellbeing of populations to:

- advocate for human rights, ensuring the protection of all and in particular
  - indigenous people and their cultures from exploitation
  - people affected by mental illness
  - people forcibly displaced from their homeland
  - children, young people and older people
  - prisoners
- act to eliminate stigma, discrimination and inequities
- engage, partner and build alliances with public, private, non-governmental, community-based and international organisations to create sustainable initiatives
- build greater community understanding of mental health and mental distress and loss of wellbeing
- empower and mobilise communities and individuals, particularly the most socially excluded, by supporting their rights and providing resources and opportunities for them to shape and initiate their own actions to promote wellbeing
- support engagement with and leadership by people with lived experience
- use evidence to inform programs and ensure appropriate research and evaluation methods are used to increase the knowledge base
- encourage the corporate sector to share responsibility by ensuring health and safety in the workplace, and to promote the health and wellbeing of employees, their families and communities.

PROTECTIVE FACTORS AND RISK FACTORS FOR MENTAL HEALTH AND WELLBEING

Protective factors

Arts and cultural engagement

Childhood: positive early childhood experiences, maternal attachment

Cultural identity

Diversity: welcomed/shared/valued

Education: accessible

Environments: safe

Empathy

Empowerment and self determination

Family: resilience, parenting competence, positive relationship with parents and/or other family members

Food: accessible, quality

Housing: affordable, accessible

Income: safe, accessible employment and work conditions

Personal resilience and social skills

Physical health

Respect

Social participation: supportive relationships, involvement in group and community activity and networks

Sport and Recreation: participation and access

Transport: accessible and affordable

Services: accessible quality health and social services

Spirituality

Risk factors

Alcohol and drugs: access and abuse

Disadvantage: social and economic

Displacement: refugee and asylum-seeker status

Disability

Discrimination and stigma

Education: lack of access

Environments: unsafe overcrowded, poorly resourced

Family: fragmentation dysfunction and child neglect, post-natal depression

Food: inadequate and unavailable

Genetics

Homelessness

Isolation and exclusion: social and geographic

Natural and human-made disasters

Peer rejection

Political repression

Physical illness

Physical inactivity

Poverty: social and economic

Racism

Unemployment: poor employment conditions and insecure employment

Violence: interpersonal, intimate and collective; war and torture

Work: stress and strain

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-3

This is the attachment marked '**GJC-3**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

Better Outcomes: Towards a Victorian Complexity-Capable Service System

A submission to the Royal Commission into Victoria's Mental Health System

Gary Croton
VDDI

July 5th 2019

About this Submission:

***Terminology*:** This submission interchangeably uses the terms *'dual diagnosis'*, *'co-occurring mental health-substance use'* and *'comorbidity'* to describe the situation of, and attendant issues around, people experiencing co-occurring mental health and substance use concerns.

Interactive PDF: Most images in this submission are 'click-able' and hyperlink to the indicated resource

Disclaimer:

This submission is drafted from the perspective of a mental health-substance use nurse who has worked in diverse mental health and substance treatment settings for 44 years and in a dedicated dual diagnosis capacity building role for the past 21 years. The views, opinions and recommendations in this submission are those of the author and are not necessarily representative of those of any current or past employer. This submission is supported by the Victorian Dual Diagnosis Initiative Leadership Group. The views, opinions and recommendations in this submission are the authors and are not necessarily representative of those of any VDDI-auspice agency or client service.

Suggested Reference:

Croton, G. (2019). Better Outcomes: Towards a Victorian Complexity-Capable Service System. Submission to the Royal Commission into Victoria's Mental Health System. Victorian Dual Diagnosis Initiative.

Contents:

RC Terms of Reference addressed in this submission

This submission addresses the following RC Terms of Reference (State of Victoria, 2019) (in bold text):

- ***How to most effectively*** *prevent mental illness and suicide, and* ***support people to recover from mental illness****, early in life, early in illness and early in episode,* ***through Victoria's mental health system****, and* ***in close partnership with other services.***
- ***How to deliver the best mental health outcomes*** *and* ***improve access to*** *and the* ***navigation of Victoria's mental health system*** *for people of all ages.*
- *How to best support* ***the needs of family members and carers of people living with mental illness****.*
- *How* ***to improve mental health outcomes****, taking into account* ***best practice*** *and* ***person-centred treatment and care models****, for those in the Victorian community, especially* ***those at greater risk of experiencing poor mental health****.*
- *How to* ***best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.***

1.
ABOUT CO-OCCURRING MENTAL HEALTH-SUBSTANCE USE CONCERNS

Terminology

A range of terms are used to describe the situation and attendant issues of people who experience co-occurring mental health and substance use concerns.

'***Comorbidity***' has been frequently used at an Australian national level and by some states. '*Comorbidity*' has been criticised for its pathological overtones.

'***Co-existing disorders***' is New Zealand's preferred term (Te Pou, Matua Raki, 2012) and has been used to embrace gambling as well as mental health and substance use concerns.

'***Co-occurring disorders***' is the USA's most commonly used term (SAMHSA, 2005) and '*concurrent disorders*' is Canada's preferred term.

'***Dual diagnosis***' has been the United Kingdom's traditional term (Turning Point, 2004) though the term is debated (Hamilton, 2014). A 2011 national guideline adopted the *'co-existing'* convention (NICE, 2011). A 2019 guideline (Clinks, 2019) has recently offered the acronym '***COMHAD***' to describe the situation of '*individuals who use health and social care services who are experiencing difficulties with both mental health and alcohol/drug use conditions at the same time.'*

'***Dual diagnosis***' has also been Victoria's, long-standing, preferred term. Given current trends towards de-emphasising medical model approaches and developing alternatives to traditional models based on psychiatric diagnosis (Johnstone, 2018) (Salkovskis, 2018) - including transdiagnostic approaches (Eaton, 2017) - it is timely for Victoria to agree an alternative term to *'dual diagnosis'*.

Recommendation 1:
That Victorian DHHS auspice a multi-stakeholder, codesign process to agree and promote a more current term than '*dual diagnosis'* to describe the situation and attendant issues of people experiencing co-occurring mental health and substance use concerns.

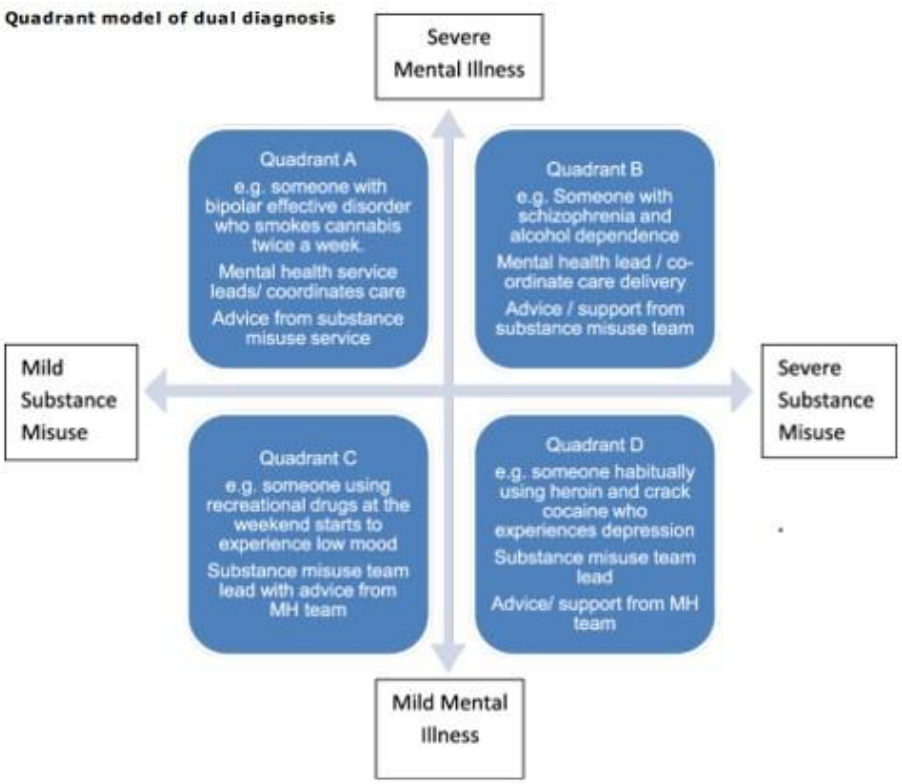
Page 6

Cohorts

People with co-occurring mental health and substance use concerns are not a homogenous group. There is a huge variation in the *combinations of concerns* and in the *severity of those concerns*. Consequently, there is also huge variation in the *treatment and support needs and preferences* of the people involved.

People with co-occurring mental health-substance use concerns are the *expectation not the exception* in both specialist mental health and substance treatment services however there tend to be different predominant cohorts in each sector. Mental health services tend more to encounter people with serious mental illness co-occurring with a range of substance use concerns. Substance treatment services tend to encounter people with more severe substance use concerns co-occurring with high prevalence mental health concerns such as anxiety and depression. There is a high prevalence of Post-Traumatic Stress Disorder amongst people receiving substance use treatment.

Several typologies have been proposed to guide services in who has primary treatment responsibility for the different predominant cohorts- the two most notable are the USA's four-quadrant model (McDonell M, 2012) and its many adaptations (Marel, 2016) (Drug and Alcohol Findings, 2015) and the 3-level schema proposed in the 2007, cross-sector, Victorian dual diagnosis policy (DHS, 2007) -see Three level schema for responding to dual diagnosis diagram on page 46.



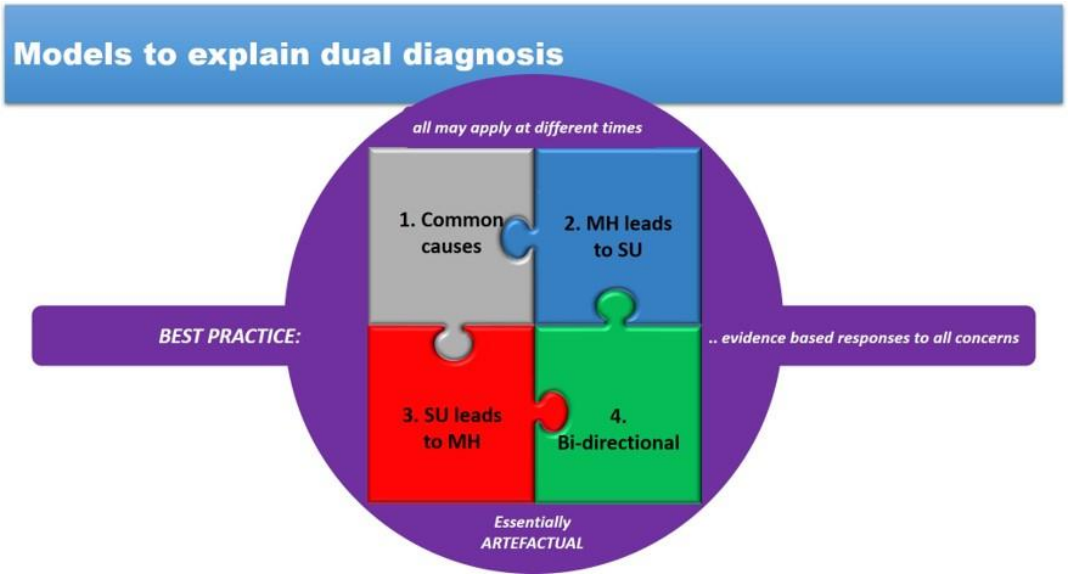
Quadrant Model of Dual Diagnosis- UK version (Drug and Alcohol Findings, 2015)

Some of the most visible cohorts of people with co-occurring mental health and substance use concerns are people experiencing co-occurring:

- Alcohol Use Disorders (Mild, Moderate or Severe) with Mood or Anxiety Disorders
- Cannabis Use Disorders with a range of mental health disorders including early psychosis
- Amphetamine Use Disorders with psychotic symptoms
- Severe mental illness with a wide range of dependant and non-dependant substance use disorders
- Anxiety Disorders with alcohol or other depressant use disorders
- Post-Traumatic Stress Disorder with alcohol or other depressant use disorders
- Nicotine Use with a range of mental health disorders

Relationships between the concerns

The literature around co-occurring disorders usually proposes four models to summarise the possible relationships between the concerns:



1. ***Common risk factors***: posits that common risk factors, such as trauma or poor cognitive functioning, may have influenced the person to develop both concerns.

2. ***Mental health concern leads to substance use concern***: included in this model are relationships such as:
   – *Self-medication hypothesis* in which a person uses substances to alleviate the symptoms of a mental health concern e.g. a person developing an alcohol use problem as an outcome of using alcohol to relieve anxiety symptoms
   - *Dysphoria model* argues that life can sometimes have fewer pleasurable moments for people with mental health concerns making the person more susceptible to the immediate, predictable, rewards of substance use
   - *Super-sensitivity model* posits that some people with mental health concerns, whether through symptoms of the illness or the effects of the medications used to treat the illness, are exquisitely susceptible to the effects of substances

3. ***Substance use leads to mental health concern***: sometimes a clear causal relationship can be observed between substance use and the subsequent development of a mental health disorder, for instance in amphetamine psychosis.

4. ***Bi-directional model****:* perhaps the most useful model that posits that each concern develops in relationship to the other – substance use influences mental health symptoms which in turn influence substance use and so on. Most commonly, when working with a person with co-occurring concerns, a clear, causal relationship of one concern leading to the other cannot be identified with confidence.

In any one person more than one of the above models may apply at different times in their progression through and recovery from co-occurring concerns. Regardless of the relationships between the concerns a guiding clinical principle is that evidence-based treatments should be provided for all the concerns that a person presents with.

Challenges

A range of challenges are encountered by people experiencing, caring for or providing services to people with co-occurring mental health and substance use concerns. The following is a by no means exhaustive list of some of the possible challenges that may be encountered by different groups affected by or responding to co-occurring mental health and substance use concerns.

Challenges - Persons experiencing co-occurring mental health and substance use concerns.

- **Access:** to effective treatment and support – there is strong evidence of poor access to treatment for either mental health and substance use concerns. Access is further compromised when a person has both disorders. A long-standing, often identified, issue occurs when a person assessed by mental health services receives feedback that before receiving any mental health service they first need to address their substance use- only then to be told by AOD services that first need to address their mental health concerns ….thus falling through the gaps receiving no treatment from either service.

- **Stigma and discrimination**: Individually mental health and substance use concerns are highly stigmatised healthcare needs. When a person experiences *both concerns,* they are likely to experience compounded stigma and discrimination with deleterious impacts on quality of life, access to, quality and effectiveness of treatment.

- **Unfriendly systems:** How to sufficiently compartmentalise their mental health and substance use concerns to address the concerns in two, often-dissimilar, systems in which the treating workers may have poor or no communication about the person's issues?

- **Harms and unwanted outcomes:** people with both concerns are more likely to experience a significant range of harms and unwanted outcomes than a person with only one of the concerns.

Challenges - Significant Others

- **Parallel issues:** The challenges experienced by the significant others of people with co-occurring mental health and substance use concerns tend to parallel those of the person with the issues.
- **Courtesy stigma**: is the '*experience of stigma as a result of a relationship with, or proximity to, a stigmatised person'* (Adfam, 2012). Significant others may experience increased isolation and compromised access to supports as a result of courtesy stigma. Again, there is 'compounded stigma' as a result of the person concerned having two of society's most stigmatised disorders.
- **Losses:** There is evidence that people caring for a person with both mental health and substance use concerns experience greater financial losses and anticipatory grief than people caring for someone with only one of the concerns.
- **Directions:** The significant others of people with co-occurring mental health and substance use concerns may experience dilemmas centred on questions of which concern has 'primacy', what treatment would be helpful, where and how to access treatment and supports and dilemmas of responsibility v consequences
- **Information:** One of the greatest challenges can be where and how to get reliable information. This could be about the concerns that the person they care for is experiencing but also could be about how to navigate complex health and social services.

Challenges – Clinicians and workers

- **Role-validity, knowledge, skills, confidence:** Mental health and substance treatment workers primary training is most often principally around single-disorders – hence they may lack role-validity, skills, knowledge and confidence when faced with responding to multiple other concerns.
- **Training standards:** To date there has seldom been agreed minimum standards and curriculum informing workplace training deployed to develop clinician's capacity to respond effectively to people with complex needs
- **Agency support:** Often workers, through workshop participation, become enthused about providing more integrated treatment only to learn that their auspice agency's tools, procedures, clinical leaders, culture and priorities do not support this practice development
- **Competing priorities:** Mental health and substance treatment workers work in time and resource-poor, crisis-focused (VAGO, 2019), pressured environments which perforce tend towards minimum, non-integrated, treatment provision. Which do not allow the time necessary for activities such as building and maintaining effective cross-sector relationships that augur towards cross sector understanding, collaboration and consultations and navigable treatment pathways.

Challenges – Local Managers, Agencies, Planning & Funding bodies

- **Resources:** Local Managers, Agencies, Planning & funding bodies are besieged by wicked problems around funding, resource allocation, systemic priorities, misaligned structural arrangements and layers of workforce challenges. Directions are heavily contested and there is an inadequate evidence base to guide decision making.
  Recent data (VAGO, 2019) (Perkins, 2019) has graphically demonstrated how under-resourced Victorian Mental Health services are to achieve against their tasks. In this context, struggling to provide effective mental health services per se, it is understandable that the services have made little recent headway in building their capacity and routine practice to provide integrated treatment to people presenting with dual diagnosis and other complex needs.

- **Systemic self-efficacy:** In trying to navigate and respond to this plethora of complex problems people with management and planning and funding responsibilities may have lost their belief that it is possible to deliver a system that is effective and efficient in responding to the needs of people with mental health concerns – loss of 'systemic self-efficacy' .

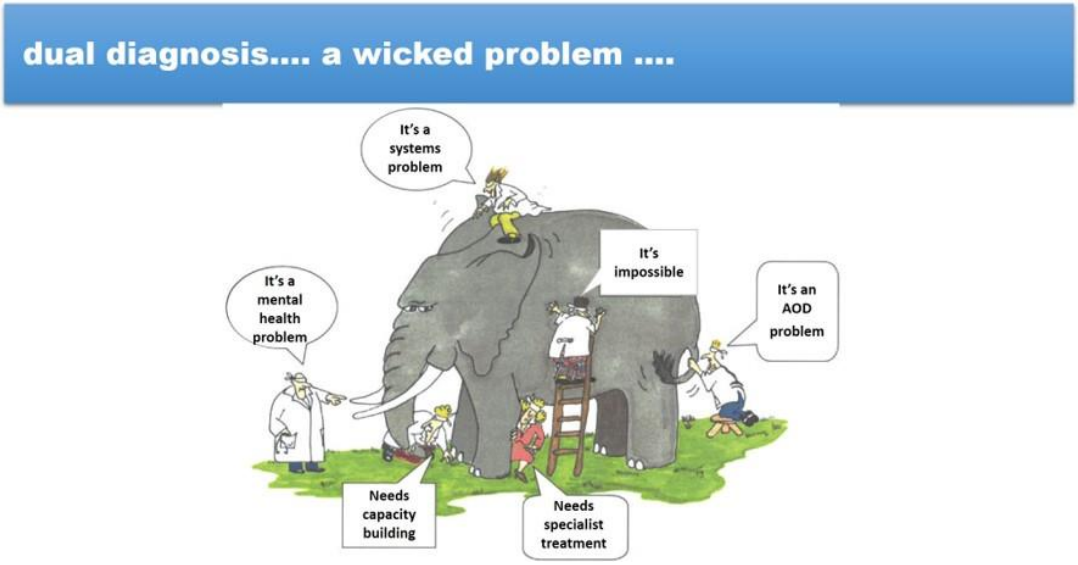
- **Competing reforms**: A clear, best practice, goal for services and systems attempting to prevent people with dual diagnosis and other complex needs from falling through the gaps is the development of a **No Wrong Door service system**. A host of central policy and planning documents in a variety of arenas identify the importance of agencies collaborating for best outcomes.
  These worthwhile goals contrast with many of the actual impacts of the last 5-years evolution of a commissioning, competitive-tendering, funding environment. Agencies which were once partners in developing local systemic dual diagnosis /complexity-capability may now view other local agencies as competitors and be averse to meaningful collaborations and local systems development initiatives.

- **Exclusion criteria**: Other best practice complexity responses such as active welcoming and flexible entry criteria are increasingly less possible due to central system design and funding mechanisms. In practice taut, limited, service entry criteria function as *exclusion* criteria and inhibit services and workers from flexibly, promptly responding to the diverse needs of the people with multiple and complex needs.

Dual diagnosis - A wicked problem?

Wicked problems are problems that are '*difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize. It refers to an idea or problem that cannot be fixed, where there is no single solution to the problem. The use of the term "wicked" here has come to denote resistance to resolution, rather than evil'* (APSC, 2007). The Australian Public Service Commission identified nine characteristics of wicked problems – these are reproduced below in italics and discussed from a dual diagnosis perspective.

1. ***Wicked problems are difficult to clearly define.*** Co-occurring mental health and substance use concerns are not homogenous – there is great variability in the combinations and the severity of the concerns. Each person impacted by co-occurring mental health and substance use concerns will have unique experiences that shape their views of the nature of and possible solutions to the challenges involved.



2. ***Wicked problems have many interdependencies and are often multi-causal.*** There are multiple, often competing, views about the causes, nature of and optimum responses to mental health concerns per se and similar contestability around the causes, nature of and responses to substance use concerns. These tensions and challenges are magnified when a person has both concerns and there is a plethora of consequent impacts on service delivery- for instance
    - an abstinence oriented AOD residential rehabilitation facility refusing to admit a person taking psychotropic medication
    - a person assessed by a MH service being advised to resolve their AOD use before they can be considered for MH treatment and then receiving mirror advice from an assessing AOD service – the MH service perceiving the AOD use as 'primary', the AOD service perceiving the MH symptoms as 'primary' and hence the person falling through the gaps, receiving no service from either agency

3. ***Attempts to address wicked problems often lead to unforeseen consequences***. Dual diagnosis capacity building efforts focused on building relationships between AOD and mental health workers, in pursuit of more navigable treatment pathways, have sometimes observed an increase, rather than a decrease,

in cross-sector disputes and disappointments as the workers are thrown more together and the challenges to cross-sector collaboration become more apparent.

4. ***Wicked problems are often not stable.*** There is considerable variation in current trends in substance use and multiple, fluid influences impacting mental health and substance service delivery. Victoria's latest '*ice-epidemic*' brought a new set of challenges to both mental health and AOD sectors. Victorian mental health and AOD sectors experienced a surge in systemic 'dual diagnosis capability' in the wake of the 2007 cross-sector, dual diagnosis policy - a surge gradually eroded by the multiple competing tensions and ongoing changes experienced in both systems.

5. ***Wicked problems usually have no clear solution.*** Because of the interplay of:
   - the complexity, variability and dynamic nature of co-occurring mental health and substance use concerns,
   - the divergent views about the nature of and solutions to the problems
   - the range of complex logistical, resource and other challenges inherent in mental health–substance use treatment delivery

   the challenges around dual diagnosis service provision will never be 'solved' with any finality. Some strategies to address particular issues will be more effective than others. Efforts to achieve better outcomes for people with co-occurring mental health-substance use concerns will always need to be iterative – not least because of unrelenting systemic 'churn' and workforce throughput.

6. ***Wicked problems are socially complex****.* A learning from Victoria's efforts to date to address dual diagnosis issues has been that the most effective strategies that have influenced service delivery are those which have involved coordinated action by a range of stakeholders. The multi-stakeholder, multi-level, collaborative cross-sector service delivery changes that ensued from the 2007 cross-sector, dual diagnosis policy are an outstanding example.

7. ***Wicked problems hardly ever sit conveniently within the responsibility of any one organisation.*** At the most elementary level responsibility for addressing the challenges of dual diagnosis lie with all specialist mental health and AOD service delivery stakeholders. At the same time people with dual diagnosis and other complex needs are also highly prevalent in Primary Care / General Practice and tend to receive services from, and may be a challenge to, a host of other social and healthcare delivery organisations- housing, forensic, general healthcare, educational.

8. ***Wicked problems involve changing behaviour****.* This is particularly relevant to the challenges around influencing the complex behaviour of mental health and substance use counselling and support providers. A consistent finding (Moyers, 2015) is that the principle determinant of client outcomes is the relationship between client and counsellor and there are multiple complex factors impacting on service provider's capacities to develop the safe, collaborative relationships necessary for change to occur. Workplace culture is a particularly salient factor. There can be an inverse relationship between a clinician's qualifications and their receptivity to further developing their skills. Sustained, complementary diverse, coherent, evolving, strategies are necessary to influence complex behaviours such as individual clinician's healthcare service delivery.

9. ***Some wicked problems are characterised by chronic policy failure****.* Policy and funding bodies face an intimidating array of challenges in devising policies to address issues that transcend traditional service system boundaries. Victoria's 2007 cross-

sector, dual diagnosis policy[7] is a standout in the Australian landscape – few other Australian policies have had a significant, enduring impact on service delivery and client outcomes.

Recommendation 2:
That systems development initiatives crafted to address the issues around co-occurring mental health–substance use issues employ primarily collaborative and iterative strategies and are devised with a robust recognition of the complexity of the challenges.

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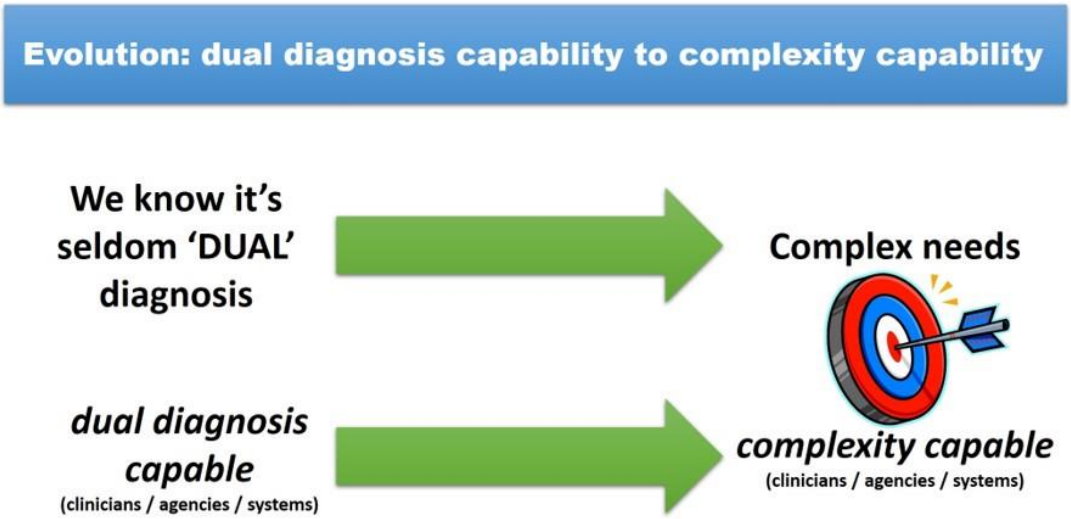
Dual Diagnosis Capability to Complexity Capability

People who present to services with co-occurring mental health-substance use concerns seldom have *only* mental health and substance use concerns. For good reasons they are at increased risk of also experiencing a range of other concerns and needs for service. This recognition has given rise to the phrase of people with '*dual diagnosis and other complex needs.'*



The United Kingdom's *All-Party Parliamentary Group on Complex Needs and Dual Diagnosis* (APPG-CNDD, 2013) defines people with complex needs as:

- *'A person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing.*
- *Such needs typically interact with and exacerbate one another leading to individuals experiencing several problems simultaneously.*
- *These needs are often severe and/or long standing, often proving difficult to ascertain, diagnose or treat.*
- *Individuals with complex needs are often at, or vulnerable to reaching crisis point and experience barriers to accessing services; usually requiring support from two or more services/agencies.*
- *Someone described as having complex needs will have (although not limited to) a co-morbidity of two or more of the following:*
    - *Mental health issues*
    - *Substance use issues*
    - *A dual diagnosis of mental health and substance use issues*
    - *A physical health condition*
    - *A learning disability*
    - *A history of offending behaviour*
    - *A physical disability*
    - *Employment problems*
    - *Homelessness or housing issues*
    - *Family or relationship difficulties*
    - *Domestic violence*
    - *Social isolation*
    - *Poverty*
    - *Trauma (physical, psychological or social)*

- *These needs are often severe, longstanding, difficult to diagnose and therefore to treat. Ongoing inequalities continue to exist and are only likely to increase as people live longer with a wider range of needs.'*

Cline and Minkoff, architects of the **Comprehensive Continuous System of Care (CCISC)** model profiled in the final chapter of this submission, note that '*in real world behavioural health and health systems, individuals and families with multiple co-occurring needs are an expectation, not an exception. Individuals and families not only have substance use and mental health issues, they frequently have medical issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues. In addition, these individuals and families are culturally and linguistically diverse. In short, these are people and families who are characterized by "complexity", and they tend to have poorer outcomes and higher costs of care.* (Cline, 2009)

However, instead of systems being designed to clearly welcome and prioritize these complex individuals and families with high risk and poor outcomes, individuals and families with complexity have historically been experienced as "misfits" at every level. This realization has become a major driver for comprehensive system change. For systems with scarce resources to successfully address the needs of the individuals and families with complex co-occurring issues who are the "expectation", it is not adequate to fund a few "special programs" to work around a fundamentally mis-designed system. We need to engage in a process of organizing everything we do, at every level, with every scarce resource we have, to be about all the complex needs of the people and families seeking help. (Cline, 2009)

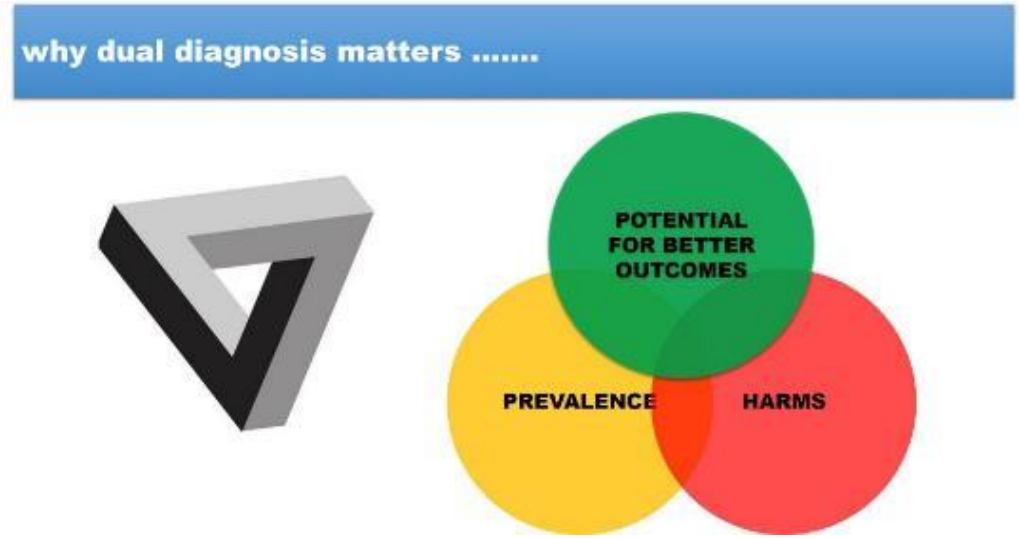
Complexity Videos

VDDI-NEXUS have developed a series of short videos profiling recovery stories that highlight and personalise the complex range of issues and challenges also experienced by people with or caring for someone with substance use and mental health issues. These are real and lived individual experiences. Some of the stories contain sensitive and confronting material.

They can be accessed at www.straightup.org.au/

2.

Why people with dual diagnosis & other complex needs must be at the centre of mental health reform



In order to be successful against its mandate it is critically important that the Royal Commission into Victoria's Mental Health System places people with dual diagnosis and other complex needs at the centre of their recommendations for mental health reform. There are three principal reasons for this priority (Croton, 2010):

1. **Prevalence**
2. **Harms**
3. **Potential for better outcomes**

1. Prevalence – the expectation not the exception

If a person experiences either a mental health or a substance use concern they are, for good reasons, at a greatly increased risk of experiencing both concerns together.

I. People with co-occurring substance concerns are the ***expectation not the exception*** **amongst people receiving treatment for mental health concerns**.

II. People with co-occurring mental health concerns are *the* ***expectation not the exception*** **amongst people receiving treatment for substance use concerns.**

III. People with co-occurring mental health-substance use concerns are ***highly prevalent*** **in a range of service systems including the justice system**

IV. People with co-occurring mental health-substance use concerns are ***highly prevalent*** **amongst people accessing General Practice.**

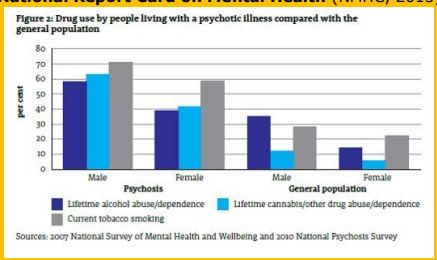
V. People with co-occurring mental health-substance use concerns are ***common*** **in the general population**

See Prevalence Snapshots on following page

Dual Diagnosis Prevalence 'snapshots'

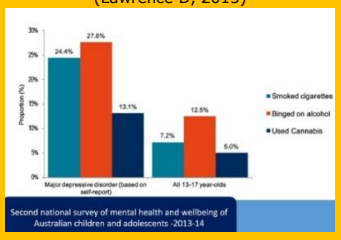
People with psychosis

National Report Card on Mental Health (NMHC, 2013)



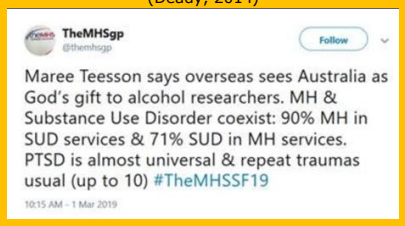
Youth

National Survey MH Australian Children Adolescents 2013-14
(Lawrence D, 2015)



Mental Health & AOD settings

(Deady, 2014)



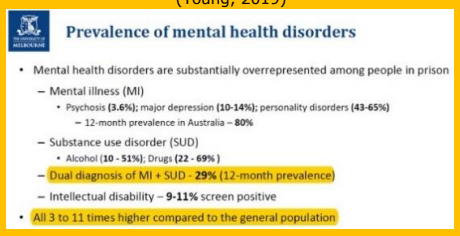
Emergency Departments

(ACEM, 2019)

Among people seeking help from EDs for mental health crises, ***1/3rd have substance use recorded as a feature of their presentation***

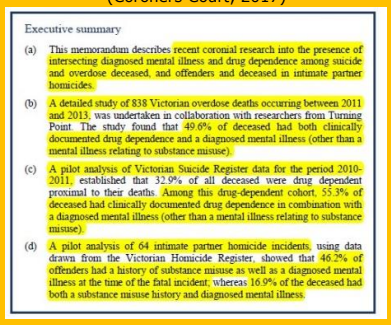
Prisoners

(Young, 2019)



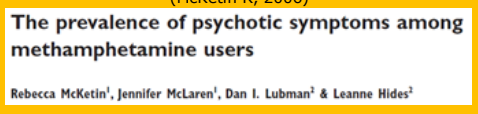
Coroner

(Coroners Court, 2017)



Methamphetamine-Mental Health

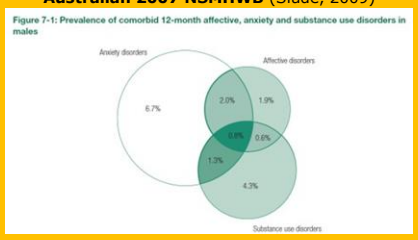
(McKetin R, 2006)



Prevalence of psychosis among methamphetamine users
11 times > than general population

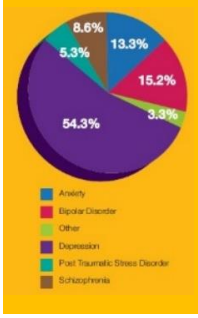
General Population

Australian 2007 NSMHWB (Slade, 2009)



AOD Residential Rehabilitation

(Odyssey House, 2015)



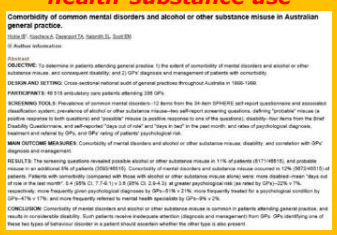
2014-15: ***46 % of clients*** reported co-existing mental illness such as depression, anxiety, bipolar disorder, schizophrenia, PTSD or borderline personality disorder.

2013-14: ***57% of clients*** had a dual diagnosis

General Practice

(Hickie I, 2001)

12% of GP attenders had comorbid mental health-substance use



Recommendation 3:
That, given

- the prevalence of people with mental health concerns presenting to Victorian AOD services
- the numbers of people with mental concerns receiving services from Victorian AOD services

that the Royal Commission extends its purview and recommendations to include reforms in the AOD system towards more effective response to people with co-occurring mental health-substance use concerns.

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Recommendation 4:
That Australia's National Survey of Mental Health and Wellbeing be funded to occur at 5-yearly intervals.

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2. Harms associated with co-occurring mental health and substance use concerns

People with co-occurring mental health-substance use concerns, compared to people with only one of the concerns, are at a substantially greater risk of experiencing diverse harms and unwanted outcomes including:

- Increased treatment costs
- More frequent relapse
- More frequent hospitalisations
- Physical disorders
- Double stigma
- Blood-borne infections
- Compounded trauma & losses experienced by significant others
- Forensic involvement
- Housing difficulties / homelessness
- Poverty
- Suicide risk
- Unemployment and work instability
- Violence and exploitation

The harms and unwanted outcomes associated with co-occurring mental health-substance use disorders are reflected in:

- **Mainstream media**- recent, confronting, Victorian tragedies have involved people with ineffectively addressed co-occurring mental health-substance use concerns. Media reports of events involving people with co-occurring Amphetamine Use Disorders-Mental Health are daily fare. Much of the reporting of these issues contributes to stigma and impaired access to treatment (AOD Media Watch, 2019)
- **Coroners reports** (Coroners Court, 2017)
- **Emergency Department reports** (ACEM, 2019)
- **Forensic system reports** (Young J, 2018)

- **Housing and homelessness reports** (Flatau, 2013)
- **Physical Health reports**
- **General Practice reports**
- **Mental Health specific reports**
- **Substance treatment specific reports**

Recommendation 5:
That the Royal Commission recommend the funding of a Victorian study to identify principal harms and estimated costs, across healthcare and social services, associated with people experiencing co-occurring mental health-substance use concerns.

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3. Potentials for better outcomes

In any one individual with co-occurring mental health and substance use concerns each concern influences the other in:

- their development,
- their severity,
- their response to treatment and
- their relapse circumstances.

Because each concern has such an influence on the other any response that only focuses on one of the concerns (the nominated 'target' of the treating worker or service) will tend to be less successful than a holistic response that identifies and works with the complexity of concerns that a person presents with. The corollary of this is that, if AOD-mental health clinicians, agencies and systems can build their capacity to recognise and respond effectively to co-occurring concerns they will be more successful in their treatment of 'target' concerns which will facilitate better outcomes for people affected by co-occurring mental health -substance use concerns.

Implications for the Royal Commission

An implication of the:

- prevalence of people with co-occurring mental health and substance use concerns
- significant harms and poor outcomes associated with co-occurring mental health and substance use concerns and other complex needs

is that any mental health reform not designed around the expectation of dual diagnosis and complex needs will be less successful.

If the Royal Commission places people with co-occurring mental health and substance use concerns and other complex needs at the centre of their recommendations for systems reform they will be more effective in addressing the mental health needs of ALL Victorians.

Recommendation 6:
That the Royal Commission places people with co-occurring mental health and substance use concerns and other complex needs at the centre of their recommendations for systems reform

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3.

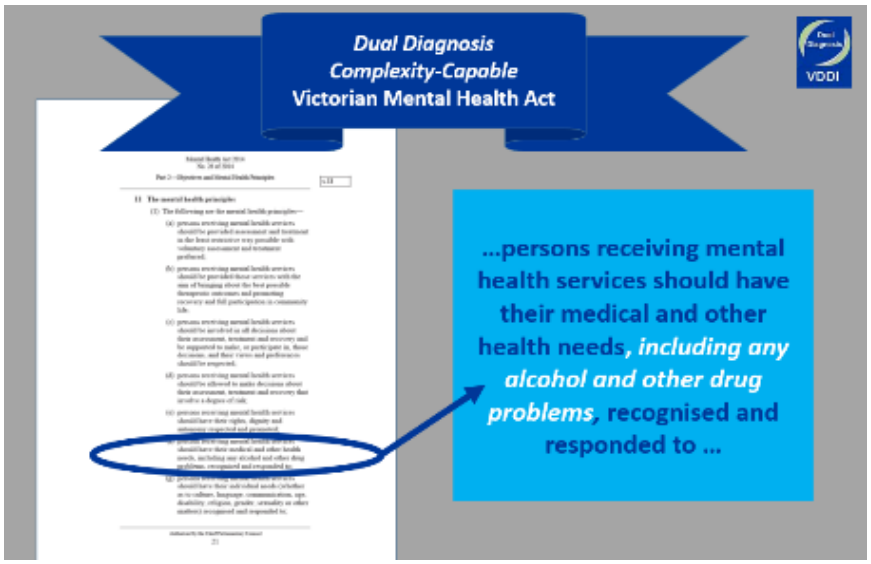
Victoria's evolution thus far:

Of all Australian states Victoria has had the longest standing, most significant, investment in achieving better outcomes for people with co-occurring mental health-substance use concerns. Victoria has been in active in developing systemic 'dual diagnosis capability' since 1998. Discussed below are:

- Victoria's 2014 Mental Health Act
- Victorian Dual Diagnosis Policy
- The Victorian Dual Diagnosis Initiative
- Homeless Youth Dual Diagnosis Initiative
- Landmarks in Victoria's evolution towards systemic dual diagnosis capability
- Impacts of work to date.

Victoria's 2014 Mental Health Act

Victoria's 2014 Mental Health Act is the only such act in Australia containing the principle that *…persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.* While this is a systems-leading development the mental health workforce and mental health system experience a range of challenges in meeting the spirit and intent of this principle.



Recommendation 7:
That the office of the Victorian Chief Psychiatrist be asked to write a Chief Psychiatrists Guideline around this Mental Health Act principle.

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Recommendation 8:
That the Mental Health Branch in partnership with Drug Treatment creates a State Chief Addiction Psychiatrist position, whose role is to influence the dual diagnosis/complexity-capability of all Victorian psychiatrists and addiction medicine specialists employed in Victorian mental health-substance treatment services

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Recommendation 9:
That the National Drug and Alcohol Research Centre be funded to develop *National Guidelines on the management of co-occurring mental health and alcohol and other drug and conditions in mental health treatment settings* that complement their 2016 *National Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings.*

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Victorian Dual Diagnosis policy

A watershed in Victoria's evolving responses was the 2007 cross-sector dual diagnosis policy ***Dual Diagnosis: Key Directions and Priorities for Service Development*** (DHS, 2007). The policy offered all stakeholders an evidence-informed vision of how the AOD and mental health treatment sectors will look, feel, behave and interact when providing effective responses to the various cohorts of people with dual diagnosis.

At the heart of the policy is an operationally-achievable definition of integrated treatment: '*Integrated treatment may be provided by a clinician who treats both the client's substance use and mental health problems. Integrated treatment can also occur when clinicians from separate agencies agree on an individual treatment plan addressing both disorders and then provide treatment. This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client.'*

The policy's vision and strategies towards a No Wrong Door service system and its unambiguous statements that '*dual diagnosis is core business'* for mental health and AOD services furthered the policy's potential to influence the mental health and AOD sectors towards integrated service delivery.

The policy includes fine-grained, time-lined, Service Development Outcomes (KPI's) that service managers were obliged to report on. These include:

- Universal screening
- Tiered 'dual diagnosis capability' of workers
- Mental health and AOD services to establish partnerships and mechanisms to support integrated assessment and treatment
- Outcomes and service responsiveness for dual diagnosis clients to be monitored and regularly reviewed
- Consumer and carer involvement in the planning and evaluation of service responses.

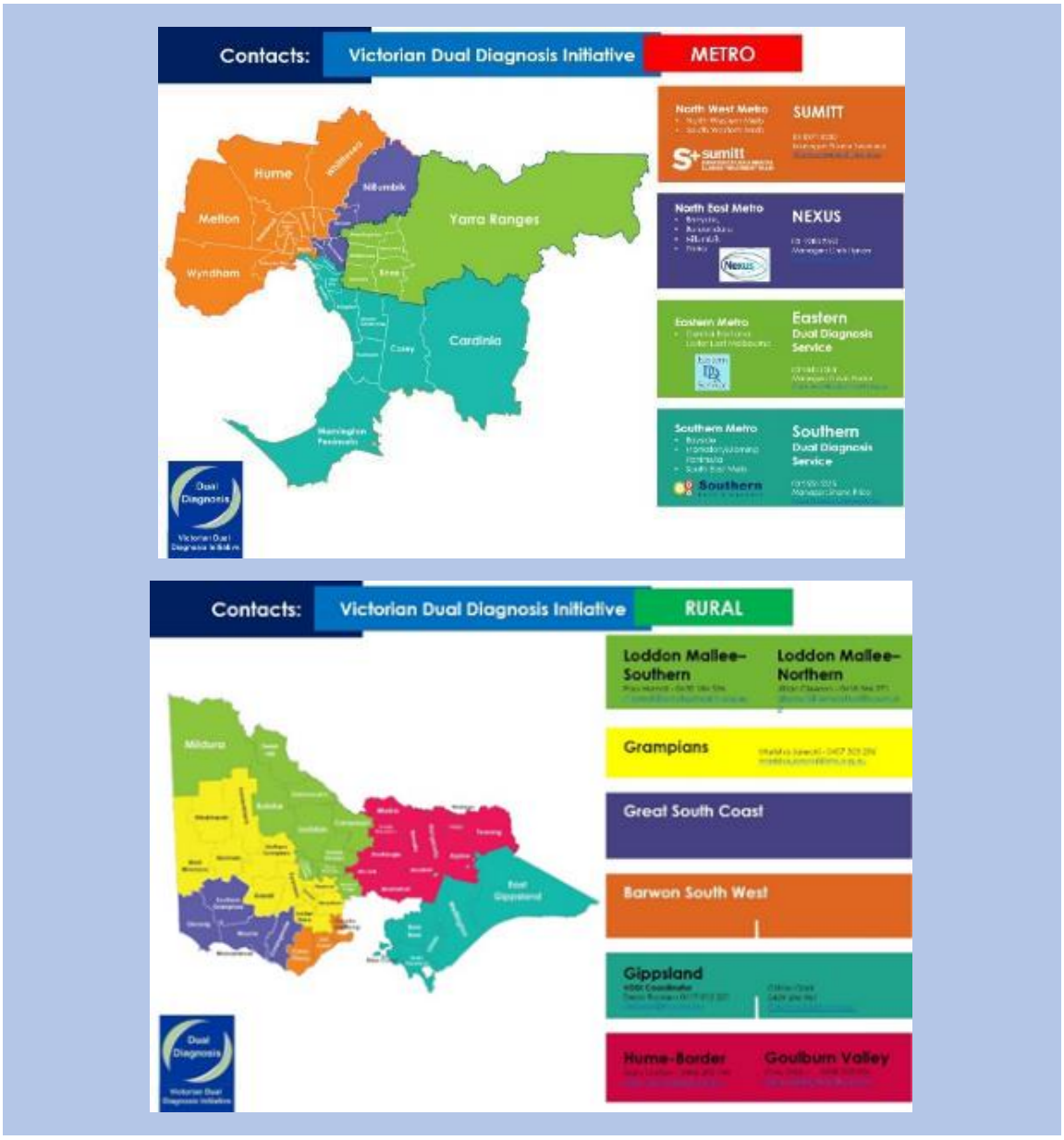
In 2017 Borgermans and Devroey (Borgermans, 2017), reflecting on the pan-European EU Project INTEGRATE, observe that 'any policy on integrated care should be a tripartite of mission, vision and strategy towards the range of factors that influence the successful development of integrated care'. This submission argues that the 2007 Victorian dual diagnosis policy abundantly meets those criteria and is a landmark Australian example of central policy influencing the development of integrated care. The Victorian policy, of comparable Australian state-level policies, is the most robust and influential in its vision of and strategies towards integrated service delivery.

The Victorian dual diagnosis policy was successful for a number of years in positively influencing practice across three sectors. The evidence informed vision that it offered provided a clear central focus around which all Victorian stakeholders – AOD and mental health managers, workers, clinicians and VDDI workers were able to unite and coordinate their efforts around. Chapter 5 discusses the potential benefits of and an approach to renewing the policy for the current Victorian environment.

The Victorian Dual Diagnosis Initiative (VDDI)

Created in 2002 the **Victorian Dual Diagnosis Initiative (VDDI)** is a cross-sector (Alcohol and Drug, Mental Health Community Support and Clinical Mental Health) initiative funded by the Victorian Department of Health, to assist mental health and drug and alcohol clinicians, agencies and sectors to develop their capacity to recognise and respond effectively to people with co-occurring mental health and substance use concerns.

The VDDI's structure includes four metropolitan agencies with links to VDDI workers embedded in each rural region. The VDDI is coordinated by the **VDDI Leadership Group (VDDILG)** and the **VDDI Rural Forum (VDDIRF)**. Metropolitan lead agencies are funded for a range of positions including psychiatrist and specialist youth workers and to provide supports to rural VDDI workers and their regions.



In December 2016 Victorian DHHS-Mental Health Branch (DHHS, 2016) defined the VDDI's role as:

> Dual Diagnosis services aim to improve treatment outcomes for individuals who have co-existing mental health and substance use issues.
> Services include:
> - education and training for mental health, drug and alcohol and MHCSS staff,
> - support to organisations to develop dual diagnosis capabilities, and
> - clinical consultations in collaboration with primary case managers.

In December 2018 Victorian DHHS-Drug Treatment (DHHS, 2018) further defined the VDDI's role as:

> **Purpose**
> The VDDI supports the development of better treatment practices and collaborative relationships between AOD treatment and mental health services. The key activities of the VDDI are:
> - the development of local networks
> - training, consultation and modelling of good practice through direct clinical intervention and shared care arrangements.
>
> **Target group**
> Mental health and AOD treatment workers who require support to respond to clients with concurrent AOD and mental health issues, and people who are experiencing issues related to concurrent AOD and mental health issues.
>
> **Key service requirements**
> The initiative includes the following functions.
> - Develop co-operative working relationships between mental health and AOD treatment services within the relevant area service catchment. This should particularly address areas of access, assessment and the development of effective treatment planning.
> - Provide training and consultation to all community mental health and AOD treatment services within the catchment with a strong focus on building capacity within the services to respond more effectively to people with a dual diagnosis.
> - Provide direct service to clients with a serious mental illness and substance use problems with a focus on developing and modelling good practice. This may be by providing a limited direct service and intensive support/consultation to case managers on specific cases.

The view of the author -a biased VDDI worker ☺ - is that the VDDI has proven to be a worthwhile investment in building systemic dual diagnosis capability. This view is supported by the 2004 (Roberts B. B., 2004) and 2011 (Australian Healthcare Associates, 2011) evaluations, discussed below.

The VDDI has a productive, innovative and resilient workforce notable for the passion and commitment of its workers. An interesting 'by-product' of the VDDI is the numbers of workers who, after working in the VDDI, have gone on to other roles in which they have continued to influence local and systemic dual diagnosis capability.

One of the VDDI's strengths has been its diffused, localised structures which have allowed the VDDI to develop in response to local needs and priorities. While that structure has significant advantages it has, in some respects, been a challenge that has

impacted on the direction of the initiative. Some regions have diverted their VDDI funding to other strategies and priorities.

While there have been some successes (VDDI-Nexus, 2012) the lead agencies have experienced geographical and logistical challenges in acquitting their responsibilities to support rural regions. The **VDDI-Rural Forum,** which with the support of VDDI-Nexus meets 3-monthly in Melbourne, has been an outstanding success in supporting the capacity-building work of isolated rural workers (DHHS, 2015). The VDDI-RF has been a template model for other healthcare initiatives attempting to support the work of isolated rural speciality workers.

The VDDI structure included a dedicated **VDDI-Education and Training Unit** in the period 2005-2015. The VDDI-ETU had significant achievements in coordinating and supporting VDDI work, in curriculum design and development, in influencing undergraduate course content and, with co-located VDDI-Nexus, in addressing dual diagnosis in particular populations. (VDDI-ETU, 2012) (VDDI-ETU, 2012b) (VDDI-Nexus, 2015)

Recommendation 10:

1. That the VDDI be reviewed state-wide against its role descriptions
2. That the VDDI continue to receive ongoing funding
3. That consideration be given to broadening the VDDI's mandate to achieving better outcomes for people with '*dual diagnosis and other complex needs'*
4. That consideration be given to what strategies (role description / structure / accountability points) could further contribute to the VDDI's effectiveness?
5. That consideration be given to refunding a **VDDI Education and Training Unit** with a remit to influence the complexity-capability of AOD-MH workforce professional development, dedicated curriculum development and the content of a range of undergraduate healthcare courses
6. That funding be allocated to support the 3-monthly meetings of the **VDDI-Rural Forum**

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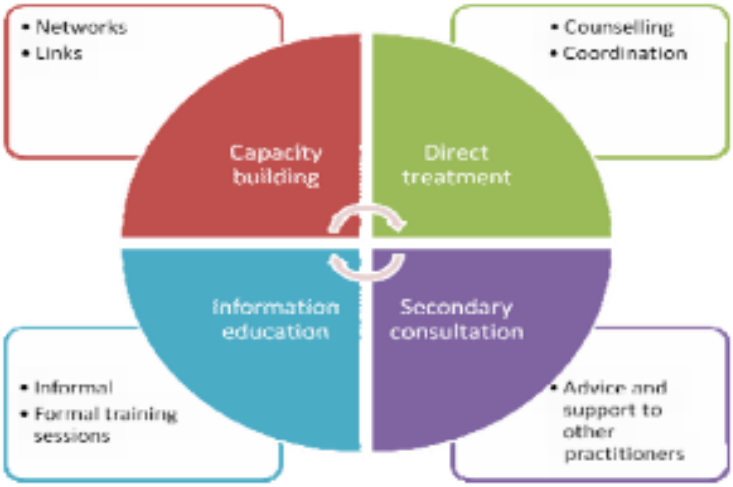
Homeless Youth Dual Diagnosis Initiative (HYDDI)

HYDDI, funded through the National Partnership Agreement on Homelessness in partnership with Victorian DHS, is a dual diagnosis service response placed within the youth homelessness service sector of each DHS region - approximately 8 workers across the state. The role of a HYDDI clinician is to identify symptoms of mental illness and substance use issues, maximise recovery and assist to establish service linkages for young homeless people who are in receipt of homelessness assistance.



HYDDI Role Components /Functions

HYDDI eligibility requirements are:

- an impacting substance use and mental health issue (no formal diagnosis required)
- a primary youth housing case manager
- an age of 16 to 25 years.

Regions with HYDDI workers have been positive about their impacts however the initiative has been impacted by annual funding uncertainties that have contributed to worker throughput and difficulties in filling positions.

Recommendation 11:

1. That there be an evaluation of the impacts of HYDDI initiative to date
2. That the HYDDI role description be updated
3. That HYDDI be extended to other Victorian regions
4. That strategies be devised to address annual funding tensions

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Landmarks in Victoria's evolution towards systemic dual diagnosis capability

1886	• **Victorian Royal Commission on Asylums for the Insane & Inebriate**- The Zox Commission - Report here
1998	• McDermott and Pyett's **Not Welcome Anywhere** report
	• **SUMHNet: *Substance Use Mental Health Network*** formed. A state-wide coalition of health care providers, consumers and carers with an interest in dual diagnosis. SUMHNet was auspiced by VICSERV and met regularly till 2002.
	• **SUMITT: *Substance Use Mental Illness Treatment Team*** pilot service. A partnership of two central policy and planning bodies - the (then) Victorian Mental Health Branch and the Drugs Policy Branch - created the SUMITT pilot in the western regions of Melbourne and rural Victoria. Direct service and capacity building functions
	• **Eastern Hume Dual Diagnosis** cross-sector project commenced in NE Victoria
	• **Conference**: *Problematic Drug and Alcohol Use and Mental Illness* auspiced by Connexions at Melbourne University
2001	• **VDDI rural forum** formed (active & ongoing)
2002:	• **Victorian Dual Diagnosis Initiative (VDDI):** Commenced. Current
	• **5 metro VDDI specialist youth dual diagnosis workers** positions instituted
2003	• 21 **Mobile Support & Treatment Teams** dual diagnosis positions created
	• **Victorian Travelling Fellowship –** VDDI fellow undertook 6-week fellowship investigating integrated treatment responses in UK, USA and NZ with subsequent report
	• **Statewide Dual Diagnosis Initiative Evaluation**
2004	• Creation of ***Dual Diagnosis Australia & New Zealand*** – www.dualdiagnosis.org.au website
	• **Rotations project:** Funded mental health or AOD workers to undertake a 3-month rotation in the 'opposite' sector as core of a 12-month staff development and education process. Evaluation available.
2005	• **State-wide Dual Diagnosis Education & Training Unit:** The VDDI E&T Unit developed nationally recognised diploma level dual diagnosis competencies
	• **Strengthening psychiatrist support project:** Extra specialist MH-SU psychiatrist time for the four lead agencies
2006	

	• At State Government cabinet level, a dedicated *Ministerial position for Mental Health and Drugs* was created. • At the central policy and planning level, the former *Mental Health Branch* and the *Drugs Policy Branch* merged into the *Division of Mental Health and Drugs*
	• **Policy:** Launch of the state-wide, cross-sector 'Dual Diagnosis: Key directions & priorities for service development' policy [7].
	• **VDDI Aboriginal Dual Diagnosis Project** Phase 1
2007	• Drs Minkoff & Cline – CCISC - 1-day forum
	• Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol & Other Drug and Mental Health Service**s** • Daylesford VDDI conference
	• **ISI commences**: 27 Victorian NGO AOD agencies funded under ISI
	• 6 Victorian General Practice Divisions received 'Can Do' Grants Program Comorbidity Projects
2008	• VDDI Screening and Assessment Training for AOD workers trained >500 AOD clinicians from > 80 agencies across Victoria.
	• Gippsland VDDI conference
	• Suite of **Checklists of Dual Diagnosis Capability** – Agency & Clinicians levels published
	• Creation of ***Dual Diagnosis Support Victoria*** –web2 social networking site(currently *c.* 2,800 members)
2009	• Beechworth ISI / VDDI conference
	• **BUDDYS** – *Building Up Dual Diagnosis Youth Service* – VDDI/ ISI partnership addressing the issues around dual diagnosis in younger people and their families
	• **Evaluation:** of the Victorian Dual Diagnosis Platform
2010	• **HYDDI – Homeless Youth Dual Diagnosis Initiative** positions commenced around Victoria
	• Lorne VDDI/ISI conference
	• VDDI capability project
2011	• Werribee ISI/VDDI conference – Drs Minkoff & Cline keynotes
	• **BUDDHAS** – *Building Up Dual Diagnosis Holistic Aged Services*
2012	• Withdrawal Guidelines in Mental Health settings
2013	

	• Aboriginal Dual Diagnosis Supervision Suite of Resources
2014	• Victorian Mental Health Act (complexity content)
	• VDDI ETU sunset
2015	• Older Persons Dual Diagnosis manual
	• Youth Dual Diagnosis Manual
2016	• VDDI Conference
	• Reasons for Use Package
2017	• NEXUS videos
	• Before During After Harm Reduction Tool (BDA)
2018	• Dual Diagnosis Residential Rehabilitations
2019	• VDDI form – Peering into the future

Impacts of work to date

There have been two relevant Victorian evaluations:

- **2004** - **Statewide Dual Diagnosis Initiative Evaluation** conducted by Turning Point (Roberts B. B., 2004)
- **2011** - **Evaluation of the Victorian Dual Diagnosis Initiative** (Australian Healthcare Associates, 2011)

Both evaluations are available by request

Also relevant is a subsequent 2014 thesis: **Dual diagnosis discourse and narratives in the State of Victoria 1985-2012** (Roberts B. , 2014)

Broader implications

Finding common ground across the specialist MH and AOD sectors and combatting the marginalisation of people with a dual diagnosis has been an ongoing challenge as social stigma and the social and structural determinants of ill-health have endured. Progress has been slow. This case study concludes, however, with a note of hope that the learning from ongoing dual diagnosis discourse will help to resolve wider systemic questions as well as those specific to dual diagnosis. An overarching finding from my research is that a focus on dual diagnosis has been a (limited) step towards a larger goal, namely a better quality, more effective response to complex, multiple needs, moving beyond dual diagnosis, as one clinician put it, to 'health'. Dual diagnosis discourse includes key contemporary issues in health care delivery: individualised and comprehensive care, workforce planning and development, sustainability and quality assurance. In particular my work recommends that better interprofessional and intersectoral practices are critical factors in the wider public health vision of person-centred care. This thesis also clearly highlights that success in these realms entails cultural change: longstanding beliefs, practices and hierarchies may be threatened; organisations and professions may not survive in their current form. The initiatives undertaken in Victoria to improve dual diagnosis capability have demonstrated the effectiveness of champions and catalysts working at the service level to provide education, training, mentoring and supervision, supported by top-down policy direction. The reported unevenness of success, on the other hand, underlines the inadequacy of funding in relation to the magnitude of the task, and the need for funding models to stimulate linkages and shared care.

Finally, the overall intention of this thesis was to provide a detailed analysis of the development of dual diagnosis discourse in the context of a particular time and place, its implications for service providers within those sectors, for policy makers in government and potentially its meaning for consumers and for other sectors. By studying, in context, the operation of a medical construct, I have highlighted two things. First, that challenging the single-diagnosis approach is a step towards and can give impetus to health and social care that sees and respects the whole person. Secondly, the path towards such a perspective continues to be limited by stigma and cultural barriers. Together these findings contribute a fresh perspective to dual diagnosis discourse. The thesis contributes to the body of qualitative research on the history and course of efforts to develop appropriate treatment and care for people experiencing difficulties with their mental health and their use of alcohol and other drugs. In doing so, the thesis also illuminates the development and implications of a medical construct over time in a particular context, adding to arguments for quality improvement, interdisciplinary, intersectoral workforce development in an integrated, adequately funded health and social support system.

Excerpt: Dual diagnosis discourse and narratives in the State of Victoria 1985-2012.
(Roberts B. , 2014)

There have been significant broad gains in the AOD and mental health service system's capacity to recognise when people have co-occurring mental health-substance use concerns. Most mental health and AOD workers now have a nuanced understanding of the impacts and interplays of co-occurring mental health-substance use concerns.

There have been outstanding examples of workers and service systems being innovative, creative and effective in delivering integrated treatment. Those examples tend to be the exception rather than routine practice, especially in highly-pressured, under-funded, Clinical Mental Health environments (VAGO, 2019). Clinical Mental Health services tend to have advanced skills and practice in particular aspects of integrated treatment (for instance responding to iatrogenic withdrawal in inpatient units) but there are ongoing tensions, in many sites, in regard to responding to people with dual diagnosis as core business, integrated assessment, cross-sector treatment pathways and the routine provision of integrated, 1-stop-shop treatment.

Substance treatment workers have been active in developing their practice to be able to respond effectively to people with co-occurring high-prevalence disorders, trauma and personality issues. Tensions in the AOD sector are principally around timely access and responding to people with long-term needs, acute suicidality and risk.

The 2007 Victorian dual diagnosis policy had significant impact upon service delivery for several years, but its influence has now waned with the impacts of reforms, workforce changes and workloads in both mental health and AOD service systems. There were significant broad developments towards an actual No Wrong Door service system in the wake of the 2017 policy. These developments were eroded by the evolution of a commissioning, competitive tendering, for-profit, environment.

The advent of the NDIS has meant a significant loss of the MHCSS sectors capacity to rapidly, flexibly respond to people with risk associated with Serious Mental Illness–Substance Use.

4.

Challenges:

Responding to the issues around dual diagnosis and other complex needs is a complex (wicked) problem with a plethora of challenges. Discussed in this section are some of our most pressing, current challenges:

- Dual Cumulative Stigma
- Access to services
- National Disability Insurance Scheme
- Systemic responsibility
- Reforms- Potential Pitfalls
- Systemic self-efficacy

Dual Cumulative Stigma

The impacts of mental health disorder stigma are well known and there has been some progress in addressing mental health stigma and discrimination. Less generally recognised and barely addressed is the stigma experienced by people with substance use disorders. Experiencing a substance use disorder remains heavily conflated with and impacted by myths around moral weakness. There is now a body of literature that identifies some of the ways in which the stigma associated with substance use disorders impacts negatively on outcomes including:

- **Accessing treatment:** people are reluctant to disclose stigmatised disorders and hence have compromised access to treatment. (Cumming, 2016)This issue is compounded in rural regions where there are fewer providers, less choice in provider and greater risk of a person being visible with substance use-mental health concerns.

- **Stigma from health care providers:** people with substance use concerns may be excluded from or receive less than optimal treatment because of health care provider's perception that they are less deserving, that they have inflicted the health care need on themselves (NCETA, 2006) . A 2013 review (van Boekel, 2013) of 28 studies of health professionals' attitudes and behaviours to people with substance use disorders found:
  - negative attitudes to service users.
  - less engaged and have diminished empathy
  - patients feel disempowered and tend to have poorer treatment outcomes
  - professionals lack education, training and support to enable them to work effectively with this group of health treatment consumers

- **Stigma from health care planners:** similar to provider's stigma, people with substance use concerns may not have needed services funded or available to them because of planning/funding bodies perception that they are less deserving- '*there are no votes in drug and alcohol'*.

- **Self-stigma:** people experiencing substance use concerns tend to have the same beliefs as the broader community and hence tend to internalise social stigma, have very negative self-esteem and this is often a significant barrier to effective treatment

- **Social exclusion** as a result of stigma is a barrier to re-integration

Australia's National Drug Strategy 2010-2015 (MCDA, 2011) aspired to '*develop a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards drug dependence, help seeking and the related problems of the individual*'. There appears to have been no progress against this strategy. In fact, many of the responses to the issues around methamphetamine appear to have exacerbated stigma.

The families of people with substance use concerns experience 'courtesy stigma' often with parallel experiences and feelings to the person with the substance use disorder, feelings of failure and guilt and inhibitions re accessing supports.

Dual stigma: People with co-occurring mental health and substance use concerns experience compounded dual stigma consequent on having two, heavily stigmatised concerns. This double-stigma has compounded effects in regard to access to, quality and effectiveness of treatment and support and recovery from mental health-substance use concerns. Families and significant others, of people with co-occurring mental health-substance use concerns experience parallel, compounded, dual 'courtesy dual stigma' which impact negatively on their lives and their capacities to support the person with the concerns.

There is now a substantial evidence base to guide systems wishing to address the stigma associated with substance use concerns (Global Commission on Drug Policy, 2017) (National Academies of Sciences, 2016) . There is potential, in addressing substance use stigma, to improve outcomes for people with co-occurring mental health and substance use concerns.

Recommendation 12:

1. That a range of strategies be funded to address
    - the stigma associate with substance use disorders per se
    - the impacts of dual stigma

2. That these strategies include strategies targeting the beliefs and attitudes of a range of relevant healthcare providers

3. That policy and resources be devoted to addressing how welcoming mental health and AOD services are – including physical layout, induction priorities and requirements and clinician and in developing worker competencies in creating a welcoming, collaborative, safe engagement with people

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Access

The seminal **Not Welcome Anywhere** report (McDermott, 1993) was the first Victorian report to highlight that people with co-occurring mental health–substance use concerns (serious mental illness cohort) frequently fall through the gaps in our service systems, tending to
a) access many services
b) with usually the only service they receive being referral onto another service.

Since then the dual diagnosis literature has frequently identified the concern that a person with dual diagnosis, on presenting to a mental health service, will be advised to resolve their substance use before they can be considered for mental health treatment and then receive mirror advice from an assessing AOD service – the person falling through the gaps, receiving no service from either agency. Variations of this scenario still occur in Victoria in 2019.

The goal of a No Wrong Door service system developed from recognition that people with mental health-substance use concerns frequently fall through the gaps. A No Wrong Door service system is one in which *'when clients appear at a facility that is not qualified to provide some type of needed service, those clients should carefully be guided to appropriate, cooperating facilities, with follow-up by staff to ensure that clients receive proper care* (SAMHSA, 2005).

No wrong door refers to *'formal recognition by a service system that individuals with co-occurring disorders may enter a range of community service sites; that they are a high priority for engagement in treatment; and that proactive efforts are necessary to welcome them into treatment and prevent them from falling through the cracks'* (SAMHSA, 2005). While there was significant Victorian progress towards a No Wrong Door service system in the wake of the 2007 Victorian dual diagnosis policy most of these gains have now been eroded by the impacts of subsequent system reforms.

A current trend across behavioural health care, perhaps in response to limited resources, increasing demand and increasingly complex presentations is for services and systems to proclaim increasingly narrow, limited, service entry criteria with complex pathways to service. Essentially, we will only provide services to you if you meet our criteria; the

person and their needs has to fit the system rather than the systems flexibly responding to the kaleidoscopic variety of possible presenting needs. These models, while they may have surface appeal to funding bodies, are neither effective nor efficient and they influence sectors, agencies and workers to be increasingly rigid, increasingly unwelcoming and increasingly defensive around scarce resources.

This model is typically built around a central infrastructure to determine client eligibility- an infrastructure that is costly, often divorced from local contexts and possibilities, that add to systemic complexity and that creates difficult to navigate, pathways to services. The most dispossessed people, the people in most urgent need of services are generally the people least equipped to navigate these pathways to service. Too often these will be the people with co-occurring metal health-substance use and other complex needs.

Recommendation 13:
That Victoria again consider the goal of a No Wrong Door service system and develops a coherent web of strategies and incentives to achieve against that goal.

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Recommendation 14:
That there is consideration given to the adoption of Single Session Therapy models in some components of the Victorian mental health and substance treatment systems.

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National Disability Insurance Scheme (NDIS)

There is now a body of literature (Smith-Merry, 2018) critiquing the effectiveness of the NDIS for people with mental health disability. To date few of these critiques have considered the challenges experienced by people with mental health disability co-occurring with substance use concerns. This is concerning given what we know about the prevalence of and harms associated with co-occurring substance use issues amongst people experiencing mental health disability.

Most of the well-documented concerns around NDIS with people with mental health disability per se are compounded when the person involved ALSO has a substance use issue. It is anecdotal evidence only but there are consistent reports of mental health workers who, in working with a person towards an NDIS application, coach the person to avoid disclosing their issues with substances to the assessing NDIS worker. Practice wisdom now is that having a co-occurring substance use issue will act as an exclusion criterion for an NDIS application. Again, this is difficult to reconcile with the known prevalence of substance use issues in people with mental health disability.

Concerns with the NDIS, from a mental health-substance use and other complex needs perspective, include:

1. **Costs and inefficiencies**: the NDIS model is predicated on a central assessing agency that determines eligibility and develops plans. There are considerable infrastructure and bureaucracy costs inherent in this model – funds that could otherwise be spent in direct service provision. Bureaucracies grow and swallow resources- we risk duplicating inefficient USA healthcare models where a sizeable proportion of each healthcare dollar is swallowed in processes and negotiations around service eligibility- especially so when that person has complex co-occurring needs that transcend traditional service system boundaries.

2. **Misaligned eligibility criteria**: people applying to the NDIS are required to prove enduring disability – this is at odds with the strengths-based, recovery focus and hopes of both mental health and AOD service provision.

3. **Access**: Note reports of mental health workers coaching clients applying to the NDIS to avoid disclosing substance use issues. There is established poor uptake of the NDIS and reluctance of eligible people with mental health disability to apply (Malbon, 2019). It is likely that eligible people with co-occurring substance use issues are even more reluctant to apply. People with severe co-occurring mental health-substance use concerns need easily-accessible, welcoming, timely, responsive services – the NDIS, which requires participants to have the skills, stability, persistence and capabilities to successfully navigate daunting, slow, cumbersome entry processes is the antithesis of this.

4. **Reliability and utility of NDIS assessments:** There have been many concerns expressed about how well equipped NDIS assessors are to assess mental health concerns and to develop a useful plan. It must be asked, given known comorbidity prevalence data, how well equipped and oriented are the NDIS assessors to non-judgementally assess and develop useful planning around co-occurring, stigmatised, substance use issues?

5. **Flexibility and responsiveness**: the NDIS model is built on an assessment at a static point in time in order to generate a plan for the next 12-months. People with mental health disability experience fluctuation in their circumstances and needs over the course of a year- amplified if they have a co-occurring substance use concern. It is difficult to see how even a very skilled, qualified assessor, can develop a plan that remains useful for a year for a person with complex, fluctuating needs.

6. **Inequity:** A recent paper (Malbon, 2019) reviewed the direct evidence that different groups benefit disproportionately from the NDIS. Their review revealed that vulnerable groups are less likely to receive supports than other NDIS participants with similar needs – quoting Mavromaras et al (Mavromaras K, 2018) :

> "*Those more vulnerable to poorer outcomes included participants with intellectual disability and/or complex needs; from CALD communities; those experiencing mental health, substance use, or forensic issues; and older carers who were socially isolated and had their own health issues. These vulnerable groups were considered to receive less funded supports in their NDIS plans than others with similar support needs and to struggle with NDIS processes."*

Presumably people with a number of these vulnerabilities, such as co-occurring mental health-substance use needs, are likely to be at even greater risk of poorer outcomes. They are less likely to apply to the NDIS; if they do apply, they are less likely to be successful and, if successful, are likely to receive less supports.

7. **'Market' failures**: the benefit of the NDIS scheme is that participants have choice and control (Malbon, 2019) over the services they receive and are able to make changes if they receive inadequate services. Rural participants often have little or no choice in providers or no available providers at all. Malbon et al note a further, related concern that some providers, wary of the costs involved, are choosing to decline to provide services to people with the most complex needs. Warr et al (Warr D, 2017) quoted in Malbon:

> "*People talk about us having choice and control but … They've got individual workers saying, 'No, I don't like that client, that client's got behavioural problems, I'm not working with them'. So they've got individual workers that are now picking and choosing their clients. So you've got clients with the most complex needs … they can't find support workers …"*

8. **Loss of MHCSS services to people with the most complex needs**
   Before the advent of NDIS Victoria boasted a world-class Mental Health Community Support System (MHCSS) that was able to rapidly, flexibly initiate often life-saving, services to substantially disenfranchised, disempowered people with complex mental health-substance use problems. MHCSS workers were particularly skilled in and committed to engaging with people who had lost other supports, who may have been averse to engaging with clinical mental health services and who were at imminent risk of adverse outcomes. Often the MHCSS worker's patient involvement would lead to the person eventually being willing to engage with other services.

   Since NDIS initiation MHCSS capacity to flexibly initiate services has been lost- people with the most complex needs are unlikely to instigate an NDIS application and, if they did and they were successful, the process would be too slow to be useful. This loss has been exacerbated by:
   - *'organisations with expertise in psychosocial disability are collapsing, merging and selecting not to engage with the NDIS due to an inability to provide effective services within the NDIA costing structure'*
   - *'Organisations are losing staff with expertise in psychosocial disability because the level of funding provided by the NDIA for instances of care does not match the cost of employing trained staff or providing training and supervision to new staff'* (Smith-Merry, 2018)

   In recognition of this issue, in September 2018 the Victorian Government allocated $70 million to Victoria's community mental health sector (Victorian Govt., 2018) so that 'people with a mental illness don't fall through the cracks'. This is a welcome initiative however a condition of entry into this service model is that the person is already case managed by Clinical Mental Health services. This condition may exclude some people with particularly complex needs.

Can recognition of how inequitable and inefficient the vessel is be enough to turn the NDIS-mental health ship around? In April 2017, Professor Patrick McGorry, Exec Director of Orygen, Professor of Youth Mental Health at The University of Melbourne, Director of the Board of the National Youth Mental Health Foundation (headspace), and Chair of the Royal Commission's Advisory Group called for mental health to be removed from the NDIS (AMA, 2017) identifying the mismatch of the NDIS disability model with the realities of mental illness.

This submission argues that all current concerns about the NDIS for people with mental health disability are *amplified* when one considers the co-occurring substance use and other complex needs that are the *expectation not the exception* in people with mental health disability. We urge the Royal Commission to include in its recommendations that mental health disability be removed from the NDIS.

Recommendation 15:
That the Royal Commission investigate:

- The capacities and qualifications of NDIS assessors to non-judgementally assess and develop useful plans for people with co-occurring mental health disability-substance use issues
- Numbers of people with a co-occurring mental health disability- substance use issue who have made successful applications to the NDIS
- Nature and size of the funding received by people with co-occurring mental health disability-substance use issue who have made successful applications to the NDIS compared to the nature and size of the funding received by people with mental health disability alone.
- Whether the presence of a co-occurring substance use issue has served as an effective exclusion criterion for people with mental health disability applying to the NDIS

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Recommendation 16:
That Victorian DHHS relax entry criteria into the new MHCSS model so that MHCSS services can flexibly initiate services with people with severe mental health concerns who do not wish to engage with clinical mental health services.

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Recommendation 17:
That the Royal Commission include in its recommendations that mental health disability be removed from the NDIS

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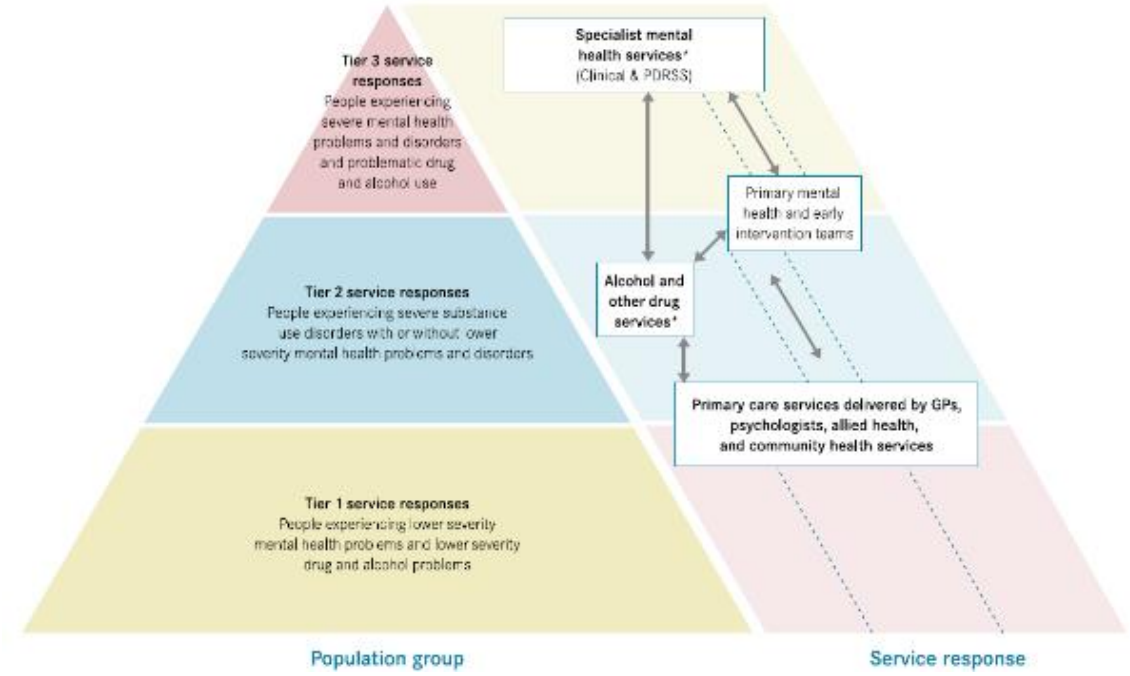
Systemic responsibility

At a national level, over the past 15 years, the Commonwealth has tended to conceptualise co-occurring mental health-substance use needs as primarily the responsibility of the specialist AOD sector. Most Commonwealth 'comorbidity' initiatives have been targeted at the AOD sector per se. While initiatives such as the Improved Services Initiative (National Improved Services Initiative Forum, 2010) and the National Comorbidity Guidelines (Marel, 2016) have been extremely valuable the Commonwealth's lack of action in also recognising and addressing comorbidity in other sectors is a missed opportunity.

The reality is that people with co-occurring mental health-substance use issues are highly prevalent in each of AOD, mental health and primary care - albeit different predominant cohorts in each sector. In Australia mental health services are approximately five times the size of AOD services. One implication of this, leaving aside questions of effectiveness, is that mental health services treat more people with substance use issues than does the AOD sector. At the same time General Practice services treat more people for either mental health or substance use issues than do either specialist mental health or specialist AOD services- 12.4% of all GP encounters in 2015–16 were mental health-related (AIHW, 2019).

Victoria has a strong record of conceptualising the issues around people with co-occurring mental health-substance use needs as cross-sector issues, of recognising that people with co-occurring mental health-substance use needs are prevalent in each of specialist mental health, specialist AOD and in primary care settings. This recognition led to the cross-sector approach of the 2007 Victorian dual diagnosis policy (DHS, 2007) and that policy's inclusion of this three-level schema for responding to dual diagnosis.



Three level schema for responding to dual diagnosis (DHS, 2007)

It is critical that future Victorian strategies towards better outcomes for people with co-occurring mental health-substance use continue to be designed around a strong recognition of the prevalence of people with mental health-substance use and other complex needs in each of specialist mental health, substance treatment and Primary Care sectors.

Recommendation 18:
That future Victorian strategies to address the needs of people with co-occurring mental health-substance use issues are designed around a robust recognition of the diversity of cohorts and the diversity of their treatment needs and preferences.

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Reforms- Potential Pitfalls

All reforms have potential for harm or unintended consequences. Dual diagnosis is best conceived of as a wicked problem that can be addressed but will not be solved by simplistic solutions. Discussed in this section are five potential pitfalls in designing strategies towards improved outcomes for people with co-occurring mental health-substance use issues

1. Subsuming AOD services into Mental Health
2. Co-location as a panacea
3. Conflation of integrated treatment with integrated services
4. Dual diagnosis specific initiatives
5. Stand-alone workforce strategies

1. Subsuming AOD services into Mental Health

Subsuming AOD services into the mental health system has not infrequently been mooted as a solution to the challenges around providing integrated treatment. While this solution has some surface appeal it does not adequately recognise the different predominant cohorts in mental health and AOD services or that, for good reasons, AOD and mental health services operate from different treatment philosophies.

The different cohorts in each sector have different treatment needs and preferences – were we to subsume AOD under mental health the most likely outcome is that the people who now engage with AOD services would fall through the gaps and receive no treatment.

Notwithstanding the above caution there is certainly a strong case for, on an enduring basis, merging mental health and AOD at a policy and planning, DHHS level.

Recommendation 19:

- That Victorian healthcare planners continue to develop a range of well-connected treatment options around the treatment needs and preferences of the different cohorts of people with co-occurring mental health-substance use concerns.

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Recommendation 20:

- That Victorian AOD services are not subsumed under mental health services

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Recommendation 21:

- That mental health and AOD are enduringly braided together at a central policy and planning, DHHS level.

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2. Co-location as a panacea

Co-location of mental health and AOD services has been frequently proposed as a strategy to build working relationships and navigable treatment pathways between the sectors. Our experience is that, while it *may* help, it is by no means a panacea. It is possible for AOD and mental health services to have strained relationships whilst all working under one roof. A more sophisticated, iterative web of strategies is necessary to develop and to maintain navigable treatment pathways and cross-sector understanding and collaboration.

3. Conflation of integrated treatment with integrated programs, integrated services and integrated systems

Not infrequently there is unhelpful conflation in the dual diagnosis literature between integrated treatment, integrated programs, integrated services and integrated systems. This conflation, at times, has impacted on the clarity and direction of change initiatives.

Integrated Treatment - the Victorian dual diagnosis policy's (DHS, 2007) definition of integrated treatment is useful here:

> '*Integrated treatment may be provided by a clinician who treats both the client's substance use and mental health problems. Integrated treatment can also occur when clinicians from separate agencies agree on an individual treatment plan addressing both disorders and then provide treatment. This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client.'*

Relevant to this definition's second, multi-sector, option for achieving integrated treatment is the Centre for Substance Abuse Treatment advice (CSAT, 2007) that the threshold for 'integration' relative to 'collaboration' is shared responsibility for the development and implementation of a treatment plan.

Integrated Programs '*are implemented within an entire provider agency or institution to enable clinicians to provide integrated treatment'* (CSAT, 2006). An example could be a community mental health agency whose staff includes a portfolio holder with AOD expertise who provides consultation and support to her/his colleague in delivering integrated treatment with an individual client.

Services Integration refers to '*any process by which mental health and substance use services are appropriately integrated or combined at either the level of direct contact with the individual client with co-occurring disorders or between providers or programs serving these individuals. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients*.' (CSAT, 2007)

Systems Integration describes the '*process by which individual systems or collaborating systems organize themselves to implement services integration to clients with co-occurring disorders and their families.*' (CSAT, 2007)

4. Dual diagnosis specific initiatives

Systems working towards better outcomes for people with mental health-substance use can be tempted to create special, dual diagnosis-specific treatment programs. There may be benefits in this approach for the relatively small numbers of people who will receive services from these specialist programs and potential best practice learnings. At the same time good practice does not spread osmotically; a range of strategies are necessary for the learnings from demonstration projects to influence a whole system's service delivery.

Other concerns with the creation of special, dual diagnosis-specific, treatment programs include that:

- They fail to recognise the prevalence of people with mental health-substance use in mental health and substance treatment settings. Specialist services can only respond to a fraction of the numbers of people with co-occurring mental health-substance use concerns.

- They add to system complexity and navigation challenges. Rather than develop a third treatment system it makes more sense to develop the capacities of our current mental health and AOD systems to respond effectively to people with co-occurring mental health-substance use concerns. Assuming we had the resources, will and time to develop a third treatment system, that was effective with all the various cohorts of people with dual diagnosis, what would our existing mental health and AOD systems do when they had lost most of their current clients?

- They send a message to the mental health and AOD workforces that, rather than being core business for both workforces, responding to people with co-occurring mental health-substance use concerns is only the domain of specialists.

- They tend to focus a system's conceptualisation of co-occurring disorders on only one cohort – generally the Seriously Mentally Ill-Severe Substance Use cohort- with a diminution of the systems recognition of the need to develop a variety of treatment options to meet the differing treatment needs of the different cohorts

- Potentially stigmatising – people receiving treatment from specialist dual diagnosis services may experience compounded dual stigma

Recommendation 22:
That central policy and planning bodies be cautious about developing dual diagnosis-specific treatment options

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5. 'Stand-alone' workforce strategies

A common response to an identified or emerging service gap is to commission training for the workforce/s involved. If this is a stand-alone strategy the impacts on service delivery are almost inevitably disappointing. It is more effective, before training is initiated, to consider:

- What is the current workforce morale level? What is the predominant workplace culture? Is the workforce feeling sufficiently secure, confident and supported to be able to contemplate and embrace changed practice? Are the demands of the workplace at a sufficiently manageable level to allow workers the space and safety to develop their practice?

- Is there a central agreed vision, and strategies to achieve that vision, that the workforce can align its efforts around? Does the workforce feel involved in the development of that vision or do they feel that it is being imposed from above without their input or expertise?

- How well understood and supported is the desired change by all levels of clinical and opinion leaders?

- What strategies can be deployed to build recognition of the need for, understanding of and enthusiasm for the desired change?

- How well aligned are existing procedures (e.g. Clinical Review / Clinical Supervision) and tools (e.g. screening and assessment documentation) with the desired change? What can be done to better align them with the desired changes well in advance of training?

Training per se tends to evaporate unless supported by a range of complementary strategies.

- What pre-training 'supplements' can be designed in to maximise the learnings from the training? These may include activities such as pre-reading, quizzes, competency assessments that can be implemented before the training.

- What post-training 'supplements' can be designed in to work in and continue to develop the learnings from the training? These may include aligned mentoring, Clinical Supervision, journal clubs, brief refreshers, portfolio holders, interest groups.

Systemic self-efficacy

People with practice development responsibilities- whether at agency, service or whole of system levels- face invidious challenges. Many of the competing problems and priorities they contend with are wicked in nature. The stakes are high and definitions of the challenges, priorities and solutions are contested territory. Changes can be slow, difficult to effect and the methods and success indicators may be disputed. Practice developments may not be sustained. In this context people with development responsibilities can begin to lose 'systemic self-efficacy' – their sense that it is possible to successfully, usefully, influence complex healthcare provider behaviours and client outcomes.

Change *is* possible, healthcare systems *are* often effective with people with complex needs and there are outstanding instances of systems that have evolved to assist workers to facilitate this. It is critical that people with change agent responsibilities celebrate existing achievements whilst contributing to the further development of an ambitious vision of a complexity-capable service system that helps all people interacting with it lead their unique vision of a happier life.

Recommendation 23:
That a range of mechanisms and incentives be devised to 'celebrate' and promote successes in developing complexity–capability – at clinician, agency and systems levels.

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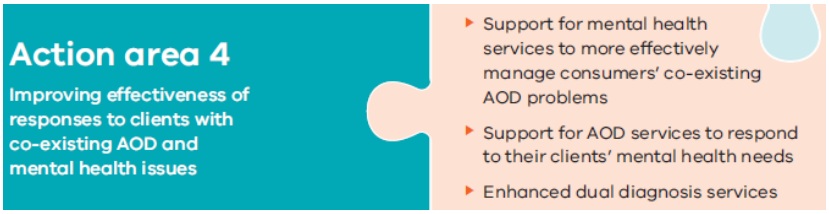
5.

Ways forward

Victoria has a strong record of action towards a dual diagnosis capable service system and continues to develop and deploy strategies towards that end. The recent Victorian Mental Health Services Annual Report 2017–18 (DHHS, 2018) proposed, as Action area 4, '*Improving effectiveness of responses to clients with co-existing AOD and mental health issues'*. This final chapter explores some of the possible strategies towards that goal.



Excerpt: Victorian Mental Health Services Annual Report 2017–18 (DHHS, 2018)

Policy renewal

As discussed throughout this submission the cross-sector 2007 Victorian dual diagnosis policy (DHS, 2007) was extraordinarily successful for a number of years in influencing practice across three sectors. While some of the changes it led to have now been eroded the policy continues to exert an influence today with its coherent, fine-grained, aspirational vision of how the three sectors will look, behave and interact when providing effective treatment to the various cohorts of people with dual diagnosis.

There is much to be gained in updating and promoting the policy for the current environment. Elements which should be considered and built on from the 2007 policy include:

- Cornerstone elements of best practice including:
    - Vision of a No Wrong Door service system
    - Core business mandate
    - Concept of developing worker 'dual diagnosis capability'
    - Routine Screening
    - Integrated assessment and treatment planning
    - Operationally useful definition of Integrated Treatment
    - Attention to cross sector treatment pathways and partnerships
    - Involvement of people with Lived Experience in training and systems development
    - Developed around recognition of the different cohorts of people with dual diagnosis
    - Routine data collection and reporting
- Time-lined KPIs with reporting requirements
- Cross-sector focus

An update of the policy has potential to harness existing learnings from Victoria's journey thus far and broaden the goal to that of a Complexity Capable Service System.

Recommendation 24:

- That the 2007 cross-sector dual diagnosis policy is revised and renewed.
- That a codesign process informs this review.
- That the focus of the renewed policy is better outcomes for people with co-occurring mental health and substance use and other complex needs.

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Comprehensive Continuous System of Care (CCISC) model

Drs Ken Minkoff and Christie Cline's **Comprehensive Continuous System of Care (CCISC)** model has been and is influential in the USA, Canada and Australia. Drs Minkoff and Cline have visited and worked in Victoria on multiple occasions and their work and model has had a substantial influence on Victorian developments to date. CCISC offers a coherent, step-wise, vision-driven, continuous quality improvement approach to develop a complexity capable service system. The following table profiles the CCISC model.

An Evidence-based Approach for Transforming Behavioural Health Systems *by* Building a Systemic, Customer-oriented, Quality Management Culture and Process

From: http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc/

The **Comprehensive Continuous Integrated System of Care** (CCISC) model has been developed over the last 15 years by ZiaPartners. It is an evidence-based model (Minkoff & Cline, 2004, 2005) that has been identified by SAMHSA as a "best practice" for system design, and has been used in dozens of local, regional, state or provincial systems of care internationally, including over 35 states in the U.S., 5 Canadian provinces, and several states in Australia. CCISC is designed to create a framework for systems to engage in this type of vision-driven transformation. It is built on the framework of the IOM Quality Chasm series, which has recommended the need for a customer-oriented quality improvement approach to inform all of health and behavioural health care.

Key Elements (CCISC)

1. The system must be built to fulfil the biggest possible vision of meeting the needs and hopes of its customers: both the individuals and families who are seeking help, and the system partners (e.g., criminal justice, child welfare, juvenile justice, homeless services, public health, etc.) that share the responsibility to respond. The emphasis always begins with those individuals and families who the system is currently not well designed to serve (people with co-occurring issues, people with cultural diversity, people in complex crisis, etc.)

2. The whole system must be organized into a horizontal and vertical continuous quality improvement partnership, in which all programs are responsible for their own data-driven quality improvement activities targeting the common vision that all programs become person/family-centered, recovery/resiliency-oriented, trauma-informed, complexity capable (that is, organized to routinely integrate services for individuals and families with multiple complex issues and conditions), and culturally/linguistically competent. In addition, all the major processes and subsystems (e.g., crisis response) must be reworked within this quality improvement partnership to be better matched to what people need.

3. The whole process is designed to implement a wide array of best practices and interventions into all the core processes of the system at an adequate level of detail to ensure fidelity and achieve associated outcomes. This is not about simply "funding special programs," but rather about defining what works, and making sure, within the systemic continuous quality improvement (CQI) practice improvement/workforce development framework, that what works is routinely provided in all settings.
4. The whole process is data driven. Each CQI component, whether at the program level, the subsystem level, or the overall system level, is driven by commitment to measurable progress toward quantifiable objectives.

5. The whole process is built within existing resources. All systems need more resources, but it is critical to challenge ourselves to use the resources we have as wisely as possible before acquiring more. In most behavioural health systems, as noted by the IOM, poor system design produces inefficient and ineffective results, and then more resources are invested to work around the poorly designed system. The goal of CCISC is to create processes to move beyond that over time.

6. The whole process is built with the assumption that every piece of practice and process improvement needs to be anchored firmly into the supporting operational administrative structure and fiscal/regulatory compliance framework. This includes not only clinical instructions, but also resource and billing instructions, quality and data instructions, paperwork and documentation requirements, and so on. The fiscal/regulatory compliance framework can be the biggest supporter of quality-driven change, if the same rigidity that may hold ineffective processes in place is "rewired" to hold improved clinical processes in place that are consistent with the overall values and mission of the systems. Many systems think that this cannot occur, and therefore stop trying. CCISC challenges systems to discover the ways that financial integrity and value-driven practice can be anchored into place simultaneously.

The whole CCISC process begins with a big vision of change and puts in place a series of change processes that proceed in an incremental, stepwise fashion over time. However, because the design of the process is to create organized accountability for change at every level of the system concurrently, thereby increasing the total activation and personal responsibility for improvement by both customers and staff (both front-line and managers), even though each part of the system may only take small steps, the whole system starts to make fundamental changes in its approach to doing business. Although a transformation process is by design "continuous improvement" and will involve significant changes over several years, the shift to implementation of a quality-driven framework process can occur in a relatively short time frame (e.g., 6-12 months).

This model is based on the following eight clinical consensus best practice principles (Minkoff and Cline, 2004, 2005) which espouse an integrated recovery philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system.

Principles

Principle 1. Co-occurring issues and conditions are an expectation, not an exception.

This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues.

Principle 2. The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship.

Within this partnership, integrated longitudinal strength-based assessment, intervention, support, and continuity of care promote step-by-step community-based learning for each issue or condition.

Principle 3. All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring-capable services for different populations.

Assignment of responsibility for provision of such relationships can be determined using the four-quadrant national consensus model for system-level planning, based on high and low severity of the psychiatric and substance disorder.

Principle 4. When co-occurring issues and conditions are present, each issue or condition is considered to be primary.

The best-practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately-matched intervention at the same time.

Principle 5. Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue.

Mental illness and substance dependence (as well as other conditions, such as medical disorders, trauma, and homelessness) are examples of chronic biopsychosocial conditions that can be understood using a condition and recovery model. Each condition has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. For each condition or issue, interventions and outcomes must be matched to stage of change and phase of recovery.

Principle 6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue.

For each co-occurring condition or issue, treatment involves getting an accurate set of recommendations for that issue, and then learning the skills (self-management skills and skills for accessing professional, peer, or family support) in order to follow those recommendations successfully over time. In order to promote learning, the right balance of care or support with contingencies and expectations must be in place for each condition, and contingencies must be applied with recognition that reward is much more effective in promoting learning than negative consequences.

Principle 7. Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual-diagnosis program or intervention for everyone.

For each individual or family, integrated treatment interventions and outcomes must be individualized according to their hopeful goals; their specific diagnoses, conditions, or issues; and the phase of recovery, stage of change, strengths, skills, and available contingencies for each condition.

Principle 8. CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring-capable.

Each program has a different job, and programs partner to help each other succeed with their own complex populations. The goal is that each individual or family is routinely welcomed into empathic, hopeful, integrated relationships, in which each co-occurring issue or condition is identified, and engaged in a continuing process of adequately supported, adequately rewarded, strength-based, stage-matched, skill-based, community-based learning for each condition, in order to help the individual or family make progress toward achieving their recovery goals.

Co-occurring Capability Resources

Resources for agencies/programs, clinicians, and system implementation teams developing co-occurring capability or competency can be found here. The steps are based on the principles above, and can be initiated by anyone to organize progress within the scope of mission, job category, and resources.

Recommendation 25:

That the Royal Commission video-conference with Drs Minkoff and Cline to consider approaches to further develop Victorian mental health and substance treatment services in alignment with the Comprehensive Continuous Integrated System of Care (CCISC) model

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New service models

It seems clear that one of the many challenges faced by the Royal Commission, particularly in strategising how best to meet the needs of the 'missing middle', is whether to place their emphasis on the development of new service models or on reform of the existing models. It is an exciting and daunting challenge.

One of the potential new service models, promoted by Professor McGorry, is profiled in the table below.

Every Australian community will have its own stigma-free, mental health collaborative care hub, with an expert multidisciplinary team of GPs, psychiatrists, allied health professionals, addiction specialists, and 24-hour mobile home intensive care unit. Developmentally appropriate versions, vertically integrated with primary care for children, young people, older adults and the elderly would be crucial. Every Federal Electorate would over time be home to at least one of these hubs. Headspace, with its one-stop-shop design, is a small-scale prototype and an example of the first step in such a reform. This solution is readily affordable, with each of these hubs costing around $15m and even less in rural and regional Australia

(The Feed, 2018)

One of the many strengths of this model is that it has been developed with a robust appreciation of the prevalence, harms and potential for better outcomes associated with experiencing co-occurring mental health-substance use and other complex needs.

Recommendation 26:
That any new service models recommended by the Royal Commission have at their core the goal of being Complexity Capable – especially in their capability to respond effectively to the different cohorts of people experiencing or impacted by co-occurring mental health-substance use concerns.

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Build on current Victorian strengths and developments

Victorian Dual Diagnosis Initiative
See earlier VDDI profile

Recommendation 27:

1. That the VDDI be reviewed state-wide against its role descriptions
2. That the VDDI continue to receive ongoing funding
3. That consideration be given to broadening the VDDI's mandate to achieving better outcomes for people with *'dual diagnosis and other complex needs'*
4. That consideration be given to what strategies (role description / structure / accountability points) could further contribute to the VDDI's effectiveness?
5. That consideration be given to refunding a **VDDI Education and Training Unit** with a remit to address AOD-MH workforce professional development, curriculum development and to influence the content of a range of undergraduate healthcare courses
6. That funding be allocated to support the 3-monthly meetings of the **VDDI-Rural Forum**

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Website / clearing house
In 2004, as the Hume-Border VDDI worker, the author created the www.dualdiagnosis.org.au website as a clearing house resource for all people with an interest in co-occurring mental health-substance use concerns. The site has been a considerable success, at times receiving 8000 individual visits a month and having a range of undergraduate healthcare courses directing their students to resources on the site.

This success has occurred despite challenges around the time available to administer and develop the site and annual funding tensions in keeping the site on the web. There are a host of resources waiting to be uploaded to the site and potential to further contribute to systemic complexity-capability in developing more site-resources tailored to the specific needs of the different people who use the site.

Recommendation 28:
That funding be allocated to support the further development of the www.dualdiagnosis.org.au website.

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Lived Experience workforces

There is exciting potential, as Victoria begins to benefit from its new Lived Experience workforces, to avoid recreating the silos (and sub-silos) of Victoria's existing mental health and substance treatment systems and agencies. In this regard we would particularly like to direct the Royal Commission's attention to these developments' innovations:

1. **Eastern Metropolitan Region Dual Diagnosis Consumer and Carer Advisory Council (DDCCAC)** Established in 2010 DDCCAC is Victoria's pre-eminent example of a region's cross-sector, consumer and carer, lived experience, co-design and service delivery towards improved service responses to people with a dual diagnosis. (DDCCAC, 2014) (DDCCAC, 2019)

2. **Self Help Addiction Resource Centre (SHARC)** –SHARC are a visionary organisation that have been actively developing and implementing self-help and peer-support approaches to AOD recovery for over 30 years. SHARC have established peer workforce partnerships across a number of domains including justice, mental health, harm reduction and gambling.
   SHARC have been deploying strategies to help the lived experience workforces avoid replicating the siloed approaches of our current mental health and AOD treatment systems. Recent activity included providing scholarships for Mental Health Lived Experience workers to participate in SHARC's 5-day AOD Peer Worker Training

3. **Lived Experience Workforce Strategies** Launched this month, each of the three strategies-
   a) Consumer Mental Health Workforce (LEWSSG, 2019)
   b) Family Carer Mental Health Workforce (LEWSSG-b, 2019)
   c) Alcohol and Other Drug Peer Workforce (LEWSSG-c, 2019)
   contain an overt recognition that many consumers and carers have experiences of seeking support from both mental health and AOD services; that lived experience workers may have experienced both mental health and substance use issues or supported a family member or friend who has experiences of both. All three Strategies recognise the '*unique opportunity for a more inter-sectorial and collaborative approach to supporting mental health and/or AOD consumers and their family/carers, regardless of which sector they interact with.'*

Recommendation 29:
That the Royal Commission, in its findings and its recommendations, recognises, celebrates and builds on these Lived Experience workforce initiatives

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Capacity building innovations

A recent Victorian development has seen the introduction of dedicated AOD-specific workers in several mental health sites (Croton G., 2019). This development aligns with the Victorian definition of integrated treatment and there are good early indications that these initiatives have had a range of notable benefits including more integrated treatment of client's co-occurring substance use issues.

Excerpt: Victoria's strategies towards integrated service delivery for people with mental health-substance use concerns. (Croton G., 2019)

Rather than the mental health staff involved perceiving that responding to substance use is only the specialist worker's responsibility it appears the mental health workers have demonstrated increased role-validity and interest in developing their capacities to respond to client's co-occurring substance use issues.

Recommendation 30:

1. That an evaluation of the impacts of the co-located AOD worker models be conducted including their impacts on organisational dual diagnosis capability.

2. That parallel strategies of funding a psychiatrist or mental health nurse practitioner into AOD services be trialled and evaluated in both rural and metropolitan sites

3. That these models be funded state-wide

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Capability tools

There is great potential to contribute to systemic capability in system leaders promoting the use of dual diagnosis capability tools. These tools can contribute in a variety of ways including

- building wide-spread, fine-grained understanding of what dual diagnosis capability is
- aligning service providers agencies and other stakeholders around a common vison of dual diagnosis capability
- celebrating existing successes in achieving dual diagnosis capability
- building enthusiasm for and a plan towards the next steps in developing dual diagnosis capability

There are a number of tools available to audit dual diagnosis capability. There are tools available to audit agency capability and to audit worker capability. Minkoff and Cline's Comprehensive continuous Integrated System of Care model has, by far, the most extensive sophisticated complementary array of tools towards implementing the CCISC model.

One of the distinctions between the available tools is whether they employ a self-auditing or an external auditor methodology. The self-audit tools tend to have the most focus on evoking, from the wisdom of the people completing the self-audit, their plan for the next steps in developing their own or their agency's dual diagnosis capability. The table below summarises some of the good things and less good things of self-audit v. external auditor methodologies

	External auditor	Self-Assessment
Good things:	When administered by objective raters who have received appropriate training, this process provides reliable ratings tied to concrete steps to improve services for individuals and families with co-occurring disorders.	Conducting the self-assessment, usually involving as many members of the team as possible in a conversation is in itself a significant dual diagnosis capacity building activity. The team discussions, group reflections, information sharing and learnings around agency progress towards dual diagnosis capability constitute a principle benefit of using this tool.
Less good things:	May have little impact on service provision or worker's understanding of and enthusiasm for developing dual diagnosis capability.	Tendency for people completing self-assessment to score higher than would an external rater -particularly on the first occasion of completing the tool

Good things & less good things of self-audit v. external auditor methodologies.

Appendix One compares some of the principal tools available for agency level audits.

Recommendation 31:

1. That DHHS promote and incentivise the use of dual diagnosis capability tools in all Victorian mental health and substance treatment services – both at agency and worker levels
2. That Victorian mental health and substance treatment agencies be tasked to provide annual reports on the strategies they are currently deploying to develop their complexity-capability.

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Recording prevalence

What gets measured gets done. An effective strategy to influence systemic dual diagnosis capability is to require all mental health and substance treatment services to develop their capacity to be able to, at the touch of a keyboard, report on

- The percentage of current clients have co-occurring substance use-mental health concerns
- The percentage of current clients don't have co-occurring substance use-mental health concerns?
- The percentage of current clients for which it is unknown whether they have co-occurring substance use-mental health concerns

This strategy has implications for the service's recognition of clients who have co-occurring substance use-mental health concerns. Increasing a service's recognition has implications for the worker's role-validity and capabilities and for the agency's intake processes, intake tools, review mechanisms and discharge planning.

Recommendation 32:

1. That DHHS require all Victorian mental health and substance treatment agencies to develop their capacity to provide fine-grained reports on the current prevalence of people with co-occurring substance use-mental health concerns within their agency.

2. That agencies are required to report on this at intervals and their reports are used in service planning

3. That, over time, this reporting requirement is deepened to include some reporting on the principle cohorts of people with co-occurring substance use-mental health concerns within their agency.

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Recommendation 33:

1. That Victorian Mental Health Services Outcomes Framework include reporting on substance use-mental health prevalence data in both mental health and substance treatment services

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Concluding words

It is critical that people with dual diagnosis and other complex needs are at the centre of the Royal Commission's recommendations for system reform because of:

- Prevalence: people with mental health-substance use and other complex needs are the *expectation not the exception* in Victorian mental health and substance treatment services

- Harms: there are a litany of significant harms and unwanted outcomes strongly associated with having mental health-substance use and other complex needs

- Potential for better outcomes: if the Royal Commission can influence the development of a complexity-capable Victorian service system it will have made a huge contribution n to the mental health and wellbeing of all Victorians

The strategies discussed in this submission are by no means an exhaustive list – there are many more possible approaches to achieving better outcomes for people with mental health-substance use and other complex needs. It is both possible and critically important that Victoria develops a complexity capable service system

To do so requires the systematic, iterative deployment of an array of complementary strategies to achieve a vision of how our treatment services will look, feel and behave when we are providing effective responses to the various cohorts of people experiencing or affected by mental health-substance use concerns and other complex needs.

Recommendations

Recommendation 1:
That Victorian DHHS auspice a multi-stakeholder, codesign process to agree and promote a more current term than '*dual diagnosis*' to describe the situation and attendant issues of people experiencing co-occurring mental health and substance use concerns.

Page 6

Recommendation 2:
That systems development initiatives crafted to address the issues around co-occurring mental health–substance use issues employ primarily collaborative and iterative strategies and are devised with a robust recognition of the complexity of the challenges.

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Recommendation 3:
That, given

- the prevalence of people with mental health concerns presenting to Victorian AOD services
- the numbers of people with mental concerns receiving services from Victorian AOD services

that the Royal Commission extends its purview and recommendations to include reforms in the AOD system towards more effective response to people with co-occurring mental health-substance use concerns.

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Recommendation 4:
That Australia's National Survey of Mental Health and Wellbeing be funded to occur at 5-yearly intervals.

Page 22

Recommendation 5:
That the Royal Commission recommend the funding of a Victorian study to identify principal harms and estimated costs, across healthcare and social services, associated with people experiencing co-occurring mental health-substance use concerns.

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Recommendation 6:
That the Royal Commission places people with co-occurring mental health and substance use concerns and other complex needs at the centre of their recommendations for systems reform

Page 25

Recommendation 7:
That the office of the Victorian Chief Psychiatrist be asked to write a Chief Psychiatrists Guideline around this Mental Health Act principle.

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Recommendation 8:
That the Mental Health Branch in partnership with Drug Treatment creates a State Chief Addiction Psychiatrist position, whose role is to influence the dual diagnosis/complexity-capability of all Victorian psychiatrists and addiction medicine specialists empoyed in Victorian mental health-substance treatment services

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Recommendation 9:
That the National Drug and Alcohol Research Centre be funded to develop *National Guidelines on the management of co-occurring mental health and alcohol and other drug and conditions in mental health treatment settings* that complement their 2016 *National Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings.*

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Recommendation 10:

7. That the VDDI be reviewed state-wide against its role descriptions

8. That the VDDI continue to receive ongoing funding

9. That consideration be given to broadening the VDDI's mandate to achieving better outcomes for people with '*dual diagnosis and other complex needs'*

10. That consideration be given to what strategies (role description / structure / accountability points) could further contribute to the VDDI's effectiveness?

11. That consideration be given to refunding a **VDDI Education and Training Unit** with a remit to influence the complexity-capability of AOD-MH workforce professional development, dedicated curriculum development and the content of a range of undergraduate healthcare courses

12. That funding be allocated to support the 3-monthly meetings of the **VDDI-Rural Forum**

Page 31

Recommendation 11:

5. That there be an evaluation of the impacts of HYDDI initiative to date

6. That the HYDDI role description be updated

7. That HYDDI be extended to other Victorian regions

8. That strategies be devised to address annual funding tensions

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Recommendation 12:

4. That a range of strategies be funded to address
   - the stigma associate with substance use disorders per se
   - the impacts of dual stigma

5. That these strategies include strategies targeting the beliefs and attitudes of a range of relevant healthcare providers

6. That policy and resources be devoted to addressing how welcoming mental health and AOD services are – including physical layout, induction priorities and requirements and clinician and in developing worker competencies in creating a welcoming, collaborative, safe engagement with people

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Recommendation 13:
That Victoria again consider the goal of a No Wrong Door service system and develops a coherent web of strategies and incentives to achieve against that goal.

Page 41

Recommendation 14:
That there is consideration given to the adoption of Single Session Therapy models in some components of the Victorian mental health and substance treatment systems.

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Recommendation 15:
That the Royal Commission investigate:

- The capacities and qualifications of NDIS assessors to non-judgementally assess and develop useful plans for people with co-occurring mental health disability-substance use issues
- Numbers of people with a co-occurring mental health disability- substance use issue who have made successful applications to the NDIS
- Nature and size of the funding received by people with co-occurring mental health disability-substance use issue who have made successful applications to the NDIS compared to the nature and size of the funding received by people with mental health disability alone.
- Whether the presence of a co-occurring substance use issue has served as an effective exclusion criterion for people with mental health disability applying to the NDIS

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Recommendation 16:
That Victorian DHHS relax entry criteria into the new MHCSS model so that MHCSS services can flexibly initiate services with people with severe mental health concerns who do not wish to engage with clinical mental health services.

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Recommendation 17:
That the Royal Commission include in its recommendations that mental health disability be removed from the NDIS

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Recommendation 18:
That future Victorian strategies to address the needs of people with co-occurring mental health-substance use issues are designed around a robust recognition of the diversity of cohorts and the diversity of their treatment needs and preferences.

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Recommendation 19:

- That Victorian healthcare planners continue to develop a range of well-connected treatment options around the treatment needs and preferences of the different cohorts of people with co-occurring mental health-substance use concerns.

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Recommendation 20:

- That Victorian AOD services are not subsumed under mental health services

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Recommendation 21:

- That mental health and AOD are enduringly braided together at a central policy and planning, DHHS level.

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Recommendation 22:
That central policy and planning bodies be cautious about developing dual diagnosis-specific treatment options

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Recommendation 23:
That a range of mechanisms and incentives be devised to 'celebrate' and promote successes in developing complexity–capability – at clinician, agency and systems levels.

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Recommendation 24:

- That the 2007 cross-sector dual diagnosis policy is revised and renewed.
- That a codesign process informs this review.
- That the focus of the renewed policy is better outcomes for people with co-occurring mental health and substance use and other complex needs.

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Recommendation 25:
That the Royal Commission video-conference with Drs Minkoff and Cline to consider approaches to further develop Victorian mental health and substance treatment services in alignment with the Comprehensive Continuous Integrated System of Care (CCISC) model

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5. That agencies are required to report on this at intervals and their reports are used in service planning

6. That, over time, this reporting requirement is deepened to include some reporting on the principle cohorts of people with co-occurring substance use-mental health concerns within their agency.

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Appendix One *Menu of options*: Dual diagnosis capability tools

1. Agency Level Tools

Options [1] : *Click icon to hyperlink:*	DDCAT / DDCMHT LINK LINK 	COMPASS-EZ™ LINK 	*Checklist* Dual Diagnosis Capability LINK 	Co-Existing Problems (CEP) Service checklist LINK 
About:	2 companion instruments: **1. Dual Diagnosis Capability in Addiction Treatment Index (DDCAT)** benchmark instrument for measuring **addiction treatment program services** for persons with co-occurring mental health and substance use disorders **2. Dual Diagnosis Capability in Mental Health Treatment (DDCMHT)** benchmark instrument for assessing **mental health treatment program** capacity for persons with co-occurring mental health and substance use disorders - Multiple capability studies have utilised the DDCAT Ratings based upon observation, conversations with program personnel and clients, and record reviews. Background documentation includes guidelines around the process of conducting a typical site visit, from scheduling to exit interview.	'Designed to help behavioural health services organise a baseline self-assessment of recovery oriented complexity (co-occurring) capability. This permits each program to develop and take ownership of a quality improvement process for making progress.' 'Using this tool all programs in a behavioural health system can work in partnership using a shared process to make progress toward the collective vision of recovery oriented complexity (co-occurring) capability across the whole system' Complemented by sophisticated array of tools to help services develop towards a Comprehensive Continuous Integrated System of Care (CCISC) model More	Developed around the 2007, cross-sector, **Victorian Dual Diagnosis Policy**. The agency/service level tool is a part of a suite of tools that MH or AOD workers OR agencies can use to: 1. Reflect on and self-assess their existing level of dual diagnosis capability 2. Identify training needs in relation to dual diagnosis capability 3. Develop a time-lined plan of actions to further develop their levels of dual diagnosis capability The tools have been used widely including in collaborative, multi-agency, multi-sector, system development processes - Report here	A brief tool for mental health and addiction/AOD services to use for self-assessment, reflection and planning to develop service level co-existing problems (CEP) responsiveness and capability. Based on the Australian Checklists Co-existing problems refers to co-occurring complex mental health, **gambling** and substance use disorders. Matua Raki & Te Pou have developed a range of resources to assist NZ mental health and AOD workforces to respond effectively to people with co-occurring mental health and substance use problems.

Methodology [2] :	**External auditor**	**Agency self-assessment**	**Agency self-assessment**	**Agency self-assessment**
Designed for:	**DDCAT** – AOD services **DDCMHT** – MH services	Behavioural Health Programs (including MH & AOD).Other Compass versions specific to Intellectual Disability Programs and Prevention & Early Intervention Programs	Mental Health (both Clinical and MHCSS) and AOD services	Mental health and addiction/AOD services
Validated:	**Yes**	**No**	**No**	**No**
Fee:	**No**	**Yes** *(Inquire here)*	**No**	**No**
Companion Tools:	**No** Agency level only	**Yes** Extensive array of aligned CCISC 'Zia-tools' – arranged at: - Systems - Agency - Primary Care / Behavioural health integration - Staff Competency and - Practice levels	**Yes** 2009 -2013 clinician-level capability tools specific to each of: - AOD - Clinical Mental Health - MH Community Support Services In 2018 DHHS commissioned an integrated (MH-AOD) clinician level tool as an aid to new, dual diagnosis-specific, resi rehabs – available here	**No** Agency level only
Domains:	1. Program Structure 2. Program Milieu 3. Assessment 4. Treatment 5. Continuity of Care 6. Staffing 7. Training	1. Program Philosophy 2. Program Policies 3. Quality Improvement and Data 4. Access 5. Screening and Identification 6. Recovery-oriented Integrated Assessment 7. Integrated Person-centered Planning 8. Integrated Treatment/ Recovery Programming 9. Integrated Treatment/ Recovery Relationships 10. Integrated Treatment/ Recovery Program Policies 11. Psychopharmacology 12. Integrated Discharge/ Transition Planning 13. Program Collab'n & Partnership	1. Agency policy & documentation 2. Detection & Assessment 3. Integrated treatment 4. Working with the broader service system 5. Quality assurance	1. Service Objectives 2. Service Workforce Development Objectives

		14. General Staff Competencies and Training 15. Specific Staff Competencies More		
Fine-grain:	35 items (33 in Australian adaptation)	69 items	45 items	19 items
Outcomes:	**For DDCAT** rating (ASAM taxonomy) of whether the service is: - Addiction Only Services (AOS), - Dual Diagnosis Capable (DDC) or - Dual Diagnosis Enhanced (DDE). **For DDCMHT** rating of whether the service is: - Mental Health Only Service (MHOS) - Dual Diagnosis Capable (DDC) or - Dual Diagnosis Enhanced (DDE).	Develop an action plan based on the learning experience with the COMPASS-EZ™ Beginning of an organised quality improvement process towards a Comprehensive Continuous Integrated System of Care (CCISC) model	- Development of a time-lined plan of strategies to further develop dual diagnosis capability - Increased understanding of what being dual diagnosis capable involves -Recognition and 'celebration' of existing achievements in developing capability - Increased self–efficacy about further developing capability	The checklist can be used to develop an action plan that identifies work to develop service level CEP responsiveness and capability (including any workforce development needs).
Country of origin:	**USA** *In 2008 an Australian adaptation, (Improved Services Initiative) omitted those items which didn't align with the Australian service system environment*	**USA**	**Australia**	**New Zealand**
Authors:	Mark McGovern Dartmouth Psychiatric Research Centre	Chris Cline & Ken Minkoff © Zia Partners	Gary Croton	Matua Raki & Te Pou
Created:	- DDCAT in development since 2003	2009-2016	2009	2012

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-4

This is the attachment marked '**GJC-4**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

Victoria's strategies towards integrated service delivery for people with mental health-substance use concerns

In 2007 Victoria's mental health and alcohol and other drug policy and planning bodies published a landmark, multi-sector, dual diagnosis policy. This policy provided mental health and drug treatment providers with a coherent, operationally achievable definition of integrated treatment: This paper reflects on what has been learned about systems change and identifies current challenges and directions in the design and provision of integrated service delivery.

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Background

In Victoria, 'dual diagnosis' is the preferred umbrella term for the diverse combinations of disorders experienced by people with co-occurring mental health-substance use concerns. Recognition that people with dual diagnosis commonly also experience a range of other treatment and social needs has given rise to the rubric of *'dual diagnosis and other complex needs'.*

A range of harms and unwanted outcomes are associated with having multiple health concerns compared to single concerns (Coroners Court Victoria 2017; Croton 2011). People experiencing dual diagnosis are prevalent – the *expectation not the exception* (Minkoff and Cline 2004) – in mental health and alcohol and other drug (AOD) settings. Workers, agencies and sectors oriented to treat single disorders may have compromised effectiveness in working with people whose treatment needs transcend traditional service boundaries.

The diversity in severity and combinations of disorders experienced by people with dual diagnosis leads to diverse treatment needs. Mental health and AOD clinicians, managers, policy and planning bodies have long-standing interest in the potential for integrated service delivery to provide more effective responses with people experiencing dual diagnosis. Australia has seen consistent calls for more integrated service delivery for people experiencing dual diagnosis since 1993 (McDermott and Pyett 1993; NSW Health 2000; Teesson & Burns 2001; Kavanagh et al. 2003; NMHC 2013; NSW Health 2015; Louie et al. 2018).

Despite 'conceptual murkiness' (Savic et al. 2017) around the definition of integrated treatment, an absence of tools to measure impacts (Armitage et al. 2009) and a lack of definitive evidence around its superiority over parallel or sequential treatment (Donald et al. 2005, Hunt et al. 2013; Nevan et al. 2018), integrated treatment has strong logical appeal for systems wishing to achieve better outcomes for people with dual diagnosis. While not definitive, integrated care does have a substantial evidence base (SAMHSA 2009) and, interestingly, provides benefit to people providing services as well as people receiving services (Longpre et al. 2014).

There are well-recognised barriers to achieving integrated care for people with dual diagnosis (Sterling et al. 2011, Padwa et al. 2015).

There are well-recognised barriers to achieving integrated care for people with dual diagnosis.

Most mental health/AOD treatment systems are active in addressing these barriers in pursuit of better outcomes for people affected by dual diagnosis.

Victorian dual diagnosis policy

Since the early 1990s Victoria has been at the vanguard of Australian states in planning and investing in effective responses to people with dual diagnosis. Strategies deployed include:

- dedicated, capacity-building workforce through the Victorian Dual Diagnosis Initiative (2002–current)
- other dual diagnosis-specific positions
- funded, cross-sector, clinician rotations (Sellars 2009)
- dual diagnosis training body.

A watershed in Victoria's evolving responses was the 2007 cross-sector dual diagnosis policy (Victorian Government 2007) that offered all stakeholders an evidence-informed vision of how the AOD & mental health treatment sectors will look, feel and behave when providing effective responses to the various cohorts of people with dual diagnosis.

At the heart of the policy is an operationally-achievable definition of integrated treatment:

'Integrated treatment may be provided by a clinician who treats both the client's substance use and mental health problems. Integrated treatment can also occur when clinicians from separate agencies agree on an individual treatment plan addressing both disorders and then provide treatment. This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client.'

Of relevance to this definition is US Center for Substance Abuse Treatment (2007) advice that the threshold for 'integration' relative to 'collaboration' is shared responsibility for the development and implementation of a treatment plan.

The policy's vision and strategies towards a No Wrong Door service system and its unambiguous statements that 'dual diagnosis is core business' for mental health and AOD services further the policy's potential to influence the mental health and AOD sectors towards integrated service delivery. The policy includes fine-grained, time-lined, service-level Service Development Outcomes (SDOs) that service managers were obliged to report on. These include:

- universal screening
- tiered 'dual diagnosis capability' of workers
- mental health and AOD services to establish partnerships and mechanisms to support integrated assessment and treatment
- outcomes and service responsiveness for dual diagnosis clients to be monitored and regularly reviewed
- consumer and carer involvement in the planning and evaluation of service responses.

Borgermans and Devroey (2017), in reflecting on the pan-European EU Project INTEGRATE, observe that any policy on integrated care should be a tripartite of mission, vision and strategy towards the range of factors that influence the successful development of integrated care. We contend that the 2007 Victorian dual diagnosis policy abundantly meets those criteria and is a landmark Australian example of central policy influencing the successful development of integrated care.

To date the Victorian policy, of comparable Australian state/federal-level policies, (Queensland Health 2008; Tasmania DHHS 2011) is the most robust in its vision of and strategies towards integrated service delivery. This paper profiles some of the subsequent Victorian AOD-mental health service developments and their alignment with the Victorian policy.

Victorian AOD-mental health service developments post-policy

There is debate about what constitutes effective mental health and/or drug treatment service delivery and priorities in the context of limited resources. These debates are compounded when considering best practice in responding to multiple disorders.

Cross-sector misunderstandings and fears can impact on effective working relationships and navigable cross sector treatment pathways. Stakeholders have differing, often hard-won and personally cherished, conceptualisations of the nature of and solutions to the various problems. In this context a major impact of the Victorian policy was to provide a clear vision of an effective, integrated treatment system, routinely providing integrated treatment and the developmental steps to achieve that vision.

Service managers, even if wary of integrated service delivery, were obliged by the reporting requirements to familiarise themselves with the fine grain of the vision. Designated change agents, such as the VDDI and the then Commonwealth-funded Victorian Improved Services Initiative workers (NISIF 2010), were united around achieving the developmental steps proposed in the policy.

The holistic Aboriginal concept of Social and Emotional Wellbeing has potential to serve as such a higher-level model if adopted more broadly in Australia.

A 2011 evaluation of Victoria's dual diagnosis initiatives (Australian Healthcare Associates 2011), found that:

- over half of clinical mental health and AOD services were screening most clients for dual diagnosis issues
- between 30-40 per cent of clients received integrated assessment in Psychiatric Disability Rehabilitation Support Services (PDRSS), 35-45 per cent in clinical mental health and 50-60 per cent in AOD services
- more work was needed in the area of integrated treatment (albeit the evaluation only considered multi-agency approaches to integrated treatment).

The 2011 evaluation identified several leading approaches to integrated treatment (see Figure 1).

While the reporting period for the policy's SDOs has now expired, it is the authors' contention that the policy's vision of integrated service delivery continues to influence AOD and mental health developments and service design. Notable here is that Victoria's *2014 Mental Health Act* (Department of Health 2014) is the only such Act in Australia that states that persons receiving mental health services should have their medical and other health needs, *including any alcohol and other drug problems*, recognised and responded to.

An example of an integrated systemic approach to developing dual diagnosis capability occurred in northeastern Melbourne in 2013. The multi-sector North East Mental Health Alliance (Jackson 2013) used fidelity tools, developed around the goals of the Victorian policy (Croton 2008), to survey and progress the systemic dual diagnosis competency of 12 AOD and mental health program areas.

Figure 1. Some of the Victorian approaches to integrated treatment at March 2011

- Northern Mallee model for integrated dual diagnosis withdrawal
- Barwon Health Jigsaw youth service with integrated screening and AOD-mental health job descriptions
- Eastern Hume's No Wrong Door Integrated Multi-Agency Dual Diagnosis Protocol around integrated service delivery for people with dual diagnosis – around 50 Hume agencies were signatories
- Eastern Hume's development of common, cross sector, integrated screening and assessment documentation

Eastern Health and its Eastern Dual Diagnosis Service provide systems leadership in their approaches to co-design. The very active Dual Diagnosis Consumer Carer Advisory Council (DDCCAC) collaboratively supports services to develop their dual diagnosis interventions with a representative body of consumer and carers. Three recent service innovations deployed by Eastern Health with DDCCAC input and participation are aimed at more integrated treatment for people with dual diagnosis; these are profiled in Figure 2 with an analysis of their alignment with the 2007 Victorian dual diagnosis policy.

Figure 2. Recent Eastern Health service innovations – alignment with 2007 Victorian dual diagnosis policy

	Recent Eastern Health Service Innovations Targeting people receiving services from Clinical Mental Health services.		
Alignment with 2007 Victorian dual diagnosis policy aims	**1. 6 peer-led dual diagnosis groups** • Inpatient & community settings • Recovery principles – person centred, strength based, integrated support • Explore resilience factors, examine personal values, evoke own conclusions re goals and needs	**2. Dedicated AOD workers in inpatient mental health units** • Partnership with Anglicare • Delivering AOD screening, assessment and treatment within a mental health inpatient unit • Seamless pathways to dedicated AOD treatment	**3. Specialist dual diagnosis clinicians working across mental health case management teams** • Workers required to have mental health and advanced AOD skills and qualifications • Shared care model
Consumers and carers involvement in planning and evaluation of service responses	Groups organised and run by Dual Diagnosis Consumer Carer Advisory Council (DDCCAC)	DDCCAC and post-discharge inpatient peer support workers involvement in service design and development	DDCCAC involvement in service design and development

Figure 2. Recent Eastern Health service innovations – alignment with 2007 Victorian dual diagnosis policy (continued)

Universal screening	Groups are dual diagnosis-specific	Screening is core worker activity and increased screening is aim of service	Service has developed the teams screening and assessment proformas and processes
Integrated treatment provided by a clinician who treats both client's substance use and mental health problems.	Focus is both mental health and substance use concerns	All Anglicare workers are employed for dual diagnosis, rather than AOD or mental health specific roles	Clients receive comprehensive AOD assessment and integrated treatment of both concerns
Integrated treatment clinicians from separate agencies agree an individual treatment plan addressing both disorders and then provide treatment.	Aimed at participants identifying and accessing any needed treatments	Has improved treatment pathways from mental health to AOD	Focus is on, where indicated, building seamless pathways to dedicated AOD services
No Wrong Door service system	Delivered in a mental health setting – oriented to clients accessing any needed AOD treatment	People entering mental health treatment are receiving needed AOD treatments delivered in both AOD & mental health settings	People entering mental health treatment are receiving needed AOD treatments
Dual diagnosis is core business	Designed around that premise	Designed around that premise	Designed around that premise
Developing tiered **'dual diagnosis capability' of workers**	Workers are predominantly consumer & carers with strong peer support and a culture of dual diagnosis capability	Modelling of integrated treatment is influencing practice of mental health workers	Modelling of integrated treatment is influencing practice of mental health workers
Mental health and AOD services to establish **partnerships and mechanisms to support integrated assessment and treatment**	Well defined pathways to any needed AOD treatment/ support	Service delivery is a collaboration between a clinical mental health and an AOD service	Model has inbuilt mechanisms to facilitate integrated treatment – partnership with Turning Point & Anglicare
Outcomes and service responsiveness for dual diagnosis clients to be monitored and regularly reviewed	Frequency of groups and numbers of participants are recorded and monitored	• c 50% lower re-admission rate for clients receiving service • Increased identification of dual diagnosis clients (2 years: 13 to 40%) • Detected increased prevalence of Amphetamine Related Presentations	Monitors: • Screening and assessment rates • Detected increased prevalence of Amphetamine Related Presentations • Increased numbers of referrals

Lessons learned

The Victorian dual diagnosis policy was clear in attributing responsibility to achieve the policy's vision to services, their management and workers. The VDDI's role in assisting this evolution is ongoing and continues to be refined in Victorian planning documents (Department of Health and Human Services 2016 & 2018). The VDDI has evolved with the systems it works with and has developed learnings about effective approaches to systems change to more integrated care. Some of these learnings (Croton 2016) are summarised in Figure 3.

Figure 3. VDDI lessons learned about capacity building towards integrated service delivery

Dual diagnosis is most usefully conceptualised as a wicked problem, in that:

- it is difficult to define
- there are multiple, often conflicting, conceptualisations of the problems and solutions
- problems aren't easily separated from their environments
- there is little agreement about who is a legitimate problem solver, and
- the effects of intervention often aren't obvious (Rittel et al. 1973).

Recognition of the problem is critical: at the systems level through recording and monitoring prevalence; at the client level through improved screening and assessment.

Integrated treatment, while not unambiguously supported by the available evidence, stands out as the most effective response.

Change is incremental and requires sustained effort using multiple, iterative, aligned, motivational strategies.

Education *per se* does little to change practice and can be harmful when it is not supported by agreed, aligned organisational values, policies and procedures and the consistent understanding and enthusiasm of the agency's leaders. To influence practice education needs to be supported over time by mentoring, clinical supervision and modelling

Current challenges and directions

Universally mental health and AOD service delivery models are in constant evolution in response to changing client needs, economic imperatives and societal values. In Australia, over the past several years, the decline of block funding, the development of competitive tendering and increasingly tautly-focused service entry criteria and processes may not help No Wrong Door, welcoming service systems and navigable, integrated, treatment pathways. At the same time there is evidence of client needs becoming increasingly complex (AIHW 2017) with concomitant increased need for effective, integrated, service delivery models.

Minkoff and Cline's (2012) Comprehensive Continuous Integrated System of Care (CCISC) model, in broad use across the US, was developed around recognition that people with complex needs are the expectation not the exception in multiple service sectors. CCISC aims to build the capacity of all service sectors to provide integrated, welcoming, recovery-oriented, trauma-informed, culturally-competent care to individuals and families with multiple co-occurring conditions. CCISC involves every part of a system in a common process to achieve a common vision of integration.

Todd (2016) has called for the development of a 'higher level model', such as quality of life, that can be shared by workers from diverse sectors to provide a unifying 'big picture' vision. The holistic Aboriginal concept of Social and Emotional Wellbeing has potential to serve as such a higher-level model if adopted more broadly in Australia.

Brousselle et al. (2010) authored a process evaluation of factors that enhance or impede service integration. Crucially, in noting the complexity of the task and the various possible ways of fostering integration, they observed that the primary focus must be on the relationships among the people involved.

Conclusions

The perennial drivers that focus systems on developing more integrated care for people with dual diagnosis are prevalence, harms and potential for better outcomes. These factors have become more pressing with time, with increasingly complex client presentations and as knowledge grows about the nature of and effective responses to mental health-substance use concerns.

Achieving more integrated systems of care in a landscape of constant change and finite resources is possible and remains a critical priority. It requires iterative, robust deployment of a web of complementary, collaboratively developed, locally-attuned strategies.

The 2007 Victorian dual diagnosis policy has demonstrated that central policy which successfully combines mission, vision and strategy (Borgermans and Devroey, 2017) is an effective and efficient lever towards more integrated systems of care.

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Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-5

This is the attachment marked '**GJC-5**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

Dual Diagnosis Initiative

The Dual Diagnosis initiative will provide training, tertiary consultation and secondary consultation to organisations delivering mental health or drug and alcohol services, and direct treatment to a small number of clients who have both a mental illness and problematic substance use.

The initiative will focus on developing the capability of hospital and community based alcohol and drug, and mental health treatment services to improve the health outcomes of people with a dual diagnosis. The development of cooperative interservice arrangements and better treatment programs tailored to individual client needs will be central activities for the initiative.

The initiative will be established through the provision of funding to 4 lead metropolitan agencies who will be major providers of both mental health and drug treatment services, to establish dual diagnosis teams. The initiative also will have a rural component which will connect specialist dual diagnosis workers in eight rural centres to the metropolitan teams.

The establishment of the four metropolitan teams will ensure that there is an appropriate critical mass to lead the initiative and deliver on the overall objectives of the initiative, while the location of specialist dual diagnosis positions in the major rural centres will ensure that the initiative is accessible and able to effectively deliver good outcomes to rural communities.

It is proposed that the positions located in the major rural centres will be linked to the four teams to ensure that training and appropriate professional development and supervision is available to workers.

Specialist Dual Diagnosis workers will have appropriate knowledge and experience of the treatment approaches of both the mental health and drug treatment service systems.

The proposed dual diagnosis teams are:

Western Team
- Coordinator
- 5.5 Specialist Dual Diagnosis Workers
- Consultant Psychiatrist - Part Time
- Registrar - Part Time
- 3 Linked Rural Specialist DD workers (Geelong, Warnambool & Ballarat)

Southern Team
- Coordinator
- 4 Specialist Dual Diagnosis Workers
- Consultant Psychiatrist - Part Time
- Registrar - Part Time
- 1 Linked Rural Specialist DD worker (Traralgon)

Northern Team
- Coordinator
- 2 Specialist Dual Diagnosis Workers
- Consultant Psychiatrist - Part Time
- Registrar - Part Time
- 2 Linked Rural Specialist DD workers (Bendigo & Mildura)

Eastern Team
- Coordinator
- 2 Specialist Dual Diagnosis Workers
- Consultant Psychiatrist - Part Time
- Registrar - Part Time

- 2 Linked Rural Specialist DD workers (Shepparton & Wangaratta / Wodonga)

Other Resources

- Curriculum Development Position - To be determined at a later time.

Roles and Functions of Dual Diagnosis Positions

The Coordinator Role

- Coordinators will have overall responsibility for ensuring that a training curriculum is available, and that support in the form of training, consultation and clinical supervision is provided to the specialist DD workers both within the metropolitan team and to those located in linked rural health services.
- Formal clinical supervision should be provided on a regular basis.
- It is expected that Coordinators will co-facilitate some of the training provided through each of the area services covered by their team, including linked rural areas. This support should particularly focus on major forums and in instances where specialist DD workers are in the process of being trained themselves.
- Coordinators will be responsible for the ongoing development of the training curriculum
- Coordination of periodic information sharing forums for all DD workers within the catchment including those employed by linking rural services. These meetings should occur on a minimum of a monthly basis and more regularly as circumstances require collaborative efforts.

The role of Specialist Dual Diagnosis Workers

- Each specialist dual diagnosis worker should be allocated a catchment for which they will be responsible for:
    - The development of cooperative working relationships between mental health and drug treatment services within the relevant area service catchment. This should particularly address issues of access, assessment and the development of effective treatment planning.
    - The provision of training and consultation to all mental health (including PDSS) and drug treatment services within the area service catchment with a strong focus on building capacity within the services to respond more effectively to people with a Dual Diagnosis.
    - The provision of direct a service to clients with a serious mental illness and substance use problems with a focus on developing and modelling good practice. This may be through providing a limited direct service and intensive support/consultation to case managers on specific cases.

Establishment Tasks

Lead Agency - Establishment Tasks

- The major Metropolitan Health Services in the southern and eastern catchment areas will be invited to consult each other and nominate a lead agency for each DD team. The lead agency should be a major provider of both mental health and drug treatment services. This will not be necessary in the Western partnership where existing arrangements are in place or the Eastern partnership where the two area mental health services are provided by the Eastern Health Service.
- The lead agency will then be required to:

- Identify how the DD team will sit within the management structure of the lead agency. This should include an accountability link to the lead agencies drug treatment and mental health service services management structures; and
- Identify the clinical and management supervision arrangements for the coordinator.

Dual Diagnosis Team Coordinator - Establishment Tasks

- The DD Team coordinator will be required to establish a reference group consisting of mental health (including Psychiatric Disability Support Services, and Drug Treatment services representatives, consumers and carers. The group should also include a rural representative and representatives from relevant DHS regional offices.
- The DD Team Coordinator will be required to develop an agreement with each linked rural health service in the catchment. The agreement should addresses:
  - the provision of training to specialist rural Dual Diagnosis workers;
  - the identification of mechanisms/strategies for the provision of clinical supervision and consultation to specialist rural DD workers; and
  - a framework for supporting specialist rural DD workers in providing training to the mental health and drug treatment services within their area service catchments.
- The Coordinator will also be required to access/develop an appropriate Dual Diagnosis training curriculum.

Specialist Rural Dual Diagnosis Workers - Establishment tasks

- Specialist Rural Dual Diagnosis workers should undertake an initial training program which addresses the delivery of effective service provision to people with a Dual Diagnosis. This should be provided by the linked metropolitan DD team.
- To establish a local advisory group consisting of mental health (including Psychiatric Disability Support Services), Drug Treatment services, relevant rural DHS office representatives, consumers and carers.
- To confirm/formalise arrangements for clinical supervision and access to consultation and training support from the Dual Diagnosis Coordinator (Lead Agency).
- To establish a mechanism for the development and modelling of good practice.
- To identify how the DD area service positions will sit within the management structure of the auspicing rural area mental health service. This should include an accountability link to the drug treatment services management structure within the auspice agency (where the agency is also a provider of drug treatment services).

Statewide Coordination

A Statewide reference group will be established consisting of the four team coordinators; a mental health service, a drug treatment service, and a rural representative from each DD team/catchment; 2 representatives from the Mental Health Branch, 2 representatives from Drugs and Health Protection Services Branch, and one representative from a rural and a metropolitan DHS office.

The group will meet monthly through the establishment period of the initiative and quarterly once the 4 teams are fully operational.

The Statewide reference group will have a steering role as well as provide an opportunity for feedback into the ongoing development of the initiative.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-6

This is the attachment marked '**GJC-6**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

Statewide Dual Diagnosis Initiative Evaluation

FINAL REPORT

October 2004

Prepared by

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Turning Point Alcohol and Drug Centre

for and with

Department of Human Services, Victoria

Rural and Regional Health and Aged Care Services Division

Drugs Policy and Services Branch

Mental Health Branch

and the four Dual Diagnosis Initiative lead agencies:

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Paul Gardiner and Rick Noble were instrumental in managing the online survey. Paul Gardiner also assisted in communicating with key informants and analysing survey responses.

Glossary

AMHS - Adult Mental Health Services

AMHS - Area Mental Health Service

AOD - Alcohol and Other Drug

CAMHS - Child and Adolescent Mental Health Service

DHS - Department of Human Services

EHDDS - Eastern Health Dual Diagnosis Service

GP(s) - General Practitioner(s)

MH - Mental Health

Nexus - Northern Nexus (northern dual diagnosis service)

PDRS - Psychiatric Disability Rehabilitation and Support

RAPID - Redevelopment of Acute and Psychiatric Information Directions

SDDS - Southern Dual Diagnosis Service

SUMITT - Substance Use and Mental Illness Treatment Team (western dual diagnosis service)

Case management: The mechanism of ensuring access to and coordination of the range of services necessary to meet the identified needs of a person within and outside the integrated mental health service. People with mental illness requiring case management are usually living in the community and have long-term needs necessitating access to health and other relevant community services.*

Capacity is the ability to carry out stated objectives. It has also been described as the “stock of resources” available to an organization or system as well as the actions that transform those resources into performance.#

Capacity building (or capacity development) is a process that improves the ability of a person, group, organization, or system to meet objectives or to perform better.#

Community capacity building: Developing investment in mental health on multiple levels in government and non-government sectors, and utilising the knowledge and expertise of consumers, carers and others in the general population.*

Dual diagnosis - A dual diagnosis client is an individual who has a co-existing mental illness and substance (use) disorder without a determination of which disorder is causative or primary**

Continuity of care: Linkage of components of individualized treatment and care across health service agencies according to individual needs.*

Early intervention: Timely interventions which target people displaying the early signs and symptoms of a mental health problem or a mental disorder. Early intervention also encompasses the early identification of patients suffering from a first episode of disorder.*

Service development: assisting agencies with processes, protocols, policy and linkages towards the development of integrated service delivery.

Theory of action: Part of a capacity-building plan that includes common objectives and shared concepts. A coherent theory of action agreed on by the key groups involved in the process states how activities are expected to produce intermediate and longer-term results and benefits. #

* (LaFond and Brown 2003)

***(Bradley & Toohey, 1999)*

(National Mental Health Plan 2003-2008)

Contents

Executive Summary

The Dual Diagnosis Initiative commenced with the appointment of the first team managers in mid 2001. This evaluation, three years later, describes the Initiative's operation since then and makes recommendations for its future direction.

The evaluation focuses on the two key elements to the provision of State-funded Dual Diagnosis services throughout Victoria, namely:

1. Four specialist Adult Dual Diagnosis Services, funded jointly through the Mental Health Budget and the Drugs Policy and Services Branch Budget
2. Youth Dual Diagnosis services established through each of the four existing Dual Diagnosis lead agencies.

The evaluation used a mixed methods design organised around monthly meetings of a collaborative working group. A wide range of data was triangulated. In approaching the evaluation, we were aware that, while a major objective was to assess the impact of the Initiative, capacity building is a process with many elements and with long term outcomes that are not reliably attributable to any one intervention.

The Executive Summary outlines the key findings in relation to nature and extent of implementation; impact; challenges and barriers; and strengths. It concludes with the list of all recommendations. Full details are provided in the report.

Key findings

Nature and extent of implementation

As a capacity-building initiative, the key elements of the Initiative were:

- Education and training
- Secondary consultation
- Primary consultation to dual diagnosis clients; and
- Service development.

The dual diagnosis services are active across all elements of the Initiative, providing primary and secondary consultation, service development and education and training to their key stakeholders.

While the balance of the elements varies from catchment to catchment and from time to time according to a range of factors, activity across the Initiative is relatively evenly focussed on each element. Stakeholders strongly value each element in the Initiative.

The resourcing of the Initiative has been characterised by

- Attraction of a skilled, experienced and committed workforce

- A somewhat protracted start-up period
- High staff turnover in two services
- Some difficulty in securing and retaining intended physical resources.

The more settled profile and processes of the pilot service, established in 1998, bear witness to the time needed for this kind of Initiative to become fully operational.

Impact

Measuring the impact of a capacity-building initiative in 12 months is not possible. Capacity-building takes many years. Nonetheless, proxy measures of impact were obtained for the evaluation. These measures included quantitative data (such as amount of service delivery, number of training sessions and so on); qualitative measures (such as case studies), and key informant data.

Quantitative data revealed that:

- The number of registered clients nearly doubled in the second full year of the Initiative, from 376 to 664.
- In 2002-2003 the number of contacts with people with a dual diagnosis was two and a half times greater than in 2001-2002.
- A more than threefold increase in the categories ‘tertiary consultation’, ‘community development’ and ‘community education’ activity is recorded between 2001-2002 and 2002-2003.
- From the service data available we estimate that in a given year up to 800 formal and informal sessions are delivered across the Initiative.

Common themes from our analysis of case stories are:

- The value of improved client assessment in assisting completion of treatment and prevention of relapse
- The building of confidence, skills and knowledge in the workforce
- The multiplier effect of the Initiative’s work.

Most surveyed stakeholders perceive the Initiative to be useful (90.9 per cent) and 88.7 per cent agree with the statement ‘I have a strong belief in the value added by the dual diagnosis initiative to my service.’ Key informants value the Initiative’s responsiveness, availability and commitment to training and consultation.

Attitudinal changes in the mental health and alcohol and drug sectors, while slow and hard to measure, were evident to most key informants. Changes in practice have been observed, such as preparedness to ask about dual diagnosis issues, better linkages and more consultative case planning.

Challenges and barriers

Environmental challenges lie in resource pressures on the wider system, general workforce shortages and staff turnover. Enduring attitudes and fears among staff in the mental health and alcohol and drug sectors must be addressed in generating interest in moving towards more integrated services.

The main operational challenges relate to ownership of the Initiative by its stakeholders, auspicing/management issues and the strategic use of limited resources.

It is timely that the Initiative's priorities are clarified and publicly restated so that more realistic expectations are held in the teams and in the sectors they are working with.

The substantial achievements of the teams and linked rural clinicians in establishing their services provide a foundation for consolidation. There is evidence of promising practice in planning, evaluation, training and other areas which could be further developed both within the services and by the services working together.

There is scope for renewing the relationship of the Initiative to the wider community.

Strengths

The evaluation strongly endorses the Initiative's 'theory of action'. The Initiative is effective when all aspects of the original brief have been implemented. There is evidence of effective and collaborative leadership, teamwork and a strong connection with the wider community of stakeholders.

Recommendations

These recommendations need to read in the context of the full report.

Leadership and shared vision

Recommendation: that the Initiative's leaders renew agreement on the capacity building purpose and strategy of the Initiative, including limitation of direct care hours and reinforcement of their purpose as an element of the Initiative through which direct care can be provided jointly for clients presenting with the most complex issues.

Promotion

Recommendation: that the Initiative's leaders develop a joint strategy for promoting the Initiative at sector management and policy levels.

Top down policy direction

Recommendation: that the MHB and DPSB consider the development of formal and specific requirements concerning the level of use of the dual diagnosis initiative by stakeholder services.

Youth Initiative

Recommendation: That process evaluation of the Youth Initiative continue, with a view to further clarification and development of the model.

Targetting stakeholders

Recommendation: (a) That the Dual Diagnosis Initiative should be targeted to the key sectors of mental health, PDRS and alcohol and drug services.
(b) That the Initiative maximise links and joint work with other initiatives related to dual or complex needs, such as the Primary Mental Health and Early Intervention Initiative, ABI/AOD Resource Workers, and the Complex Clients Initiative, in order to channel limited resources more effectively.

Functional coordination across teams

Recommendation: That the Initiative's leaders foster the coordination of some functions across the Initiative.

Data collection

Recommendation: That the DHS continue efforts to improve RAPID and work with auspice agencies support appropriate local and consistent data recording and retrieval systems.

Common planning framework

Recommendation: that all the dual diagnosis services adopt a simple common framework for an annual planning, review and evaluation cycle and present plans to each other and to the field.

Professional development of dual diagnosis clinicians

Recommendation: that a portion of the Initiative's time and funding be allocated to joint efforts to define a workforce development strategy and access advanced professional development.

Coordination of functions

Recommendation: that the dual diagnosis services investigate the potential for successful coordination in such areas as development of core competencies, provision of joint workshops and conferences, training needs analysis methods, refinement of core curriculum modules, training delivery and evaluation.

Recommendation: that a portion of Initiative resources is explicitly dedicated to an information clearing house.

Recommendation: that the rural dual diagnosis forum continue to be supported, with the main aims of improving the model and supporting the workforce.

Recommendation: That statewide youth dual diagnosis clinician meetings be continued.

Recommendation: that annual one or two day meetings of the Initiative's teams and clinicians be held, for planning, review and professional development.

Education and training accreditation

Recommendation: that the dual diagnosis services take a joint and strategic approach towards accreditation of dual diagnosis training and the inclusion of dual diagnosis subjects in relevant undergraduate and postgraduate courses.

Steering and reference groups

Recommendation: that the dual diagnosis services review the operation of reference groups, pool their expertise, and trial and evaluate improvements.

The research community

Recommendation: that the dual diagnosis services coordinate efforts to contribute to the conduct of research relevant to Victorian needs.

A note on resources

The above recommendations relate to current resource levels. We note that concerns about the adequacy of the Initiative's funds for the size of the task have been expressed from the earliest meetings of the Statewide Steering Committee. Suggested investments, should further resources become available, are:

- An increase in numbers of clinicians.
- Additional resources for travel to support management and supervision in the Initiative and networking for rural workers.
- Further research and documentation of good practice
- The greater involvement of addiction medicine specialists, in order to balance the input of mental health specialists.
- Expansion of the stakeholder list into other service sectors, in particular concerning General Practitioners, young people, aged people, Indigenous and CALD communities and people in the justice system.

Introduction

The first team managers for the Dual Diagnosis Initiative were appointed in mid 2001. This evaluation, three years later, describes the Initiative's operation since then and makes recommendations for its future direction.

Throughout the report we refer to the capacity building theory behind the Initiative. We also register the pressures in the health system which lead to demands for dual diagnosis services to be a direct service solving immediate and difficult problems presented by clients.

Capacity building practitioners and researchers emphasise the need for common objectives, shared concepts and clarity about how activities are expected to produce intermediate and longer term results and benefits – the need for a 'theory of action'. (LaFond and Brown 2003)

We hope that this evaluation will shed light on the Initiative's theory of action and its progress towards long term benefits for people with co-occurring mental health and alcohol and drug problems. For a relatively small endeavour (involving some 40 staff in a workforce of several thousand), accurate focus is clearly essential. As a leading thinker on capacity building writes:

> Without a theory of action, a capacity development effort could become a fragmented exercise in wishful thinking, rather than a coherent initiative with a high probability of success" (Horton,2001).

The evaluation occurs at an opportune time when the dual diagnosis services and their supporters have had up to three years to work with the statewide model and learn its strengths and challenges. We hope that this report captures key learnings and will help to guide ongoing development of a coherent initiative.

Structure of the report

After outlining the evaluation objectives and methods and summarising the research, policy and service context, we examine the Initiative in a logical sequence: we look at the intended model, the resources in place, the activities conducted, the impacts observed and finally recommendations for the future.

The resources and process of the Adult and Youth Dual Diagnosis Initiatives are considered separately.

The section on impacts and recommendations relate to the Initiative as a whole unless otherwise specified.

The evaluation generated rich and varied data. In order to keep the main report to a manageable size, we have provided significant supporting information in appendices.

Evaluation background and purpose

The evaluation focuses on the two key elements to the provision of State-funded Dual Diagnosis services throughout Victoria, namely:

1. Four specialist Adult Dual Diagnosis Services, funded jointly through the Mental Health Budget and the Drug Policy and Services Branch Budget, and operated through Melbourne Health (SUMITT), St Vincent's Health (Northern Nexus), Southern Health (Southern Dual Diagnosis Service) and Eastern Health (Eastern Health Dual Diagnosis Service). Each lead agency is formally linked to specialist rural dual diagnosis workers located in area mental health services across Victoria.
2. Youth Dual Diagnosis services established through each of the four existing Dual Diagnosis Lead Agencies. The Youth Dual Diagnosis services are being piloted as part of a focus on creating new service options for consumers in greatest need, which emphasise an early intervention framework

Evaluation Objectives

The objectives of this evaluation are to determine:

1. The nature and extent of the implementation of the Dual Diagnosis Initiative ('the Initiative') in relation to the key elements of clinical consultation, education and training, and community development**.**

2. The impact of the Adult Dual Diagnosis Initiative on service providers, i.e. Adult Mental Health Service, Alcohol and Drug Treatment Services and Psychiatric Disability Rehabilitation Support Services (PDRSS).
3. The process of the early stages of development of the Youth focussed Dual Diagnosis Initiative in relation to the Youth Alcohol and Drug Treatment Services, the Child and Adolescent Mental Health Services (CAMHS) and where required, the PDRSS.
4. The relationship between the Initiative and service providers in the wider system who are not specified as stakeholders.
5. The impact of the Initiative on outcomes for clients with concurrent mental illness and substance use problems.
6. Factors in the Initiative that account for improved outcomes for service providers and their clients.
7. Barriers that impede the effectiveness of the Initiative.
8. Recommendations, based on the evaluation evidence, for maintaining or redefining the service elements and their relative weightings in order to improve the capacity-building effect of the Initiative.

Evaluation design and methods

The evaluation used a mixed methods design organised around monthly meetings of a collaborative working group. A range of data was triangulated:

- Service documents such as reports and presentations; aggregated statistical data reported to the DHS
- Research and policy literature

- Key informant interviews (n=36)
- Staff views (from a questionnaire and group discussion) and details of qualifications and experience (n=39)
- A survey of stakeholders (n=186)
- Case studies reported by clinicians (n=26)

Further technical details are attached as Appendix A.

The evaluation plan was supported through Turning Point's internal ethical facilitation process.

In approaching the evaluation, we were aware that, while a major objective was to assess the impact of the Initiative, capacity building is a process with many elements and with long term outcomes that are not reliably attributable to any one intervention. References to impact in the report should be read with this in mind.

The research and policy context

In a brief review (Appendix D), we explored three research areas that have shaped the Dual Diagnosis Initiative as an approach to improving the health and wellbeing of people with co-occurring mental health and alcohol and drug problems:

- Dual diagnosis and service responses to people with a dual diagnosis
- Capacity building
- Intersectoral collaboration

We also considered the policy and service context of the Initiative.

The importance of responsiveness to dual diagnosis

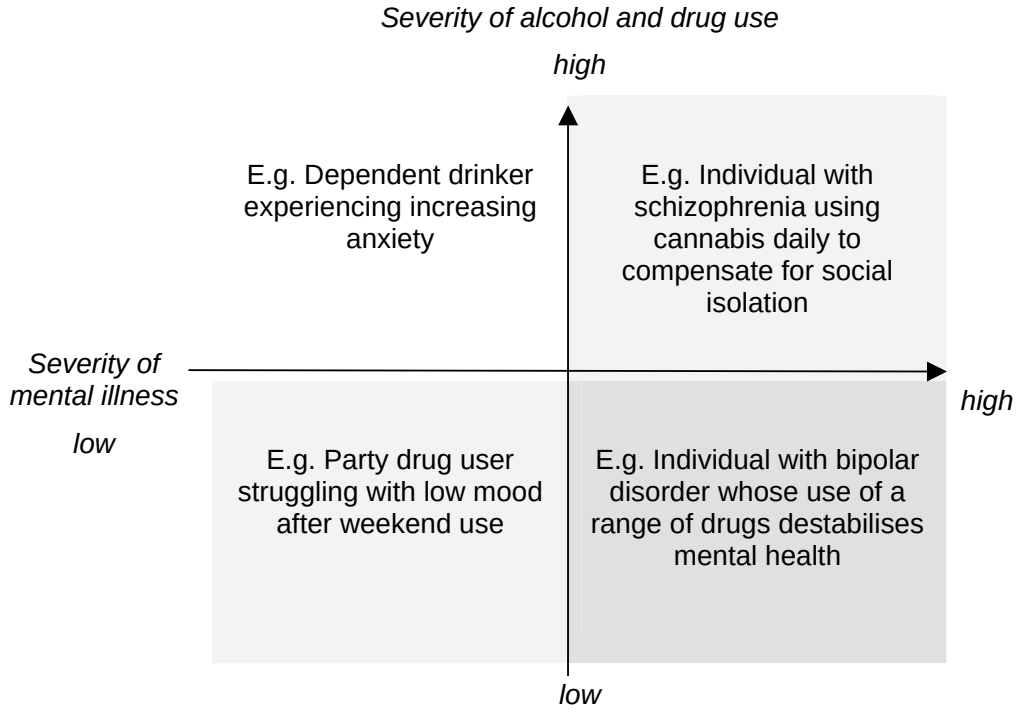
- Mental health and alcohol and drug disorders contribute 20% to the burden of disease in society
- Among people aged 15-24 these disorders form nine out of ten leading causes of the burden of disease in males and eight out of ten in females.
- Dual diagnosis is the rule rather than the exception among mental health and alcohol and drug service clients:
    - 35-65% of adults engaged with a mental health service may have a history of problematic substance use
    - 55 -75% of clients of alcohol and drug services may have a history of a mental illness
    - Dual diagnosis in adolescent clinical psychiatric populations may be 50 - 71%.
- Disorders complicate each other and people with more than one disorder are recognised as having a poorer prognosis than those with one.
- Problems are likely to become chronic, multiple and disabling. It is frequently commented that people with 'dual diagnosis' rarely have only two disorders and that associated medical, psychological, social and legal problems add to complications. Complexities, and enduring problems, increase over time. Earlier

intervention can reduce long-term severity. (Lindsay and McDermott 2000; Todd, Sellman et al. 2002; Siggins Miller Consultants 2003; Teesson and Proudfoot 2003)

The scope of disorders and treatment settings

The nature and severity of a person's disorders have important implications for the type and setting of treatment. Mental health and alcohol and drug problems can co-exist in a wide range of different ways. The following matrix, based on a UK good practice guide (Department of Health 2002), is in common use as an aid to defining which service sectors are most appropriate for which clients.

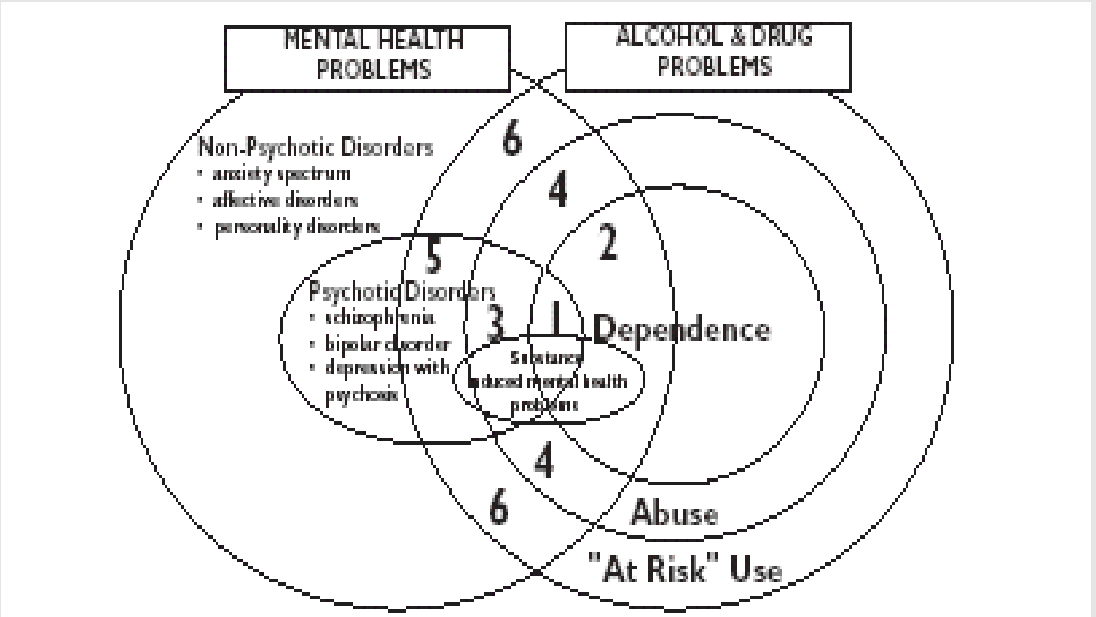
Figure 1: dual diagnosis matrix



People in the top left quadrant are more likely to be using an alcohol and drug service than a mental health service. The converse is true for people in the bottom right quadrant. Those in the top right quadrant, with severe problems in both domains are seen as requiring the most attention to both their diagnoses. It is important, however, for both service sectors to detect and appropriately respond to either problem at an early stage.

The following diagram gives a more detailed idea of types of disorder.(Jenner, Kavanagh, Greenaway *et al* (1998) in (Siggins Miller Consultants 2003)

Figure 2: Model of dual diagnosis



The model identifies six types of dual diagnosis clients, and provides a useful framework for conceptualising patterns of dual diagnosis:
Type 1: Clients with psychotic spectrum disorders (schizophrenia, bipolar affective disorder, major depression etc.) who satisfy DSM-IV criteria for substance dependence.
Type 2: Clients with non-psychotic spectrum disorders who satisfy criteria for DSM-IV substance dependence.
Type 3: Clients with a psychotic spectrum disorder who also satisfy DSM-IV criteria for a substance abuse disorder.
Type 4: Clients with non-psychotic spectrum disorders who also satisfy DSM-IV criteria for a substance abuse disorder.
Type 5: Clients with psychotic spectrum disorders who are also using substances in a way that puts them at risk for harm to their physical or mental health.
Type 6: Clients with non-psychotic spectrum disorders who are also using substances in ways that put them at risk for harm to their physical or mental health.

Serial, parallel and integrated services

People with both mental health and substance use problems encounter up to three types of service response:

- An emphasis on dealing with one problem (or group of problems) before the other. This is known as a serial model. It is used in acute episodes, where the most urgent need is dealt with before referral for other treatment and less helpfully, in non-acute situations, when the person is advised by both services to approach the other.(Ries 1993; Teesson and Proudfoot 2003)
- Separate but concurrent treatment by mental health and alcohol and other drug services – the parallel model. This is currently the dominant system.
- Attention to both problems by one service or by two services in close collaboration - the integrated model.

Evidence suggests that an integrated response to co-occurring disorders is more effective than parallel or serial treatment and, by improving client outcomes, will lead to an eventual reduction in demand for services.

Towards an integrated response: capacity building

Capacity building is

> An approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over. (Hawe, 1999, cited in (NSW Health Department 2001)

The literature on capacity building strongly supports the concept as a process undertaken by systems, organisations and communities that is owned by these entities and individuals within them. The role of any experts or consultants is best seen as facilitating development rather than filling gaps.

A key concept is 'sustainable change'. The new structures, processes and/or values created by the capacity building effort should be ongoing without the need for future funding. There should be 'a commitment to ensuring that projects initially funded with a target of capacity building are not subsequently treated as pilot projects and refunded on a recurrent basis.'(Crisp, Swerissen et al. 2000)

Intersectoral collaboration

Improving services for people with dual diagnosis in Victoria requires significant change in practice and extensive collaboration.

Key determinants of effective community-based intersectoral action for health have been identified. (Harris, Wise et al. June 1995),(Maskill and Hodges October 2001 pp xx-xxiii)]:

- All partners agree on the necessity for intersectoral action and accept it as part of their core business
- Support exists in the wider community
- Capacity exists to carry through the planned action
- Relationships enabling action are defined and developed
- Agreed actions are planned and implemented
- Outcomes are monitored

Barriers to collaboration include poor interpersonal relationships, particularly among senior people, 'turf' issues such as professional defensiveness and status differences, different planning philosophies and planning practices and disagreement on the nature of problems and their solutions. Resource limitations can either impede collaboration or encourage it by stimulating creative thinking. (Challis, Fuller et al. 1988; Walker 2000).

Avoiding or overcoming these barriers requires clear structures and processes, trust and collaborative negotiating skills. Perhaps most interestingly for the Dual Diagnosis Initiative, Walker cites eight critical success factors (Mays, Halverson et al. 1998; Walker 2000):

- Identification of a collaboration tactician or boundary spanner
- Securing buy-in from key stakeholders and opinion leaders
- Recognising and responding to participation constraints

- Keeping the structure simple
- Ensuring incentive compatibility among participants (i.e. every organisation must benefit in some way)
- Ensuring effective communication and information flows among participants (including dealing with confidentiality issues)
- Developing an explicit evaluation strategy
- Maintaining momentum through successes (i.e. early, short term successes can be the foundation for more complex projects)

Conclusion

The review concludes that effective services for people with a dual diagnosis, capacity-building endeavours and intersectoral collaboration share some critical success factors:

- An agreement on the nature of the core business
- Support in the community (especially from opinion leaders) and an environment that is conducive to change
- Empathic and hopeful relationships that enable action, among participants who include leaders, managers, key tacticians, clients, and a critical mass of committed staff.
- Resources for developing capacities and implementing change.
- Planning and implementation of agreed actions (supported by research-based guidelines) on a number of levels.
- Monitoring of outcomes, with a long-term perspective on the change process and an understanding that short term successes are useful in maintaining momentum.

Victoria has seen significant developments in addressing dual diagnosis. The Dual Diagnosis Initiative is its first statewide approach.

Adult dual diagnosis services - nature and extent of implementation (Evaluation Objective One)

This section describes the implementation of the adult Initiative:

- the initial brief
- resources established, including auspicing, the workforce and the physical infrastructure
- activities conducted.

The brief

Funding and structure

In 2000-01 the DHS committed $2 million per annum in recurrent funding for a Statewide Dual Diagnosis Strategy. The Strategy (brief attached as Appendix B) built on the Substance Use and Mental Illness Treatment Team (SUMITT) pilot project established in 1998 and led to the establishment of four Dual Diagnosis teams and linked rural workers in Victoria, jointly funded by the Mental Health Branch and the Drugs Policy and Services Branch.

Aim

The aims of the Initiative are described in the DHS brief as follows:

- to improve the responses of mental health and drug treatment services to people with a mental illness and substance use problems
- to develop the capability of (these services) to improve the health outcomes of people with a dual diagnosis
- These aims are similar to those of the 1998 pilot, which also emphasised 'building on existing systems and programs wherever possible and minimising the extent to which additional specialised dual diagnosis programs are developed' (Fox 2000).
- The overarching aim is clearly to build capacity in mental health, PDRS and alcohol and drug services, where dual diagnosis issues are addressed as 'core business', rather than to provide an additional and separate specialist service. Long term goals (such as structural integration, or parallel dual diagnosis-responsive services) are not stated.

Elements

The brief for the adult initiative states that the teams will provide 'training, tertiary, secondary and primary consultation …(and) direct treatment to [approximately five] dually diagnosed clients' per equivalent full time (EFT) clinician position.

Target group

The teams were briefed to provide support to organisations delivering specialist mental health services, drug and alcohol services and psychiatric disability and rehabilitation services.

Management

In order to strengthen and sustain ownership of the initiative:

- Auspicing agencies were expected to provide leadership
- Teams/workers would be located in both sectors, with the teams based in alcohol and drug services and local workers outposted in mental health services
- Effective linkages between the main auspicing agencies and the rural services were essential
- A statewide reference group was announced, which would have 'a steering role as well as provide an opportunity for feedback into the ongoing development of the Initiative.' Membership included the team coordinators, auspicing agency managers, a rural representative, and carer and consumer representatives, in addition to staff of the Mental Health Branch and the Drugs Policy and Services Branch who were responsible for the design of the Initiative.

Staffing and skills profile

The Initiative brief specifies the number of positions per team, based on one per adult mental health service catchment, and that there should be a coordinator, a part time consultant psychiatrist and a part time registrar per team. Roles and functions, and the advanced competencies required, are outlined. It is specified that each dual diagnosis worker will have an agreed catchment in which they will be responsible for all the elements of the Initiative, while the coordinator will be responsible for day to day management, extra training and consultation support, supervision, establishment and ongoing development of a training curriculum and facilitation of team meetings that include the rural workers.

The SUMITT team was allocated a one-year position 'for the purpose of leading the further development of curriculum for use by all the dual diagnosis teams and to facilitate the provision of training to staff recruited into all the new specialist dual diagnosis positions across the state.'

Monitoring and evaluation

Lead agencies are required to submit a service plan, regular reports and evidence of written protocols between the service sectors.

The 'roll-out'

The processes of launching the plan and securing the commitment of the lead auspicing agencies are an important consideration. Where more than one agency was eligible in a metropolitan region, by having responsibility for both mental health and alcohol and drug programs, a competitive process was used. Otherwise the DHS approached the single eligible agency.

The four metropolitan auspicing agencies and eight linked rural agencies received DHS funding for staff based on clinicians at the level of SW/OT/P 3 RPN 4 and start-up costs.

Recruitment and orientation dominated the first year of funding for the three new teams. Three managers were appointed in mid 2001 and one in November. The first Statewide Reference Group met in October and the newly appointed clinicians began work between October 2001 and April 2002. Clinicians in SUMITT, Wangaratta and Ballarat were already established in dual diagnosis roles which merged into the new Initiative. The Eastern Health Dual Diagnosis Service (EHDDS) remained incomplete for some time (in particular lacking a consultant psychiatrist), and its manager

resigned near the end of 2002. All the new teams had difficulty in filling the registrar positions.

SUMITT was responsible for initial training of the new clinicians across all teams. After providing an introductory two-day workshop SUMITT developed, in collaboration with the team managers, a series of six workshops utilising expertise within the teams and involving expert external speakers.

Current resources - workforce

Table 1 and Figure 1 show the location and composition of each team and its linked rural workers, as well as the estimated population of each catchment.

The size and population density of catchment areas varies widely.

Table 1: Adult Dual Diagnosis Initiative: structure

	Lead and auspicing agencies	Teams/ linked workers	Equivalent full time position (EFT	Main location	Catchments
DHS Mental Health Branch and Drugs Policy and Services Branch	Eastern Health (AMHS, EACH, ACCESS)	Eastern Health Dual Diagnosis Service	Coordinator Consultant Psychiatrist 2 EFT: adult (I FT / 2 x PT) 1 EFT: youth	Upton House, Box Hill	AMHS: Outer East, Central East *LGA: Yarra Ranges, Whitehorse, Manningham, Maroondah, Knox, Monash* DHS region: Eastern Metropolitan
	Northeastern Hume..		1 EFT	Wangaratta	DHS region: Hume (north)
	St Vincent's Hospital Melbourne Turning Point (as partner)	Northern Nexus	2 EFT adult 2 EFT youth Manager (1 EFT) Cons Psychiatrist (1 day/week) Psych Registrar (1 day/week, rotating quarterly)	St Vincent's, Fitzroy	AMHS: North East, Inner Urban East LGA: Yarra, Banyule, Boroondara, Nillumbik
	Bendigo Health		1 EFT	Bendigo.	DHS region: Loddon Mallee (south)
	Ramsay Health		1 EFT	Mildura	DHS region: Loddon-Mallee (north)
	Southern Health	Southern Health Dual Diagnosis Service	4 EFT adult 2 EFT youth Manager (1 EFT) Cons Psychiatrist (1 day/week) Psych Registrar (1 day/week, rotating quarterly (Admin assistant – vacant	Thomas St, Dandenong	AMHS: Inner South East, Middle South, Dandenong, Peninsula. *LGA, Port Phillip, Glen Eira, Stonnington, Bayside, Kingston, Greater Dandenong, Frankston, Casey, Cardinia, Mornington Peninsula, Bass Coast*
	LaTrobe Regional Health		2 EFT		DHS region: Gippsland
	Melbourne Health (NW Mental Health) Western Health (DASWEST)	Substance Use and Mental Illness Treatment Team (SUMITT)	6 EFT adult 3 EFT youth Manager (1 EFT) Cons Psychiatrist (1 day/week) Psych Registrar (5 sessions)	Eleanor St, Footscray	AMHS: South West, Mid West, Inner West, North West, Northern; Orygen Youth Health (Western and North Western Melbourne). *LGA: Brimbank, Maribyrong, Melbourne, Darebin, Whittlesea, Hobson's Bay, Moonee Valley, Moreland, Hume, Melton, Wyndham* DHS Region: Western Metropolitan,
	Barwon Health Care Group		1 EFT	Geelong	DHS region: Barwon South West (Barwon)
	South West Health		1 EFT	Warrnambool	DHS region: Barwon South West (SW)
	Goulburn Valley Health		1 EFT	Shepparton	DHS region: Hume (south)
	Grampians Health		1 EFT	Ballarat	DHS region: Grampians

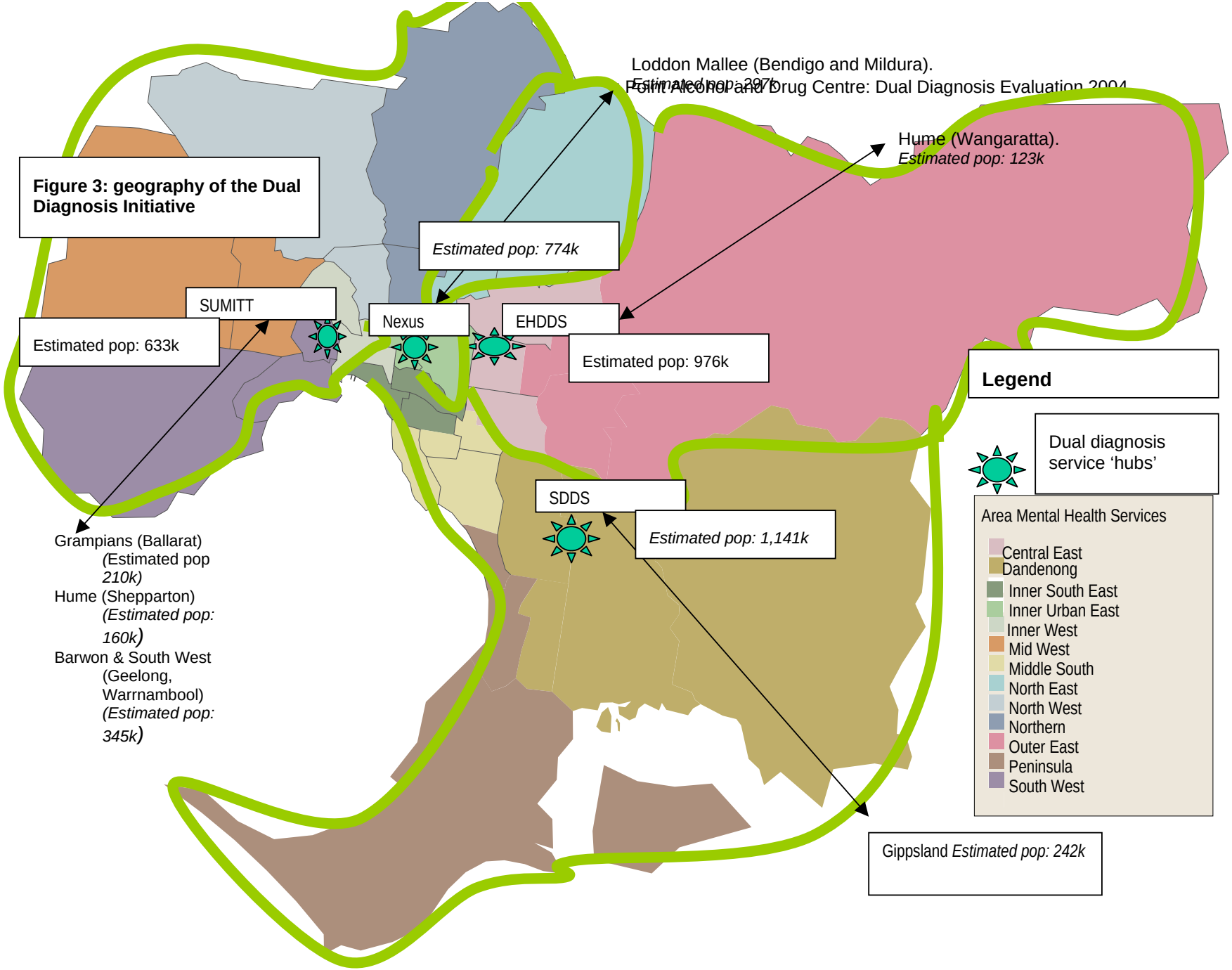


Figure 3: geography of the Dual Diagnosis Initiative

Table 2: History of service development and role occupancy (dates are approximate)

Equivalent full time	Part time

Teams/ linked workers		Jul-Sept 01	Oct-Dec 01	Jan-Mar 02	Apr-June 02	Jul-Sept 02	Oct-Dec 02	Jan-Mar 03	Apr-June 03	Jul-Sept 03	Oct-Dec 03	Jan-Mar 04	Apr-June 04
EHDDS	Coordinator												
	Psychiatrist												
	Registrar												
	Adult							Sick leave		New			
	Adult				0.6 EFT					Maternity	leave		
	Adult					0.4 EFT				New	0.6 EFT		
	Admin	0.2 EFT						New					
NE Hume	Clinician												
Northern Nexus	Manager												
	Psychiatrist	1 day/week											
	Registrar*												
	Adult												
	Adult						Secondment						
	Admin												
Bendigo	Adult												
Mildura	Adult												
Southern Health DDS	Manager												
	Psychiatrist												
	Registrar												
	Adult - DC												
	Adult - KH												
	Adult - PH												
	Adult - Leig												
	Admin	0.2 EFT						Casual and occasional					
Gippsland	Adult												
	Adult						New						

Table 2 (continued): History of service development and role occupancy (dates are approximate)

Teams/ linked workers		Jul-Sept 01	Oct-Dec 01	Jan-Mar 02	Apr-June 02	Jul-Sept 02	Oct-Dec 02	Jan-Mar 03	Apr-June 03	Jul-Sept 03	Oct-Dec 03	Jan-Mar 04	Apr-June 04
SUMITT	Manager												
	Psychiatrist												
	Registrar												
	Adult - MW												
	Adult – N'n												
	Adult - SW												
	Adult - NW												
	Adult - IW												
	Orygen												
	Admin												
Barwon	Adult												
South West	Adult												
Goulburn Val	Adult												
Grampians	Adult												

Notes

- Among the adult initiative clinicians, at least 11 of 23 positions have changed hands since establishment.
- Some clinicians have moved within their team or to another team (not indicated above).
- EHDDS experienced difficulty in employing a consultant psychiatrist.
- Registrar positions
  - SDSS – has not been funded
  - Nexus – 3 monthly rotation, varied occupancy (0 to 2)
- Addictions medicine registrar began rotation through Nexus in late 2003.
- Provision and continuity of administrative support has been an issue for three of the four teams

Workforce roles and responsibilities

Responsibility for the Initiative is complex. The DHS Mental Health Branch and Drugs Policy and Services Branch manage the contracts awarded to the auspicing agencies. They also convene the statewide reference group, which met quarterly in the first year and now meets twice a year. DHS project officers attend regular statewide meetings with dual diagnosis team managers to facilitate coordination and further development.

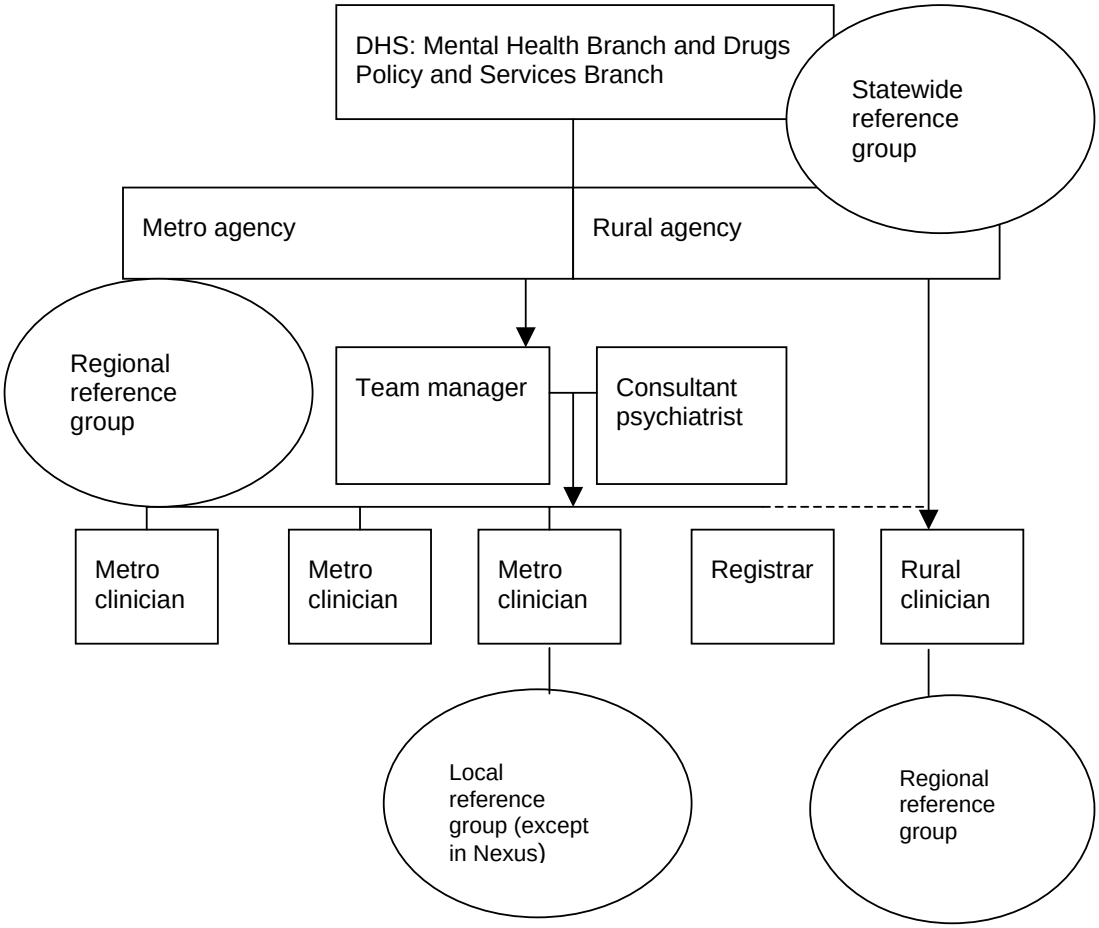
Auspicing agencies hold financial and management responsibility. In practice, the major responsibility lies with the mental health managers and alcohol and drug managers are less involved.

Team managers have taken on the role described in the plan, developing and supervising the teams and organising and supporting the training curriculum. For some, resource negotiations with auspicing agency management have been an additional preoccupation.

Key informants comment that good management by the auspicing agency, as well as by the team manager, is essential, in order to ensure clarity of position and role, realistic workloads, professional development and peer support in and between teams.

Team managers have also taken on responsibility for regional reference or advisory groups, while each clinician is responsible for recruiting members and convening meetings of an area group. Varying amounts of activity are reported.

Figure 4: Accountability diagram

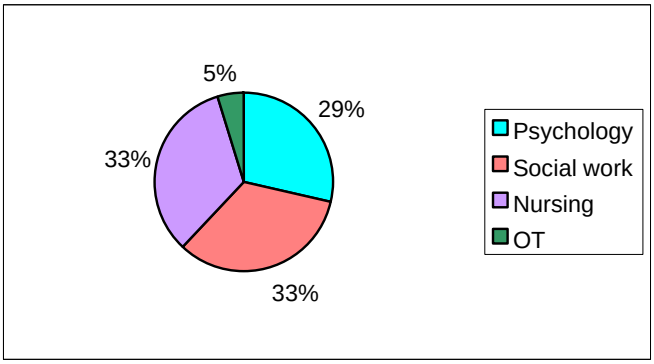


Workforce profile

Professional backgrounds

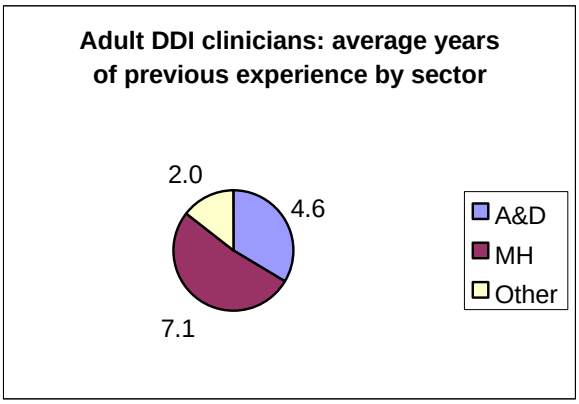
Clinicians' professional backgrounds are clinical or counselling psychology, nursing (principally psychiatric nursing), social work and (in a small minority) occupational therapy. There are three consultant psychiatrists contributing a limited number of weekly sessions.

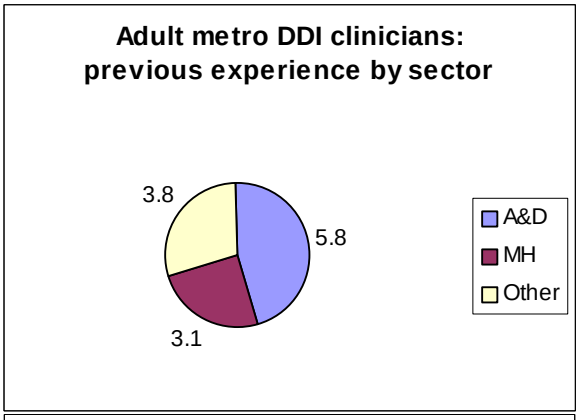
Figure 5: adult clinicians – first qualifications

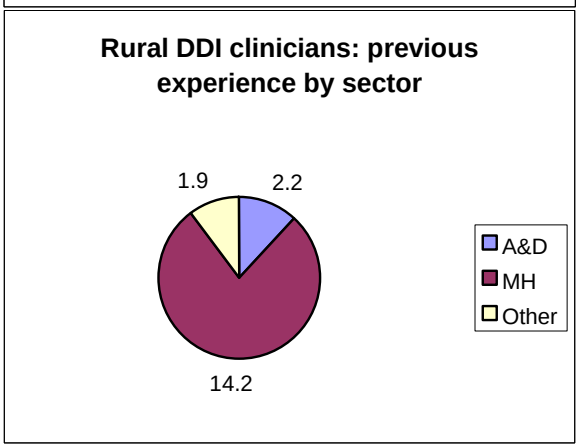


Staff were asked about their work experience.

Figure 6: adult clinicians - experience







- The majority of previous experience has been in the mental health sector.
- About 75 per cent of those with mental health or alcohol and drug service experience have also worked in the opposite sector for at least a year.
- About 90 per cent of the staff have previous experience in mental health, ranging from 1 to 27 years.
- About 75 per cent have worked in the alcohol and other drug sector (from one to 16 years).
- About half of the clinicians have experience in other sectors (e.g. with the homeless, with Indigenous communities, with young people) ranging from 1 to 20 years.
- The rural clinicians have a background principally in the mental health sector and six of the eight first qualified as nurses.
- They are a senior workforce, with an average of 14 years relevant work experience. The metropolitan average is lower (11 years) than the rural (18 years).
- Few have experience in specifically dual diagnosis positions. Most have, however, chosen professional development opportunities which demonstrated a commitment to dual diagnosis issues.

Professional development, supervision and support

Finding appropriate educational and supervisory support for staff who, like their clients, do not fit neatly into existing structures, is a challenge.

Most clinicians have been able to broaden their skills in mental health or alcohol and drug competencies while employed in the Dual Diagnosis Initiative, principally through occasional workshops, conferences and short courses. Some have been

able to undertake recognised postgraduate courses (Graduate Certificate in Alcohol and Other Drug Studies at Turning Point, Victoria University's Graduate Diploma in Substance Abuse Studies) or have specialised in dual diagnosis in Masters or PhD level studies.

Seven clinicians have completed Certificate IV in Workplace Assessment and Training.

Access to training and education is limited not only by finances but by the sheer availability of appropriate courses. Dual diagnosis courses are few in number. Courses in Canberra (where ANU clinical psychology incorporates a strong addictions component) and New Zealand (at the National Addiction Centre) are mentioned as potentially valuable.

Staff mention a variety of supervision needs, which are not all able to be met by the Initiative. Metropolitan-based clinicians have good access to managerial and psychiatric clinical supervision (although the latter was lacking in the EHDDS for some time before the appointment of a consultant psychiatrist.)

This access is less immediate and personal for the rural linked clinicians, who either face long journeys to attend fortnightly team meetings or participate through telephone conference calls. As one comments 'this does not allow for informal learning and support which is a big part of learning in the health care field.' Videoconferencing has proved to be impractical because of the expense of hiring or maintaining the equipment. The option of a visiting supervisor is mooted.

Some clinicians (metropolitan and rural) find that the metropolitan meeting is too clinical in its focus at the expense of community development and educational issues.

Psychologists and social workers express a need for discipline-specific supervision. In some cases this is found outside the Initiative.

Staff and management have been creative in developing other forms of supervision and support:

- The rural clinicians meet every two months and, having developed written profiles of their work and a shared understanding of how their role works in each region, they plan in 2004 to document rural dual diagnosis service guidelines.
- One rural clinician shares managerial and cross-disciplinary support with a Primary Mental Health and Early Intervention Team.
- Peer support from other dual diagnosis clinicians is frequently mentioned as invaluable.

Special requirements

A need is expressed for ongoing professional development that is multidisciplinary, addresses system change and uses and builds on the clinicians' expertise. The work requires substantial clinical and educational skills, and experience in both AOD and MH, are important. They have to be change agents who can overcome interprofessional barriers and hierarchies both within their teams and in the sectors they work in. *'They have to be super-practitioners '(Key informant).*

Professional development and supervision for the managers and psychiatrists should not be overlooked. As one comments:

> We are learning together as we go… there is very little opportunity to inject diverse ideas into the team because there is very little dual diagnosis expertise in Victoria that has not already been harnessed by the teams.

Careful recruitment and retention are understood to be a key to the success of the initiative. It is important to sell the job's advantages but not minimise the demands. The job requires the worker to form 'a new identity and a new set of skills' and

> You manage your own area, you're clinically responsible for it, you do community development and run training - it all leads to a sense of importance but also can lead to burn-out.

Workforce summary

The Initiative has attracted and to a large extent retained, a skilled and committed workforce. Sustainability may be an issue. The unique and varied demands placed on these people require careful attention to their support structures. Larger teams have experienced less staff turnover. Supervision and professional development needs to encompass the range of roles that the workforce is expected to fulfil. With adequate resources and other support, there is potential for the services to develop and consolidate their learning and markedly increase their influence.

Physical infrastructure

All four teams currently have a physical base. SDDS, however, experienced a hiatus in 2003 when they had no office for most of the year.

Three metropolitan bases are in or adjacent to alcohol and drug services, while one (Nexus) has moved a few hundred metres from Turning Point Alcohol and Drug Centre to St Vincent's Hospital.

The linked rural workers are based in mental health services. In Wangaratta and Mildura the clinicians sit with the Primary Mental Health and Early Intervention Team.

The clinicians have varying amounts of office space and other facilities. Some have a desk at the team base and at a service (usually a CMHS) in their designated Area Mental Health Service. The latter service is provided according to the discretion and good will of the host service and does not attract specific funding.

A laptop, a mobile phone and a car are considered to be essential resources for supporting outreach to clients and services across each catchment. Some delays in the provision of these resources have been encountered in two services.

Resource summary

The resourcing of the Initiative has been characterised by

- Attraction of a skilled, experienced and committed workforce
- A somewhat protracted start-up period
- High staff turnover in two services
- Some difficulty in securing and retaining intended physical resources.

The model in action

This section aims to describe how the Initiative operates from day to day. It draws on service documents, consultations with staff and feedback from key informants and stakeholders. The case stories (Appendix E) are also helpful in illustrating the model.

Staff perceptions of the model

Asked how they would describe their model of service, staff consistently describe it as capacity building, to assist the development of an integrated approach in mental health and alcohol and other drug services to people with a dual diagnosis. They see it as an holistic model that incorporates a number of theories and approaches.

One team emphasised that capacity building was not just raising skills but more effectively harnessing existing resources.

Structurally they see it as essentially a single-worker model – most evidently in the country regions but also in metropolitan regions (the 'hub and spoke' model). The model relies on the worker having 'a foot in several camps'.

They emphasise that the aim is to improve responses to all people with co-occurring mental health and substance use disorders, not only those with 'serious mental illness'.

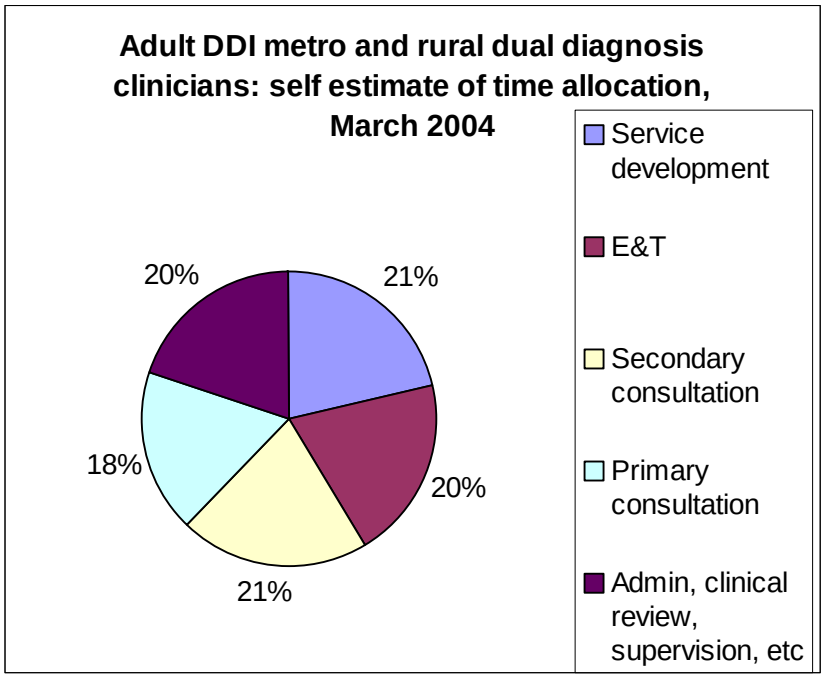
Balancing different elements

The day-to-day organisation of work across the different elements of the model is challenging to quantify. Flexibility is important for the staff. They see themselves as 'looking for learning opportunities': training with a worker and client or with a group might follow from an assessment and joint case planning. The approach is to 'create relationships and dialogue and find out what work is possible. The essence is to listen to stakeholders and build on what we hear.'

Staff estimates of time allocation

Individual clinicians estimated the time they were spending on each type of work and aggregated team estimates were discussed within each team. The following chart shows the average for area clinicians, excluding psychiatrists and team managers. Also excluded for this purpose is a rural clinician who was setting up the service after a period when the post was unfilled.

Figure 7: Average estimated time allocation by clinicians (excl psychiatrists and managers)



While the above chart shows a relatively even allocation of time across the elements, the estimates for each region show differences in emphasis:

Table 3: average estimated time allocation by clinicians (excl psychiatrists and managers

	Service development, %	Education and training %	Secondary consultation %	Primary consultation %	Other (admin, professional development, supervision) %
EHDDS	5	20	40	15	20
SDDS	27	21	24	11	20
Nexus	23	27	20	10	20
SUMITT	18	18	19	25	20

From these estimates, we can note that, in March 2004:

- SUMITT was allocating the most time to primary consultation (25%), with relatively equal time spent on the other elements.
- The average time spent on primary consultation in other teams was 10-15%. For individual clinicians the range was 5% (in SDDS) to 35% (in SUMITT).
- Nexus had a focus on education and training, followed by service development and secondary consultation.
- SDDS' principal focus, in terms of time, was perceived as service development, followed by secondary consultation and education and training.
- EHDDS (represented in these data by one part-time clinician) was principally engaged in secondary consultation.

In making these estimates, staff noted that the elements overlapped and precise categorisation is not always possible.

A recent position description for a Senior Clinician in EHDDS provides another view of the perceived time allocation, indicating that 30 per cent of the time will be devoted to training and education, 30 per cent to clinical consultation, 30 per cent to service development and 10 per cent to human resources activities (professional development, work planning, quality improvement).

Unfortunately, statistics supplied by services through the RAPID system are not helpful for detecting the relative weightings of the service elements.

Travel

While most clinicians spend a significant amount of time travelling during the day, this is not well quantified. Rural clinicians commented that travel is often in their own time and not recorded. It was said that metropolitan travel time could be up to 4 hours a day, including collecting and returning a car.

Flexibility

Flexibility is important. Distribution of time may change somewhat according to needs, regional differences, opportunities ('whatever gets a foot in the door') and personal skills/interests, as well as the length of time a clinician has been in his or

her position - initial months are normally spent building relationships. (In the estimates of time spent on each element new workers record the most time spent on community development.) Also, each service, in its annual review and planning cycle, may consciously adjust its focus each year: SDDS, for example, prioritised education and training development in the first part of 2004.

Working in three sectors

Each clinician is expected to work with many mental health, alcohol and drug and PDRS agencies in his or her area. The mental health system is more than four times larger than the alcohol and drug and PDRS sectors (which are similar in size). SDDS nominally allocates two days per week to mental health and PDRS and two to alcohol and drug services (with a day for team management, clinical review and supervision.) In contrast, SUMITT metropolitan clinicians are seen as working mainly with the mental health services, as their primary consultations are almost all with mental health registered clients. (The SUMITT psychiatric registrar, however, provides primary consultations mainly within the alcohol and drug service.)

Relationship with service providers in the wider system who are not specified as stakeholders (Evaluation Objective Four)

The services report that GPs, general health and welfare services, emergency department, forensic and other services who routinely encounter people with dual or complex problems frequently seek help from the Dual Diagnosis Initiative.

The level of this demand has not been well quantified across the state, although RAPID data includes a minority of contacts with services other than mental health, PDRS and alcohol and drug. Qualitative data from staff, stakeholders and key informants has not yielded strong evidence on the issue of how the Initiative should respond.

While the demand is very real, the dual diagnosis services are generally clear that their current resources cannot stretch beyond the key stakeholders.

Where possible, the Initiative links these services to one or other of the key stakeholders. In addition, formal education and training attendances (particularly for SUMITT's public calendar of training) include staff from generalist services.

The nature of the key elements

This section describes what is involved in each of the service elements of community development, consultation and education and training.

A complementary view can be seen in the case stories collected for the evaluation (Appendix E). These stories, touching on a range of complex situations and issues faced by people with a dual diagnosis and by service providers, demonstrate ways in which the dual diagnosis services intervene by adapting and selecting, according to the circumstances, from all the elements of the DDI model.

Service development

Nexus writes:

> Service Development (is) either *intra- service* by assisting individual agencies with review and development processes, protocols & policy; or *inter- service* by facilitating the establishment and improvement of partnerships and linkages, with a view to developing integrated models of service delivery.

The dual diagnosis services have assisted their client services to improve referral forms and procedures and identify screening and assessment tools, and have encouraged and supported dual diagnosis portfolio-holders or other 'culture carriers'. SUMITT has written comprehensive operational policy guidelines on substance use, one for acute inpatient units and another for community care and other residential rehabilitation units.

Inter-service work has included facilitating meetings between mental health and alcohol and drug managers, development of Memoranda of Understanding between services, facilitating ethical access by alcohol and drug services to a client's mental health records and wider community work such as convening regional forums.

A key linkage is with other dual diagnosis clinicians outside the Initiative, for further development of a dual diagnosis network. Some close links with the MST and PDRS dual diagnosis positions are reported, with clinicians (variously) being involved in the recruitment process, providing formal supervision, helping to establish a peer support network, co-facilitate training needs analysis and training delivery or simply developing informal links. In some cases, however, these relationships have been difficult to establish.

In the western metropolitan region, Orygen Youth Health's focus on dual diagnosis research and treatment offers the potential for useful synergies and in Ballarat the SUMITT clinician works closely with the NIDS-funded dual diagnosis clinician employed by UnitingCare. Other relevant linkages are with the ABI/AOD Resource Worker Initiative and the Primary Mental Health and Early Intervention Initiative.

Case story

Early stages of engagement with a service provider

A Continuing Care Team in a Community Mental Health Centre has approximately 40 case managed clients per EFT case manager.

The dual diagnosis clinician observes a 'world-weariness' with dual diagnosis problems and an emphasis on management to discharge rather than treatment.

The clinician attends the team's weekly Intake and ISP (individual service plan) meeting as a forum for:

- Identifying dual diagnosis issues at point of intake and orientation of case managers to thinking in terms of dual diagnosis assessment
- Educating staff about substance use and its relation to the mental health presentation.
- Following up primary and secondary consultations which follow on from the identification of dual diagnosis issues within this meeting
- Providing a framework for planning professional development for this team

Offers of further information and support were generally refused by the more experienced case managers but four in the team have increased their engagement in dual diagnosis orientated case management and their use of the DDI as a support/resource.

Consultation

Clinical consultation entails the provision of clinical guidance to mental health and alcohol and drug service providers in relation to issues presented by specific individuals with co-occurring mental health and substance use problems. It is concerned with improving client assessment and case planning to create a more integrated approach to mental health and substance use issues. In the model promoted by the dual diagnosis services the beneficiaries are intended to be not only the client and the case manager or key worker in question but other clients and workers they come into contact with subsequently: the multiplier or ripple effect of capacity building.

- ***Direct service - primary consultation and shared case management***

The dual diagnosis services generally promote primary consultation as a joint process with the individual client and their case manager or key worker. Consultations are face-to-face and may be single session or ongoing, and vary in intensity.

At the more intense end of the spectrum, SUMITT offers '*shared case management'* (sometimes called 'shared care') as an option in their primary consultation work. The client must be registered with the mental health system. As described in Case story 2, this can involve intense outreach (two contacts per week) for a short period, including practical assistance as required, as well as regular contact with the other case manager to liaise and to report on the client's progress.

One clinician describes the role:

> The role ranges from making recommendations to actual case management. Can get caught up in doing things. The bulk of the engagement is and should be counselling but the relationship may need to be built by, for example, driving the client to appointments.

- ***Rationale for direct service***

Clinicians across the services agree that joint primary consultation is an important way of (a) role modelling the dual diagnosis questions and how to ask them and (b) getting first hand information from the client. Key informants emphasise its importance in maintaining clinicians' direct care skills and earning credibility by demonstrating their expertise.

Consultations can lead to case review meetings and case presentations at clinical reviews, where the dual diagnosis clinician is present for further consultation and there is wider discussion of dual diagnosis treatment approaches in the service. This discussion may lead to further consultations and/or to education and training opportunities.

The dual diagnosis services are aware of a risk that their primary input may be used only to alleviate mental health or alcohol and drug services' (and their clients') immediate difficulties rather than as part of a long-term skills improvement opportunity for those services. If this is the case, a further risk is perpetuation of the split between the two sectors.

Key informants expect the dual diagnosis clinicians to focus on the most complex clients with multiple problems and high risk factors. For these clients it is critical that the clinician has the time, ability and other resources to follow through on any commitment to primary work. Some staff in each team believe the current caseload should be restricted to five active cases per clinician (as in the DHS brief).

With these considerations in mind, it seems important to monitor resources carefully to ensure

- quality care
- a match with the rationale of the Initiative (e.g. by conducting primary work jointly with the client service where possible and articulating this with informal and formal education and training and service development)
- a balance with other service elements
- professional development for the dual diagnosis clinician.

- ***Secondary consultation***

In *Secondary consultation* the dual diagnosis clinician does not see the client, who is identified to the dual diagnosis clinician only with the client's consent.

- ***Clinical consultation issues***

The following table indicates the main issues addressed in clinical consultation. It should be noted that the evaluation did not examine the details of clinical practice (e.g. the pros and cons of different screening and assessment tools and therapeutic interventions) but rather registered that the dual diagnosis services were active in working on the ground towards identification of good practice.

Dual Diagnosis Services: clinical case consultation interventions

Engagement strategies
Screening and assessment tools and techniques, including assessment and management of risk of harm to self and others
Medical
- introduction to pharmacotherapies
- education on safer use of alcohol and other drugs
- introduction of medically supervised withdrawal procedures in mental health inpatient facilitie

Psychological
- Psycho-education
- Motivational interviewing
- Working with identity issues and stigma
- Working with feelings of hopelessness
- Relapse prevention

Social
- Service linkages and coordination
- Family support
- Attending to basic needs – income, security, housing, nutrition
- Day programs and vocational issues
- Advocacy

Note: while much of the consultation work is with individuals, group work also occurs, with clients or families and with or without other staff.

Education and training

The dual diagnosis services are involved in a number of different education and training settings. They are called upon to answer a wide range of training needs among people with a variety of educational and professional backgrounds.

They deliver training on a regional basis as well as in-house for particular services.

All services have conducted at least one formal training needs analysis in their catchments, by means of written questionnaires completed by service managers or through a series of focus groups. Dual diagnosis clinicians also identify training needs in the normal course of their consultation and community development work.

The early emphasis has been on knowledge and skills about the ‘other’ sector or issue but more advanced dual diagnosis topics are also addressed. Some joint training occurs, with mental health and alcohol and drug workers learning together, but the data does not indicate how much. The table below is a composite list of topics in the curriculum.

Education and training topics in the dual diagnosis services

Mental health topics for alcohol and drug services

The MH service system
Mental Status Examination / Brief Psychiatric Evaluation
Depressive disorders
Personality disorders
Borderline Personality Disorder

Alcohol & drug topics for mental health services

The AOD service system
Harm minimisation
Substance intoxication/withdrawal
Overdose
Motivational interviewing
A series organised by drug type – alcohol, amphetamines, benzodiazepines, hallucinogens, opiates, tobacco etc.

Dual diagnosis topics

Dual diagnosis – general
Youth dual diagnosis
Drugs and psychosis
Cannabis and psychosis
Risk assessment, harm minimisation and relapse prevention from a dual diagnosis perspective
Worker Self Care
Dual Diagnosis Assessment
Dual Diagnosis Prevalence & Service Issues

Each clinician develops their own session plans for their local audience based on modules developed in the team.

While most of the training is not articulated with professional or tertiary education systems, exceptions are:

- Dual Diagnosis elective in Graduate Diploma in Community Mental Health (Monash University and the University of Melbourne, six weeks). (SUMITT)
- Development of an elective in Drug and Alcohol Psychiatry in the Masters of Psychological Medicine (Monash) and Masters of Medicine (University of Melbourne). (SUMITT)
- Two postgraduate subjects (‘Dual Diagnosis: Contextual Issues’ and ’Dual Diagnosis: Models of Care and Therapeutic Interventions’) in the Graduate Certificate in Alcohol and Other Drug Studies offered by Turning Point Alcohol and Drug Centre (Nexus)

Clinicians also educate and train informally and opportunistically as potential ‘learning moments ‘ are encountered in their work with individual clinicians or teams.

One service (Nexus) is developing flexible online delivery of dual diagnosis training.

More broadly, the services have:

- Written journal and newsletter articles
- Developed email lists for circulation of dual diagnosis information (EHDDS Eastern Hume and Nexus) and opened an internet site for discussion and information sharing on dual diagnosis.

- Organised and presented at conferences, both individually and, in 2004, as a whole Initiative (at the DHS Alcohol and Drug Service Providers Conference, TheMHS and APSAD).

Case story

A training plan in an inpatient unit

The DDS was invited by the Area Mental Health Manager and unit's Nurse Manager to help develop a more integrated approach to treatment for dually diagnosed patients. The research highlighted that currently patients were treated from a parallel approach. The substance using patient was generally referred for alcohol and drug counselling if the patient was motivated for this support.

The DDS clinician recognised a general reluctance among staff to respond to dual diagnosis as it was not considered part of their service provision. It was noted also that there was a general lack of knowledge and skills to deliver treatment in this area.

The DDS clinician developed a plan with the manager that involved regular training and education for staff on dual diagnosis treatment and primary and secondary consultation to staff on treatment issues over the course of a year. The plan included:

- Facilitation of a patient group for one hour per week. This group session was based on the Brief Intervention Model focussing on patients who had a substance use history.
- The treating staff were encouraged to consider the patient group and assess who would be suitable for attending the group.
- The treating staff were encouraged to attend the group as supports. After the sessions the DDS clinician and staff would discuss the functioning of the group, highlighting dual diagnosis issues and treatment options.
- Staff then attended regular training and education sessions on dual diagnosis issues delivered by the DDS clinician. Particular attention was given to treatment for substance abuse. These sessions were provided across a broad range of levels with the DDS clinician attending discipline-specific meetings to provide training and education.
- Staff were provided a workbook or manual including journal articles and references, relevant pamphlets and written information on AOD issues and services.
- The staff were encouraged to refer patients with dual diagnosis issues to the DDS clinician who provided primary consultation with the patient and staff together. Case discussion and review with the staff highlighted the treatment approach used for working with a patient with a dual diagnosis.

This plan operated for a year and has been extended for a second year.

Other significant activities

Research

The Initiative brief does not include research, except in the context of training needs analysis and curriculum development. A number of opportunities have, however, been pursued:

- development of a collaborative research project on the planning and implementation of assessment and referral pathways between the Austin & Repatriation Acute Psychiatry Unit, Moreland Hall and NEODAS.
- partnership with the Mental Health Research Institute of Victoria to complete randomised control trials to evaluate a Group-Based Intervention Program for with people with concurrent schizophrenia and problematic substance use
- Victorian Travelling Fellowship, investigating service systems and integrated treatment in the UK, the US and New Zealand
- PhD research aimed at building the evidence base for development of dual diagnosis integrated responses
- Studies (SUMITT and La Trobe University, 1999) of the coping and relationship factors surrounding substance use in people with a dual diagnosis.

Monitoring and evaluation

All the teams have produced evidence of reporting, review and planning activities.

For example, SUMITT clinicians provide detailed quarterly written reports on the number and nature of client and other contacts, and the whole range of their activities. Planning days are held periodically. A full training evaluation was conducted internally in 2003-2004. A program evaluation in 2000 endorsed the service model and encouraged the creation of the statewide initiative (Fox 2000)

Services have developed their own databases for evaluation data.

Reference groups have the potential to be developed further as monitoring and evaluation forums. Such groups appear to thrive better in the rural regions.

The unsuitability of CMI/RAPID for useful program monitoring has been a constant issue for the DD services. Concerns are of two types: that the data loses meaning because of inconsistent definitions of contact and service categories; and that service reports are not available to aid management. At the time of the evaluation revisions were being trialled.

Case story reflections on activities

Selected case stories (Appendix E and throughout the report) illustrate some key features of the way the model operates:

- Primary consultation can highlight a training need and lead to a training intervention in the service. Similarly, planned training can lead to primary and secondary consultation.
- Much of the work relies on the effectiveness of the DD clinician as a role model who is able to gain respect, pass on skills and build on the specialist worker's existing skills.
- The work highlights occasions for the use of screening and assessment tools that assist workers in each sector to adequately identify dual diagnosis issues – and the general need for good practice models
- Dual diagnosis clinicians must negotiate pragmatically and creatively with a service in deciding their role and activities. This appears to be most effectively done when managers of that service are proactive. Personal and opportunistic relationship building at the level of individual workers alone may not be enough to effect change.

Key informants and stakeholders views of the service elements

Key informants

The general feeling is that the combination of service elements is appropriate. The amount of direct care gives rise to the most comment, with some (mainly mental health) informants saying there should be more emphasis on direct care. Others are concerned that clinical casework with mental health clients could absorb all the Initiaitve's resources, although a small number of demonstration cases is appropriate.

> My guess is people are missing out if the dual diagnosis team is doing primary consults.' (Key informant)
>
> If the dual diagnosis clinicians were to spend a large proportion of time conducting primary consultations, this may limit the opportunity for workers in both A+D and MH to be supported through the process of learning and refining practice. (Survey respondent)

While secondary consultation is accepted as a key element, there is a minor suggestion that there would be less demand for direct care if secondary consultation were used more effectively.

Education and training are seen as another essential element. Not only formal sessions and courses, but *'mentoring... looking for the best way of influencing clinical practice*.'

Service development is mentioned less. But there is understanding that the model requires an incremental and evolving process and the types of work done will depend on *'the area worked with, whether agreements are in place, where personal relationships between services are at…etc'*

Stakeholder survey

Findings from the survey of stakeholders included the following:

- Secondary consultation was both the most frequently used and the most important element in the Initiative's work.
- Education and training, accessed occasionally, was the second most important function.
- Facilitating MH/AOD dialogue was the third most important element, followed by joint planning of care.
- All the items relating to primary consultation were also highly rated in importance, although accessed less frequently.
- Among SUMITT stakeholders, 35% rated shared case management (only offered by that team) as fairly important, 49% as very important.

Distinctive features of the services

A strength of multi-team structure is that it has produced rich and diverse responses. The dual diagnosis services have developed differently according to such factors as variations in local needs and service contexts found across the State, the skills, interests and experience of the staff teams, and the size of catchment areas. It is also noted that the ratio of clinicians to population and area varies widely).

The following is a brief view of the main unique features:

Table 4: distinctive features of the teams

Service	Unique features	Challenges
EHDDS	Activities in 2003- 2004 reflect a new team in the early stages of assessing needs and developing relationships in the region.	Smallest team in the Initiative. The team has rarely been complete and, except for the linked worker in Eastern Hume, has changed completely since the start of the Initiative. Difficulties in resource negotiations.
Nexus	Strong emphasis on the clinician as dual diagnosis service's client, and therefore on professional development and facilitating linkages.	Relatively small team and high turnover.
SDDS	A team of clinicians with a bias towards psychology. Emphasis on capacity building. Clinical Director has a national profile in the development of awareness of and responses to dual diagnosis.	Difficulties in resource negotiations.
SUMITT	Five-year period of operation – the service strategies are well embedded in the system. The practice of shared case management.	

The Youth Initiative – nature and extent of implementation (Evaluation Objective Three)

The purpose of this section is to focus on the process of the early stages of the Youth Initiative.

In 2002 the Mental Health Branch added a Youth Dual Diagnosis Initiative to the Adult DDI structure (with Guidelines for Service Delivery as attached at Appendix C).

According to the guidelines, the aims are:

- to promote greater collaboration between CAMHS and youth drug and alcohol treatment services – 'the ultimate aim is to foster a commitment … to take responsibility for creating a sustainable culture of mutual respect and collaborative client care practices, supported by appropriate policy and protocols.'
- to enhance the confidence and skills of workers in both sectors to work with young people with a dual diagnosis
- to provide direct treatment and support to a small number of young people (aged up to 18) who have a complex presentation of both a mental illness and problematic substance use, across a range of key health, mental health and social wellbeing areas … It is expected that shared-care caseloads … will be restricted to a maximum of five active clients.

The youth initiative is described as having four elements: 'promoting collaborative practice, education and training, secondary consultation and direct service … restricted to a maximum of five active clients'.

In the Youth Initiative guidelines, the service plan 'will serve as a memorandum of understanding between the dual diagnosis lead agency, child and adolescent mental health services (CAMHS) and youth alcohol and drug treatment services describing how they will work together to improve service for young people with a dual diagnosis.'

Key performance measures were to be established in relation to hours of education and training, number of workers trained, number of secondary consultation contacts and number of clients seen for primary consultation.

It was hoped that an independent evaluation of the Youth initiative would commence with the onset of the initiative and also collect data at 12 months post commencement.

Resources

Eight youth-specific clinicians were in post at the time of the evaluation. An additional .5 EFT position was allocated to SUMITT to add to an existing .5 position dedicated to Orygen Youth Health (working with people up to the age of 26). Data on this position appears in the Adult Initiative sections of the report.

The eight youth clinicians were based in the four metropolitan teams, with responsibility for designated CAMHS catchment areas. One position in SUMITT was funded to focus on training, while the others worked across all the elements of the Initiative.

Table 5: Youth Dual Diagnosis Initiative: structure and role occupancy

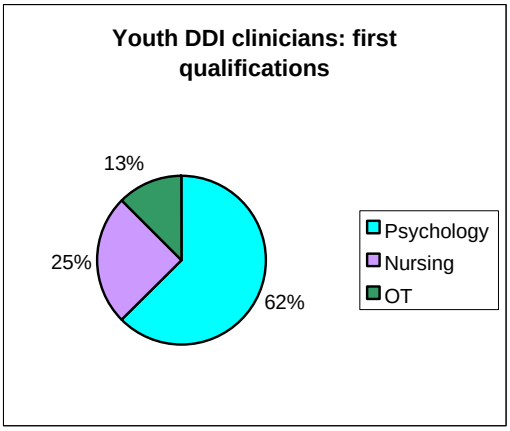
A shaded box indicates that a position has been occupied in the period indicated.

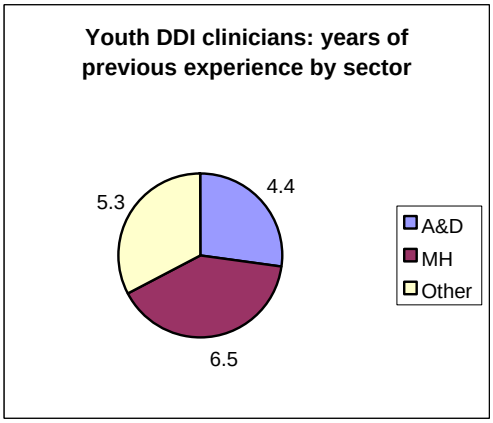
Team	EFT	Catchment	Jan-Mar 03	Apr-June 03	Jul-Sept 03	Oct-Dec 03	Jan-Mar 04	Apr-June 04
EHDDS	1	Eastern CAMHS, North East Hume						
Nexus*	2	North Eastern CAMHS Loddon Mallee			New			
							New	
SDDS	2	Inner Southern CAMHS, South East CAMHS, Gippsland					New	
SUMITT	3	North Western CAMHS Barwon and South West Goulburn, Grampians						

* first incumbent currently on maternity leave

Five of the clinicians have a psychology background, two are psychiatric nurses and one an occupational therapist. All have significant postgraduate qualifications and relevant employment experience.

Figure 8: Youth clinicians qualifications and experience





Supervision within the teams has been augmented by networking among the youth clinicians. They began to meet regularly in 2003. In 2004, funding for Dual Diagnosis Initiative training was used to bring into this network a pilot series of facilitated group supervision sessions.

Three of the eight positions have changed hands since the start of the Youth Initiative.

Activities

Needs assessments

All the services have conducted needs assessment in their regions. Stakeholders' needs (from a Nexus report) include:

- Education and training for staff in relation to:
    - ⇨ Youth dual diagnosis presentations
    - ⇨ Assessment and treatment strategies including behavioural management strategies, pharmacotherapies and medication
    - ⇨ Orientation to AOD and MH services
- Secondary consultation / clinical case discussion
- Assistance with service linkages. Consultation re the further development of interagency protocols.
- Advocacy for clients.

Service elements

Service development

All clinicians have held stakeholder forums as part of service development.

Consultation

The major target group for the direct service activities of the Youth Dual Diagnosis services is specified in the guidelines as young people aged up to 18 with a dual diagnosis of mental illness and problematic substance use.

Education and training

All the services have provided education and training in response to assessed needs.

Rural links

The Initiative guidelines specify that there should be 'a regular outreach service to [each clinician's] partner rural/regional catchments.'

SUMITT reports that youth-specific training is being delivered to all their linked rural regions but rural secondary consultations are low, with the local clinician being the

Working with CAMHS 1

Building a relationship

DDS activities:

- Surveyed all teams to complete a needs analysis
- Organised for youth DD clinicians to become honorary staff members
- One clinician initially attended case conferences for one team
- (New clinician) met team leaders and then staff, to explain the DD role and discuss ways we could work together to build workforce capacity and clinical leadership
- Building service linkages and protocols by making plans for a forum on dual diagnosis for mental health workers
- Assisting service development by making plans for developing a model of dual diagnosis service for CAMHS.
- Planning for gradual development of relationship.

preferred contact person. Other clinicians have arranged periodic visits to the rural regions, with the local clinician preparing the ground.

.

A younger woman encountered in a youth refuge by a substance abuse outreach worker.

A youth substance abuse outreach worker consulted the DDS about Ms E, a young woman of 16, living in a youth refuge. Binge drinking and frequent cannabis use reported, over previous two years. Ms E identifies a self-medication function of current drug use, reporting sadness and anxiety.

DDI response

Clinician agreed to help both client and worker to gain an understanding of the interaction of substance use and mental health symptoms.

A number of pertinent issues emerged. The client had a CAMHS history that the youth substance abuse worker was not aware of. Mental health history included suicidal ideation, dysthymia, self-harming, in the context of family conflict –particularly around mother's mental health – and chaotic lifestyle. Previous treatment included 6-month participation in the CAMHS day program, case management, some family work and one hospitalisation. Client also reports sexually assulted at 8 years old.

Persistence from the youth substance abuse staff and encouragement from the dual diagnosis clinician was required in order to attain a treatment history from CAMHS for this client. It also became clear that during CAMHS treatment the substance use issues had remained unaddressed.

The primary consultation highlighted a training need and training was later provided to the youth substance abuse team on dual diagnosis, assessment and collaboration with CAMHS.

Reflections

- Primary consult was an opportunity to highlight the importance of history taking with the youth substance abuse team.
- Outreach worker was able to observe a risk assessment being conducted.
- Provided a basis for consultation to both outreach worker and residential withdrawal staff around risk assessment, management of client and crisis planning, which focused on context of behaviours and interaction with stress and substance use.
- Later feedback from Withdrawal unit was without this assistance they felt they would not have been able to provide services to this client. With consultation the withdrawal program had been useful to client and manageable for staff.

Working with CAMHS 2

Maintaining a relationship

DDS activity in a CAMHS inpatient unit;

- Training around AOD treatment framework - harm minimisation and collaborative approach with client
- Primary consults with ward staff, clients and families with identified alcohol and drug issues
- Direct care - education and harm reduction group run on the unit by the dual diagnosis clinician and AOD workers from local agencies along with ward staff
- Regular secondary consults during clinical reviews
- Service development discussions with unit manager and YSAS manager to discuss service gaps around shared clients. Issues identified that will require ongoing collaborative work with unit to address:
    - Non threatening, collaborative approach to addressing substance use
    - Treatment and discharge planning which includes AOD workers appropriately
    - Uniform thorough assessment so interventions and diagnosis can be fully informed
    - Training around impact of assessment, withdrawal, and motivational approaches.

Youth Initiative issues

Designated stakeholders

Clinicians are gradually building relationships with CAMHS. The prevalent view in the CAMHS that they do not deal with clients who have a dual diagnosis or are already capable of responding to dual diagnosis issues is part of the ongoing challenge in developing the Initiative.

They report that youth alcohol and drug services are actively welcoming the Initiative and keen to develop their assessment skills and their mental health literacy.

Relationships with PDRS services are embryonic at this stage, except where PDRS have employed dual diagnosis specialist workers.

The Youth Initiative Guidelines note that

> between them Dual Diagnosis services, specialist mental health services and youth drug and alcohol treatment services share responsibility for assisting other non-mental health and non- drug and alcohol agencies to support young people with a dual diagnosis.

and that

> The target group for the activities of the Youth Dual Diagnosis services are the CAMHS and youth drug and alcohol treatment services in their catchment region.

and that

> The major target group for the direct service activities of the Youth Dual Diagnosis services are young people aged up to 18 with a dual diagnosis of mental illness and problematic substance use.

Young people with emerging or diagnosed co-occurring problems may not be found in the specialist services. Staff find the model restrictive in that they cannot work with all relevant stakeholders (including, that is, general youth health and welfare services) that come into contact with the young people and therefore cannot reach the young people most in need of early intervention.

Staff would like to see the Initiative widened to other stakeholders (after mapping where the young people are according to risk indicators), with emphasis on an early intervention model and the needs of young people who have fallen through the gaps and are in the welfare/youth services, with no formal diagnosis.

Clarification of the model is required, to emphasise that the objective is to close the gaps by working through and with the key stakeholders. This involves using the service development and education and training elements of the model to prepare the ground for direct service to the young people. Full history-taking, so that dual diagnosis issues are detected, and acceptance of responsibility for a response to these issues, are key first steps. Education around the evidence for the need for this type of change in the youth dual diagnosis response may be required.

The three case stories including in this section of the report illustrate how this model operates and some of the systemic difficulties that need to be overcome.

Transition between services

One of the issues for young people, summarised by a key informant, is the age and method of transition between youth and adult services:

> Child and Adolescent Mental Health services cut off too early. The late teens is a critical time when issues are emerging. The transition to the adult services is too big. If a young person is well attached to a service before the age of 18 they should be able to stay with that service until 21 and leave it by 22 after a transition period to adult services.

Recommendations

That process evaluation of the Youth Initiative continue, with a view to further clarification of the model.

What is the impact of the Initiative on service providers and people with a dual diagnosis? (Evaluation Objectives Two and Five)

Introduction

This section uses

- Information on the levels of activity in the Initiative as an indication of likely impact
- Case stories illustrating outcomes for clients, service providers and the system
- Data from key informant interviews and a survey of staff employed in stakeholder services who have used the dual diagnosis service.

As noted previously, the impact of a capacity building process defies measurement. These findings are therefore presented as no more than suggestive of impact. They nevertheless highlight process issues which will be useful in the ongoing development of the Initiative.

Outputs/extent of activity

The data available on the quantity of activity makes only approximate summaries possible in this evaluation.

Service documents contain variety of methods for recording activities in reports. While the statewide RAPID database aims for consistency and accuracy, many anomalies are evident in the aggregate reports for the Initiative. It is well accepted that the use of the statistical data reporting system is a work in progress and considerable efforts are being made by all concerned to make it more valuable for monitoring and evaluation of the work.

Using RAPID data for the years 2001-2002 and 2002-2003, we have chosen totals at the state level as an approximation of trends in activity in the Adult Initiative. These are summarised below. The data include a small number of statistics for the early months of the Youth Initiative, which are not able to be separated.

- The number of registered clients nearly doubled in the second full year of the Initiative, from 376 to 664.
- In 2002-2003 the number of contacts with people with a dual diagnosis was two and a half times greater than in 2001-2002.
- There was a similar increase in recorded contacts with other service recipients.
- Data on ‘community contact types’ does not relate well to service impacts, as the categories ‘tertiary consultation’, ‘community development’ and ‘community education’ have to be used for recording both service development and education and training. A more than threefold increase in activity is however recorded between 2001-2002 and 2002-2003.
- Education and training sessions are recorded to some extent within the teams. From the service data available we estimate that in a given year up to 800 formal and informal sessions are delivered across the Initiative.

Table 6: aggregate RAPID data, 2001-2003

	2001-02	2002-03	Notes
Number of clients (registered)	376	664	Excludes: 1. clients not registered in the mental health system who may receive primary service from the dual diagnosis service 2. registered clients where for a variety of reasons the DDS site did not have the necessary access to RAPID
Number of Contacts (with clients with a dual diagnosis)	3,315	8,127	
Contacts with service recipients other than clients	3,006	8,269	
Total Community contact types	1992	6,888	Denotes type of contact in relation to unregistered clients and service providers. Excludes registered clients.
Primary consultation	*38*	*381*	
Secondary consultation	*642*	*2729*	
Tertiary consultation	*240*	*585*	
Community development	*785*	*2103*	*Includes some education and training and service development*
Community education	*287*	*1090*	*Includes education and training*

RAPID data on the diagnoses of the clients registered with the mental health system indicate that schizophrenia and delusional disorders are by far the most common diagnoses, followed by mood (affective) disorders.

Case stories

Case stories collected for the evaluation suggest that the impact of the Initiative is often unclear in the short term. Any shifts in understanding and practice are likely to be gradual. Some reflections on impact have, however, arisen from the stories and subsequent discussion, which flesh out the way the Initiative works at the system, workforce and client levels. Common themes are:

- The value of improved client assessment
- Confidence-building in the workforce
- The multiplier effect of the Initiative's work

For people with a dual diagnosis (and families):

- continuity of engagement and consideration of a full history can lead to
    - completed episodes of treatment (e.g. withdrawal, rehabilitation.)
    - more realistic planning and pursuit of health and personal goals
    - better knowledge of the interaction between substance use and mental disorder
    - prevention of relapse in mental health and substance use, and early intervention in substance use lapses
- harm minimisation education for mental health clients is important
- people are less likely to need intensive mental health crisis support if they have increased skills in managing their substance use

Impacts on workers include:

- Increased confidence to engage
- Knowledge of therapeutic strategies, systems and players in the 'other' service
- History-taking skill
- Strategies for risk assessment, management of client and crisis planning, harm minimisation and motivational strategies
- Learning from education delivered to clients (thus reaching those who may not choose to approach the DD clinician for help) and to colleagues (the latter more pronounced if a consultation leads to in-house training and education.)

Four case stories touching on outcomes for individual clients follow.

Engagement of an older woman with long-term alcohol and mental health issues

A concerned AMHS clinician referred Ms G in connection with a recent inpatient admission and continuing alcohol use.

Ms G is in her late 50s, unemployed, on disability support pension with long history of both alcohol dependence and schizophrenia. Has close contact with mother but limited other social networks.

Previous history of several psychotic episodes before her alcohol dependence. Currently her use of alcohol interacts with her mental illness and appears a significant trigger to relapse of psychosis. Reason for drinking is for comfort due to social isolation, enjoys effects and taste, low motivation to change and a belief that change impossible.

- ***DDS response***

Initial sessions conducted with clinician provided role modelling of interviewing techniques, engagement and motivational interviewing. Over time Ms G began to acknowledge some negatives to alcohol use such as rebound sleep disturbance and through education re her mental disorder she could identify this became an early warning sign to relapse of symptoms of psychosis. This insight led to new motivation to change substance use and client now has long periods of abstinence with occasional “lapses” that the clinician and the DDS clinician are able to become involved with and assist client with problem solving triggers to drinking.

Facilitated neuropsychological assessment.

- ***Impact***

Client:

No relapse of mental disorder since involvement

Early intervention into substance use, preventing lapses becoming relapses.

Some gains in terms of client pursuing alternative activity and pursuit of personal goals, to address issues of social isolation and dependence on mother.

Worker:

The DDS was helpful for the mental health worker in providing a role model and imparting some basic counselling skills towards the issue of substance use such as not to over-react to “lapses” but rather utilise as opportunities for discussion and problem solving.

System:

Reinforcement of the value of addressing the alcohol issue as a key factor in cycle of mental disorder. It would be valuable to have an assessment tool that aims to adequately identify the intersection of substance and mental disorder.

A homeless woman who has encountered service gaps and barriers over a long period.

At the age of 24, Ms B was homeless, depressed, a survivor of childhood sexual abuse and a user of a variety of drugs. Periodically homeless since the age of 16 she has made numerous suicide attempts. Diagnoses have fluctuated from bipolar disorder to borderline personality disorder. She has been a client of several emergency, crisis, mental health and alcohol and drug agencies in several regions.

She reports sexual abuse in her childhood and has had periods of homelessness since age 16.

- ***DDS response***

The dual diagnosis service became involved in primary, secondary and tertiary consultations modelling inter-service engagement and collaborative case planning and the development of training for AOD residential withdrawal and residential rehabilitation services

- ***Impact***

Client

The service was flexible enough to accommodate Ms B's chaotic lifestyle. Ms B benefited from a continuity of engagement that she had not experienced before. Over time she was assisted to construct a realistic plan of how to address her opiate dependency and emotional volatility. She has now completed a residential withdrawal and remained in a therapeutic community for more than six months drug free and with episodes of acting out that both she and the service provider considered manageable.

Worker

Within one service, an AOD counsellor was able to develop a strong positive engagement with Ms B, which allowed the agency to take a leadership role in Ms B's treatment and management. With DDS support, their input became increasingly influenced by therapeutic strategies that capitalised on her strengths and engaged her as a collaborator.

System

Ms B provoked considerable anxiety in services and service personnel. The DDS resisted service providers' efforts to distance themselves from the client after each crisis had been dealt with.

Once a clinical service was prepared to make an ongoing commitment it became possible for the DDS to engage other service providers in the support of a more comprehensive continuum of care.

Issues for a substance using man, other residents and staff in a residential mental health facility.

Mr F is 40 year old single pensioner with a 20 year history of schizophrenia complicated by use of amphetamines. Initially referred for primary consultation by a Community Care Unit for AOD assessment and clarification of the impact of dual diagnosis on persistent psychiatric symptoms. The CCU reported that Mr F was at a precontemplative stage of change. Some practical interventions (such as access to limited amounts of money each day) were in place, as well as random urinalysis.

- ***DDS response***

An initial phone consultation took place, followed by direct consultation the next day with the CCU Occupational Therapist. Initial assessment with Mr F and CCU clinician six days later and a final consultation with staff (including Psychologist, Manager, Consultant Psychiatrist and OT a week after that. A second scheduled appointment with Mr F was not kept.

The DDS identified harm minimisation as a key issue and recommended, in a detailed written report, techniques to motivate and engage Mr F in harm minimisation interventions. The DDS clinician involved staff in identifying the risks in Mr F's situation and noted that while Mr F's drug use had responsible aspects, such as using the needle exchange, his injecting practice was harmful (infection control, sharing needles, bruising).

It was clear that time was needed to work on these issues and to explore reasons for a recent increase in drug use. Three weeks after the initial referral, however, the DDS was informed that Mr F had been asked to leave the CCU after the discovery that he had shared a needle with a co-resident. He was discharged to a rooming house with interim outreach support to be offered by the CCU pending a referral to the Mobile Support Team (MST).

- ***Impact***

Client

The impact on the primary client is not known. Other residents of the CCU were involved in harm minimisation education.

Worker

Increased knowledge of risk assessment and management, harm minimisation and motivational strategies among CCU staff.

The practice of shared case management in relation to a young man with psychosis and long term drug use.

Mr D, aged 23, was referred for help with heroin withdrawal and abstinence after earlier assistance concerning Ice use. He experiences psychotic symptoms in the context of polysubstance misuse and psychosocial stressors. On referral he was using heroin, cannabis and alcohol.

In conflict with his family, his social network consists mainly of substance using peers. He has pending charges for cannabis cultivation and numerous speeding fines. .

- ***DDS response***

The mental health case manager, the DDS clinician and the client agreed to ongoing shared case management and negotiated short-term admission into the youth mental health service's inpatient unit. Advised medical staff of heroin withdrawal regime. Referred client to specialist pharmacotherapy team for maintenance buprenorphine. Arranged dispensing pharmacist, finances for passport photos and first week's dispensing fees. The DDS clinician transported Mr D to collect his first few doses and to subsequent appointments. Monitored and liaised with the case manager re Mr D's mental state. Provided Mr D with psycho-education about different substances. Provided support and psycho-education to mother and father. Conducted regular home visits as part of strengthening engagement.

The plan for future is utilise motivational interviewing, CBT and social skills training, and introduce concerns about ongoing cannabis and alcohol misuse.

- ***Impact***

Client:

Although in the early stages of engagement with the DDS, the client achieved his goal of abstaining from heroin. He has also had the opportunity to discuss and explore consequences of the interaction between substance use and mental health and to develop a trusting and open relationship with a professional in which he can begin to explore thoughts and behaviours previously unknown.

Some support to the family was provided.

Worker

The mental health case manager is more informed about the processes and costs involved in referring clients for substitute pharmacotherapy treatment. Through the joint home visits, the case manager had the opportunity to participate in various strategies to engage the client from a different perspective and enhance her skill and knowledge base.

The case manager attended an appointment with Mr D and the AOD medical officer therefore creating the opportunity to build on this relationship. This may have a flow-on effect with other case managers. Mental health inpatient medical staff were made more aware of current heroin withdrawal regime.

Stakeholder survey

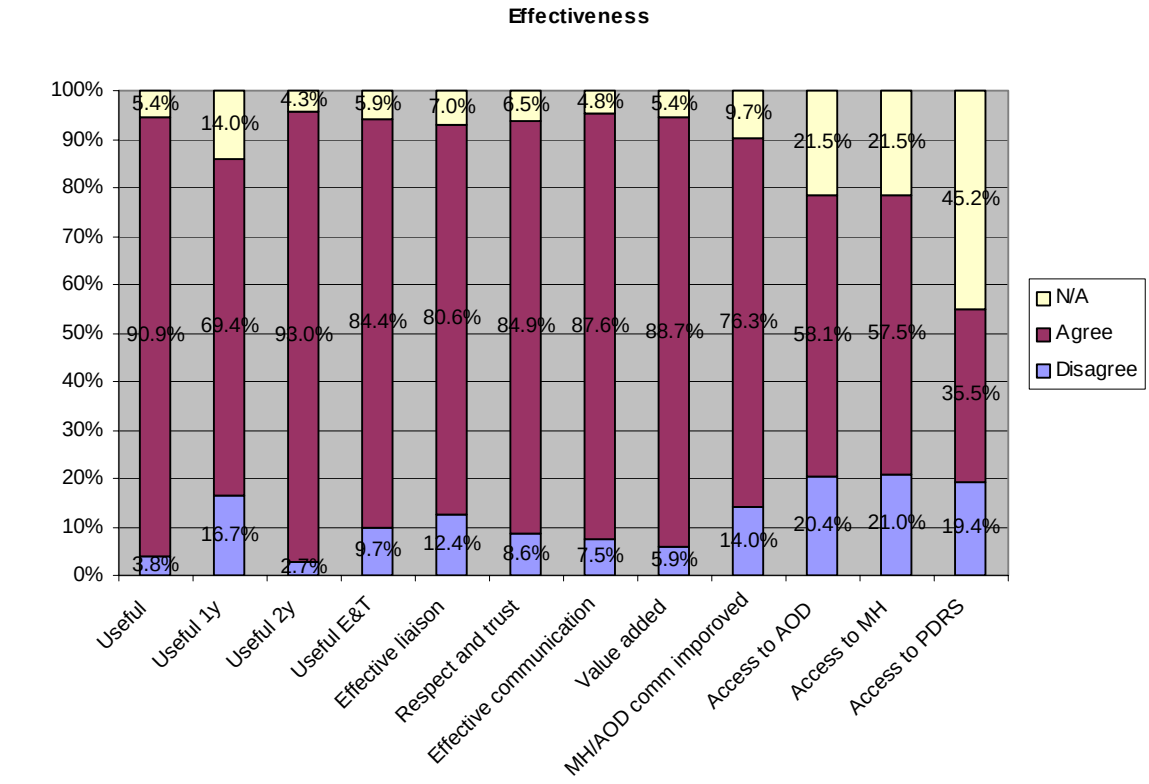
Summary findings from analysis of a survey of stakeholders (n=186) are as follows:

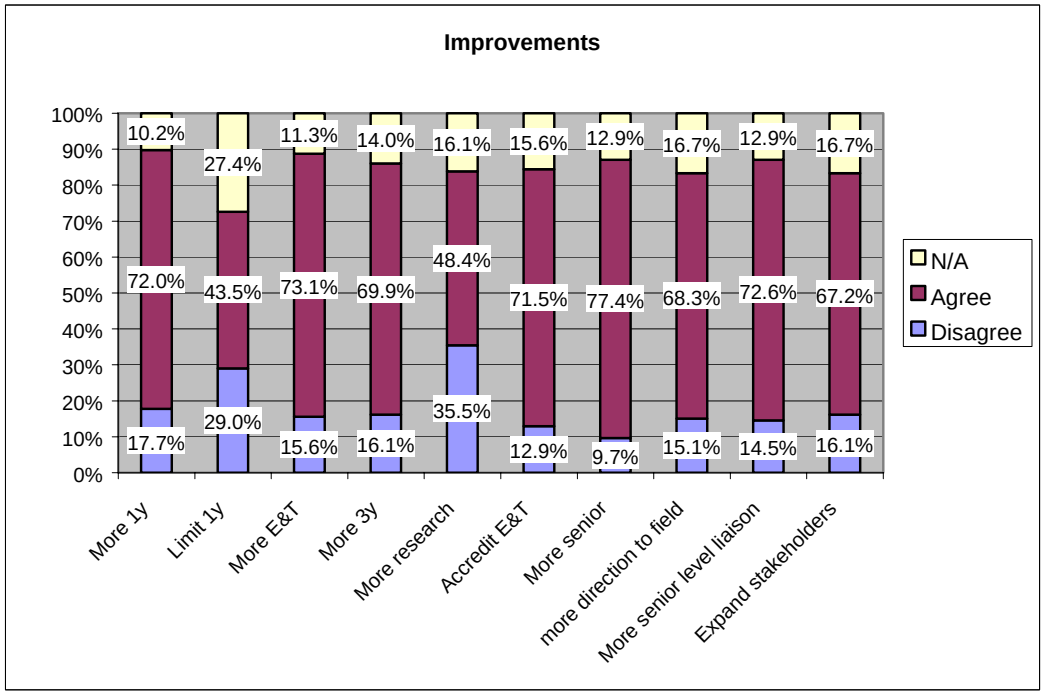
- There is a perceived improvement in dual diagnosis capacity over the last two years.
- Most stakeholders perceive the Initiative to be useful (90.9 per cent) and 88.7 per cent agree with the statement 'I have a strong belief in the value added by the dual diagnosis initiative to my service.'
- Secondary consultation is perceived as useful by 93% and education and training by 84.4%.
- Primary consultation usefulness attracted least agreement, but this is may be explained by the high number of respondents who say they seldom or never use this service.
- Respondents are less clear about whether access to specialist service sectors has improved, with many answering 'Don't know/Not applicable'. However, on the, respondents are three times more likely to agree than disagree that 'access to mental health and alcohol and drug services has improved.' In relation to PDRS, respondents are twice as likely to agree.

Variations by region are generally modest, with the following exceptions:

- The rural clinicians have collectively received the highest ratings on five items: usefulness of education and training, improvement in communication between mental health, PDRS and alcohol and drug services, and improved access to MH/PDRS and AOD services.
- EHDDS received the highest responses in regard to usefulness (97%) and primary consultation (79%) and a strong response on secondary consultation (94%) but was generally lower than other services on all the other items.
- For SDDS, 95% (the highest percentage) agreed that the dual diagnosis clinicians provided an effective liaison service between mental health and alcohol and drug services.
- SDDS had low ratings (60% agreement, 25% disagreement) on primary consultation. A quarter of Nexus respondents (25%) answered 'Not applicable/don't know' on the usefulness of the primary consultation. These data possibly reflect these teams' strategic emphasis on service development, secondary consultation and education and training.
- SUMITT, the largest and longest established service, received a strong response on all items, including 78% on the usefulness of their primary consultation, and 93% on effective communication with stakeholders.

Figure 9: stakeholder views of effectiveness and improvements





- There is support for more investment in every element of the initiative.
- Many (27.4%) are unsure about the limitation of primary consultation to five active clients per clinician. Of those who have expressed a view, 60% agreed with the limitation.

Qualitative data from key informants and stakeholders

Most informants are positive, mentioning the Initiative's:

- Responsiveness
- Availability
- Commitment to training and consultation

Attitudinal changes, while slow and hard to measure, are evident to most key informants:

> The dual diagnosis positions have been really helpful in dual assessment and consultative role. Can be a great way to link into MH and have a good experience rather than wait until they have a psychosis. (Youth A&D service provider)
>
> Our clinician's surveys show knowledge has improved, attitudes worsened! But we are seeing attitudes shift - more acceptance of DD as core business and there is talk of harm minimisation. Better relationship with A&D. A positive cultural shift. (Mental health)
>
> Most CMHS have a greater knowledge now - even if only knowing what they don't know. I think the DDSs have changed this - people have seen that they need to understand. The DDS has gone in with knowledge and strategies, e.g. stages of change, motivational interviewing, do's and don't's, saying 'try this and call us if you need to. Word of mouth has spread. (Mental health)
>
> Some staff are frustrated because they want strategies to apply and some of the heat taken out of their work. What they see is extra assessment work. Others see it as an additional tool in their kit.(PDRS)
>
> There have been huge improvements in services, especially in adult withdrawal, where there are more entrenched mh and aod issues - involvement of CATT (used to groan when the name was mentioned) has improved. Has been as a result of the DDI's work. (Alcohol and drug service).
>
> The professionalism and respect demonstrated by the DD clinicians working with my team has been coherent with their models of motivational change. I believe this has enabled my staff to move from a base-line position of peripheral ignorance to engaged interest and raised awareness.(MH stakeholder)
>
> I believe this is one of the more effective initiatives that we have experienced in the AOD service industry.(Rural AOD stakeholder)

Changes have been observed in practice as well as in awareness. They include:

- Clinicians being more prepared to ask questions about the 'other' issue
- Better linkages for referral
- Increase in mental health assertive management
- Better use of secondary consultation (by both the DDS and clinicians in the field).
- More consultative or joint case planning.

One stakeholder captures a common view that change is a long term process that needs continuing facilitation and more resources:

> While we have seen some gains in communication/liaison between AOD services and mental health services, this also tends to fluctuate and can be fragile at times. It is evident that when the DD Clinician is regularly on site that this improves but due to huge demands on the DD clinicians time they cannot, within their current capacity, spend the amount of time that would be required to see real consolidation of improved communication and liaison. Certainly the DD Clinician has been great in terms of facilitating dialogue but AOD services and CMH services are still mostly not in a place to continue that without a facilitator.

Challenges (Evaluation Objective Seven)

External and internal challenges and potential barriers to the success of the Initiative have been identified in the course of the evaluation.

Challenges in the environment

Pressures are great on the public mental health services and on the general health services which manage them. Many priorities compete for attention with dual diagnosis issues. Crisis management easily takes precedence over long-term capacity building. Specialist mental health services are rarely available to alcohol and drug service clients.

General workforce shortages add to the difficulty of recruiting and retaining staff to the Initiative, when those staff are expected to be highly skilled in the new field of dual diagnosis. Clinicians who are required to be experienced across the sectors and able to be clinicians, educators and clinical and organisational consultants, may not live up to the field's high expectations.

The difficulty in attracting consulting and training psychiatrists to the work is thought to reflect 'the inadequate public medical psychiatric workforce in general as well as the paucity of psychiatrists with knowledge, skills or interest in addiction psychiatry' (Key informant).

Other barriers include the separate administration of mental health and alcohol and drug funding; business competition between agencies and between units within agencies; funding variations among regions; confusing service boundaries; and legal issues.

Many informants mention entrenched professional cultures and attitudes, including (variously) fear of doing the wrong thing, fear of admitting to inadequate knowledge/skill, lack of awareness of inadequate competence, intersectoral and interprofessional hierarchies. Any of these is a particularly strong barrier if found in a key decision maker or gatekeeper.

Although the stakeholder survey indicates that dual diagnosis responsiveness has improved in recent times, the view of the dual diagnosis services is that the majority of the field is in a pre-contemplative stage in regard to taking a more integrated approach to dual diagnosis, with small numbers in preparation and action stages. The dual diagnosis services are still required to focus on raising awareness and generating interest.

The inability to meet demand for training and other support from generalist health and welfare services is another challenge impacting on the Initiative.

Operational challenges

Major operational challenges encountered by the Initiative are:

- Securing a sense of ownership of the model among all its stakeholders. There does not yet appear to be widespread acceptance that dual diagnosis capacity building is a part of core work.
- Resolving management issues between auspicing agencies and DHS concerning budgets, pay levels and the suitability of the model. There is a perception that some agencies have protected the DDI funds more than others and there are reported variations in the amount of extra support provided by auspicing and other agencies where clinicians are based or outposted (e.g. office space and overheads, administrative time, advice.)
- Creating a comprehensive dual diagnosis approach which encompasses a wide range of clinical issues. The services receive some criticism for becoming too influenced by the current public mental health system (and its necessary focus on 'serious mental illness' at the expense of the concerns of the alcohol and drug sector and its clients' experience of, for example, depression, anxiety and personality disorders.
- Strategically balancing the elements of the Initiative in order to build capacity and minimise the risk of perpetuating the divisions between the mental health and alcohol and drug sectors. (It is reportedly common for the mental health workforce to think of the dual diagnosis clinician as 'the D&A worker' and the alcohol and drug sector to see them as 'the mental health worker.')
- Assessment of long term outcomes of the work. These outcomes might include a reduction in deterioration of mental health symptoms, less harmful drug use, fewer hospitalisations, improved client perceptions of continuity of care and quality of life. System change might be evident in, for example, records of full assessments, active linkages, workforce profiles.
- Assessment of short term impact is constrained by data collection, recording and retrieval issues, to do with (a) the need for a system that meets management as well as accountability requirements, and (b) the availability of administrative support.
- Maintaining a service (EHDDS) with a small team which lacks the diversity of skills and mutual support found in larger teams.
- Coordination among the teams. Some perceive that the creation of four teams has led to tensions and a lack of 'critical mass', as well as to the duplication of effort, for example in the development of training modules.
- Resources. The Initiative is tightly constrained and there are many calls for an increase in resources.

Strengths – factors which account for improved outcomes (Evaluation Objective 6)

The great majority of key informants and stakeholders see the Initiative continuing to have a useful long term function. There is much support for refinement of the model and 'a new injection of enthusiasm'. The evaluation process has highlighted key strengths and ideas for building on these strengths.

Most of the key informants approve of the model as a good use of limited resources in a complex approach. They understand its goal to be continually improving attitudes, knowledge, skills, practices and systems in both sectors.

> A resource for our people to work better
>
> One of the best initiatives to happen
>
> MH and AOD may be 'on different planets but when they work together, have concrete plans, systems and parts to play in the system, they do it… The only thing I've seen with positive outcomes is local integration. Funding agreements, …legislating, regulating doesn't work. There has to be a serious integration of what you do as part of your system, very hard to do. The Dual Diagnosis Initiative gives you a sense of how it could be. (Community Health key informant for Rural and Regional AOD Services Review)

The hub and spoke structure (i.e. a base in one service with one worker designated for and working in each mental health catchment area) is supported. It is considered that the catchment areas are feasible if organised properly and with flexibility. However a disadvantage of single designated worker per catchment is that the service is limited by the clinician's particular expertise.

Thoughtful approaches to co-location are appreciated. Solutions that reduce the risk of the service getting lost in a larger system are seen to be successful, from the metropolitan team bases in community alcohol and drug services to a rural clinician's attachment to a Primary Mental Health and Early Intervention team.

- Key informant data and written comments from the survey respondents contained the following themes (with the strongest first):
- That the Initiative was under-resourced and clinicians needed to be able to be a more frequent presence in the services for primary consultation, training, and facilitation of service development and linkages. The inability to maintain a complement of staff, offices and other resources is noted. 'Tokenism' is mentioned.
- That more joint training, forums, supervision and research should be conducted.
- That more top-down direction is required, to support an integrated dual diagnosis response.
- That there is a need for the development of more dual diagnosis intervention strategies, especially relating to depression and anxiety.

Our evaluation is that the Initiative is most effective where all aspects of the original brief have been implemented and there is strong all round connectedness. Three overlapping dimensions can be identified:

- Coherence of vision and effective, collaborative *leadership* on the part of the DHS, managers in auspicing agencies and dual diagnosis service managers/coordinators ('the Initiative's leaders'.)
- Shared philosophy*, teamwork* and realistic targets within stable teams, and networking among clinicians across teams. It has been clear during the process of the evaluation that there is increasing cooperation.
- A strong connection with the *community*, in particular with other dual diagnosis endeavours, with a functioning advisory/reference group and with professional and educational systems.

Improvements and recommendations (Evaluation Objective 8)

The evaluation evidence leads us to make the following recommendations. They are grouped according to the three dimensions of leadership and shared vision, teamwork and community. A summary action framework concludes this section.

Leadership and shared vision

It is timely that the Initiative's priorities are clarified and publicly restated so that more realistic expectations are held in the teams and in the sectors they are working with.

Renewed dialogue on a number of the following issues may help to maximise the collaborative support and guidance of the mental health and alcohol and drug managers in the auspicing agencies.

Primary consultation/direct care

In particular the role of primary consultation work should be clarified and guidance given on the balancing of direct care with the other service elements. The Initiative needs to protect the strategy of increasing integrated responses to dual diagnosis and manage any excessive demands for the dual diagnosis clinicians to relieve immediate needs.

This is not to say that the time allocated to primary consultation should be uniform across the state, as local demographic and service contexts may require variations. Rather it is to alleviate any doubts about whether the dual diagnosis services are providing the services intended under the Initiative.

As we have identified in the report, direct care in the Initiative has two main purposes:

- Provision of quality care for people with the most difficult and complex needs
- Joint work with the client service which can provide role modelling and mentoring opportunities and which articulates with informal and formal education and training and service development

Continued development of the dual diagnosis clinician's skills is a further outcome of direct care.

Agreement on how to quantify the primary consultation workload is required. The number of clients receiving active shared case management is a measure that fits only the SUMITT approach and admission criteria, and does not necessarily control the amount of time spent with clients. A target number of contact hours may be preferable, together with the specification that client contact should normally occur jointly with the client's case manager or key worker.

Recommendation: that the Initiative's leaders renew agreement on the capacity building purpose and strategy of the Initiative, including limitation of direct care hours and reinforcement of their purpose as an element of the Initiative through which direct care can be provided jointly for clients presenting with the most complex issues.

Promotion

Once clarified, the Initiative would benefit from greater statewide promotion. Some suggest reviewing how it is named and 'branded', but the main theme is to improve understanding and ownership in any way possible.

Strong arguments have been made for the importance of fostering the support of opinion leaders in the sectors. While the clinicians' efforts also change opinion, the Initiative's leaders have a key responsibility to locate and foster champions or ambassadors at influential levels.

Recommendation: that the Initiative's leaders develop a joint strategy for promoting the Initiative at sector management and policy levels.

Top down policy direction

Many informants request consideration of firmer top-down policy direction to support local action in the field. Examples include directives regarding the amount and frequency of dual diagnosis training attendances; conduct of client assessments, development of protocols; formal relationships with dual diagnosis positions in MST and PDRS services.

Articulation of a system-wide dual diagnosis policy (as recommended by (Croton 2004) would be valuable in clarifying the context for the Initiative but is a matter beyond the scope of this evaluation.

Recommendation: that the MHB and DPSB consider the development of formal and specific requirements concerning the level of use of the dual diagnosis initiative by stakeholder services.

Youth Initiative

We have noted particular issues in the Youth Initiative with regard to clarification of the early intervention model, policy direction and work with key stakeholder agencies.

Recommendation: That process evaluation of the Youth Initiative continue, with a view to further clarification and development of the model.

Key stakeholders

In both the Adult and the Youth Initiative there is a demand for dual diagnosis support for generalist agencies who work with people with a dual diagnosis who are using neither mental health nor alcohol and drug services.

Recommendation: (a) That the Dual Diagnosis Initiative should be targeted to the key sectors of mental health, PDRS and alcohol and drug services.

(b) That the Initiative maximise links and joint work with other initiatives related to dual or complex needs, such as the Primary Mental Health and Early Intervention Initiative, ABI/AOD Resource Workers, and the Complex Clients Initiative, in order to channel limited resources more effectively.

Functional coordination across teams

The regional structure of the Initiative has the strength of local relevance and integration. There is a need, however, to address the risk of fragmentation and the disadvantages faced by the small Eastern Health Dual Diagnosis Service and by isolated rural workers.

Recommendation: That the Initiative's leaders foster the coordination of functions across the Initiative.

Data collection

Consistent data collection across the Initiative would greatly improve the potential for understanding how the Initiative works, under what circumstances, and how it could be improved. Internal databases as well as the DHS mental health data collection mechanism (RAPID) will benefit from continued work towards access to meaningful data for service improvement.

Recommendation: That the DHS continue efforts to improve RAPID and work with auspice agencies to support appropriate local and consistent data recording and retrieval systems.

Teamwork

The substantial achievements of the teams and linked rural clinicians in establishing their services provide a foundation for consolidation. There is evidence of promising practice in planning, evaluation, training and other areas which could be further developed both within the services and by the services working together.

Common planning framework

Staff and key informants feel that the Initiative can seem too diverse and thinly spread. They would like to see more use of annual plans containing realistic short term objectives that contribute to the overall strategy. Plans may focus, for example, on a particular sector, such as PDRS, which has had less involvement in the Initiative to date, or on a target group or a type of work.

A more open and organised review and planning cycle would not only guide staff but help in enlisting support from the leadership and the sector.

A self-evaluation component in this cycle would enable further learning from experience. While the services are already undertaking some self-evaluation, there is room for development of a common framework and the acquisition of further self-evaluation skills.

Both process improvement and the evaluation of effectiveness (to the extent possible in an Initiative of this type) should be addressed.

Recommendation: that all the dual diagnosis services adopt a simple common framework for an annual planning, review and evaluation cycle and present plans to each other and to the field.

Professional development of dual diagnosis clinicians

Self-evaluation and reflective practice may help to compensate for the lack of advanced dual diagnosis capacity-building training for the dual diagnosis services. There is, however, an ongoing need to secure the best available inservice training, including face to face and distance learning. Training needs are now clearer and

more advanced than in the Initiative's early stages, when SUMITT was responsible for initial training. Train-the-trainer courses, subjects in organisational change and international dual diagnosis courses should now be considered alongside those on alcohol and drugs and mental health. Specialist dual diagnosis workers outside the Initiative (such as the MST/PDRS dual diagnosis clinicians) could also benefit.

Recommendation: that a portion of the Initiative's time and funding be allocated to joint efforts to define a workforce development strategy and access advanced professional development.

Coordination of functions

The education and training element of the teams' work is highly valued and is reported to have increasingly met the sectors' needs. The local connection between the sectors and 'their' clinician has been important for the credibility of the clinician/trainer/consultant, has helped the tailoring of training to local needs and can be followed up by the clinician. There is potential, while maintaining this local creativity and responsiveness, to reduce duplication through cross-team collaboration on training needs analysis, refinement of core curriculum modules, training delivery and evaluation.

Recommendation: that the dual diagnosis services investigate the potential for successful coordination in such areas as development of core competencies, provision of joint workshops and conferences, training needs analysis methods, refinement of core curriculum modules, training delivery and evaluation.

The sharing of information, research, resources and ideas across the Initiative's clinicians and teams is a strength, thanks to the commitment and interest of individuals. Consideration could be given to recognising its value and channelling some of the Initiative's resources into building and promoting a more formal information clearing house.

Recommendation: that a portion of Initiative resources is explicitly dedicated to an information clearing house.

Rural clinicians seek a better understanding of rural difficulties and the qualities developed in the rural services. Their work in documenting their model has been progressing in parallel with this evaluation and should be a valuable planning resource.

Recommendation: that the rural dual diagnosis forum continue to be supported, with the main aims of improving the model and supporting the workforce.

Youth clinicians have also networked across the regions and have undertaken group supervision

Recommendation: That statewide youth dual diagnosis clinician meetings be continued.

Periodic meetings of the dual diagnosis services would provide a physical focus of cross-team collaboration, building on the benefits of current meetings of managers, rural clinicians and youth clinicians.

Recommendation: that annual one or two day meetings of the Initiative's teams and clinicians be held, for planning, review and professional development.

Education and training accreditation

Another improvement to education and training may lie in further work towards formalisation of some of its aspects and links with Registered Training Organisations and universities, so that the training articulates with recognised qualifications.

Recommendation: that the dual diagnosis services take a joint and strategic approach towards accreditation of dual diagnosis training and the inclusion of dual diagnosis subjects in relevant undergraduate and postgraduate courses.

Community

As already mentioned, there is scope for renewing the relationship of the Initiative to the wider community.

Steering and reference groups

Steering and reference groups are a significant feature of the model. Feedback on the local advisory/reference groups is that their operation has been patchy. When successful they have achieved carer and consumer participation, been a sounding board for program implementation plans, informed the clinician about needs and have 'chewed into an issue', rather than operating simply as a reporting forum. In some cases their function has been successfully merged with another similar group, in others a review of membership and terms of reference has produced new life. Consideration should be given to prioritising the creation of active and purposeful reference groups in each area or region. This finding resonates with Croton's recommendations for the formation of Regional Integrated Treatment Implementation Planning Groups (Croton 2004).

Recommendation: that the dual diagnosis services review the operation of reference groups, pool their expertise, and trial and evaluate improvements.

The research community

Links with others in the dual diagnosis field outside the Initiative are desirable: not only with the MST dual diagnosis clinicians but also with researchers. Working with researchers to fund and conduct much-needed projects can bring mutual benefits. Future projects could include:

- Development and validation of good practice guidelines and standards for mental health, PDRS and alcohol and drug services.
- Development and trial of models for clinical intervention.

A key to such collaboration will be networking along the lines of the now dormant Substance Use and Mental Health Network (SUMHNET).

Recommendation: that the dual diagnosis services coordinate efforts to contribute to the conduct of research relevant to Victorian needs.

A note on resources

The above recommendations relate to current resource levels. We note that concerns about the adequacy of the Initiative's funds for the size of the task have been expressed from the earliest meetings of the Statewide Steering Committee.

Suggested investments, should further resources become available, are:

- An increase in numbers of clinicians.
- Additional resources for travel to support management and supervision in the Initiative and networking for rural workers.
- Further research and documentation of good practice
- The greater involvement of addiction medicine specialists, in order to balance the input of mental health specialists.
- Expansion of the stakeholder list into other service sectors, in particular concerning General Practitioners, young people, aged people, Indigenous and CALD communities and people in the justice system.

Summary action framework

Table 7: action framework

Main players	Leadership	Dual diagnosis services	Community
Activities	Renewal of vision and agreement		
	Top-down direction to stakeholders		
	Promotion/marketing strategy and implementation		
	Explore and support coordination of some functions		
	Common annual planning and evaluation framework		
	Advanced professional development		
		Develop information clearing house	
		Continue rural forum	
		Continue youth forum	
	Consider resourcing annual 1-2 day gathering		
		Accreditation of E&T. Inclusion of DD subjects in tertiary courses	
	Links with other complex needs initiatives		
	Continue development of steering and reference groups		
		Develop research links with others with dual diagnosis interests	

Conclusion and key findings

This report has described the nature and extent of implementation of the Dual Diagnosis Initiative, and expanded on the mechanism by which the service elements of consultation, education and training and community development interact to build capacity in stakeholder services.

We have found strong support for the effectiveness of the model. We emphasise that the Initiative is in a developmental stage. Ongoing evaluation will be required to provide help ensure that it is operating to effect sustainable change in the mental health, PDRS and alcohol and drug sectors.

Nature and extent of implementation

As a capacity-building initiative, the key elements of the Initiative were:

- Education and training
- Secondary consultation
- Primary consultation to dual diagnosis clients; and
- Service development.

The dual diagnosis services are active across all elements of the Initiative, providing primary and secondary consultation, service development and education and training to their key stakeholders.

While the balance of the elements varies from catchment to catchment and from time to time according to a range of factors, activity across the Initiative is relatively evenly focussed on each element. Stakeholders strongly value each element in the Initiative.

The resourcing of the Initiative has been characterised by

- Attraction of a skilled, experienced and committed workforce
- A somewhat protracted start-up period
- High staff turnover in two services
- Some difficulty in securing and retaining intended physical resources.

The more settled profile and processes of the pilot service, established in 1998, bear witness to the time needed for this kind of Initiative to become fully operational.

Impact

Most surveyed stakeholders perceive the Initiative to be useful (90.9 per cent) and 88.7 per cent agree with the statement ‘I have a strong belief in the value added by the dual diagnosis initiative to my service.’ Key informants value the Initiative’s responsiveness, availability and commitment to training and consultation.

Attitudinal changes in the mental health and alcohol and drug sectors, while slow and hard to measure, were evident to most key informants. Changes in practice have been observed, such as preparedness to ask about dual diagnosis issues, better linkages and more consultative case planning. Measuring the impact of a capacity-building initiative in 12 months is not possible. Capacity-building takes many years. Nonetheless, proxy measures of impact were obtained for the evaluation. These measures included quantitative data (such as amount of service delivery, number of training sessions and so on); qualitative measures (such as case studies), and key informant data.

Quantitative data revealed that:

- The number of registered clients nearly doubled in the second full year of the Initiative, from 376 to 664.

- In 2002-2003 the number of contacts with people with a dual diagnosis was two and a half times greater than in 2001-2002.
- A more than threefold increase in the categories ‘tertiary consultation’, ‘community development’ and ‘community education’ activity is recorded between 2001-2002 and 2002-2003.
- From the service data available we estimate that in a given year up to 800 formal and informal sessions are delivered across the Initiative.

Common themes from our analysis of case stories are:

- The value of improved client assessment in assisting completion of treatment and prevention of relapse
- The building of confidence, skills and knowledge in the workforce
- The multiplier effect of the Initiative’s work.

Challenges and barriers

Environmental challenges lie in resource pressures on the wider system, general workforce shortages and staff turnover. Enduring attitudes and fears among staff in the mental health and alcohol and drug sectors must be addressed in generating interest in moving towards more integrated services.

The main operational challenges relate to ownership of the Initiative by its stakeholders, auspicing/management issues and the strategic use of limited resources.

It is timely that the Initiative’s priorities are clarified and publicly restated so that more realistic expectations are held in the teams and in the sectors they are working with.

The substantial achievements of the teams and linked rural clinicians in establishing their services provide a foundation for consolidation. There is evidence of promising practice in planning, evaluation, training and other areas which could be further developed both within the services and by the services working together.

There is scope for renewing the relationship of the Initiative to the wider community.

Strengths

The evaluation strongly endorses the Initiative’s ‘theory of action’. The Initiative is effective when all aspects of the original brief have been implemented. There is evidence of effective and collaborative leadership, teamwork and a strong connection with the wider community of stakeholders.

Appendices

Royal Commission into
Victoria's Mental Health System

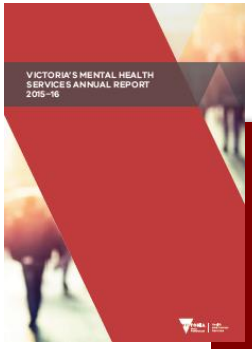
ATTACHMENT GJC-7

This is the attachment marked '**GJC-7**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

Role description: Victorian Dual Diagnosis Initiative @ Jan 2019

December 2016:

VICTORIA'S MENTAL HEALTH SERVICES ANNUAL REPORT 2015–16

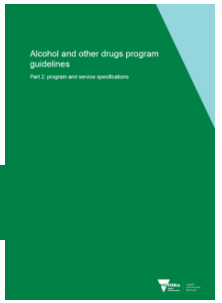


Dual Diagnosis services aim to improve treatment outcomes for individuals who have co-existing mental health and substance use issues.
Services include:

- education and training for mental health, drug and alcohol and MHCSS staff,
- support to organisations to develop dual diagnosis capabilities, and
- clinical consultations in collaboration with primary case managers.

September 2018:

ALCOHOL & OTHER DRUGS PROGRAM & SERVICE SPECIFICATIONS



6.5 The Victorian dual diagnosis initiative

There is a range of State and Commonwealth funding allocated to enhance the capacity of AOD treatment services and mental health services to respond to clients with concurrent mental health and drug issues. As dual diagnosis is prevalent, staff should be trained in dual diagnosis and provided with appropriate education and learning opportunities.

The Victorian dual diagnosis initiative's (VDDI) structure includes four metropolitan agencies with links to workers embedded in each rural region. AOD treatment services are supported by the VDDI which provides training and consultation services and has some direct service provision responsibilities to clients.

For more information on dual diagnosis and responding to client needs, please see the department's website, dual diagnosis. <www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis>.

6.5.1 Purpose

The VDDI supports the development of better treatment practices and collaborative relationships between AOD treatment and mental health services. The key activities of the VDDI are:

- the development of local networks
- training, consultation and modelling of good practice through direct clinical intervention and shared care arrangements.

6.5.2 Target group

Mental health and AOD treatment workers who require support to respond to clients with concurrent AOD and mental health issues, and people who are experiencing issues related to concurrent AOD and mental health issues.

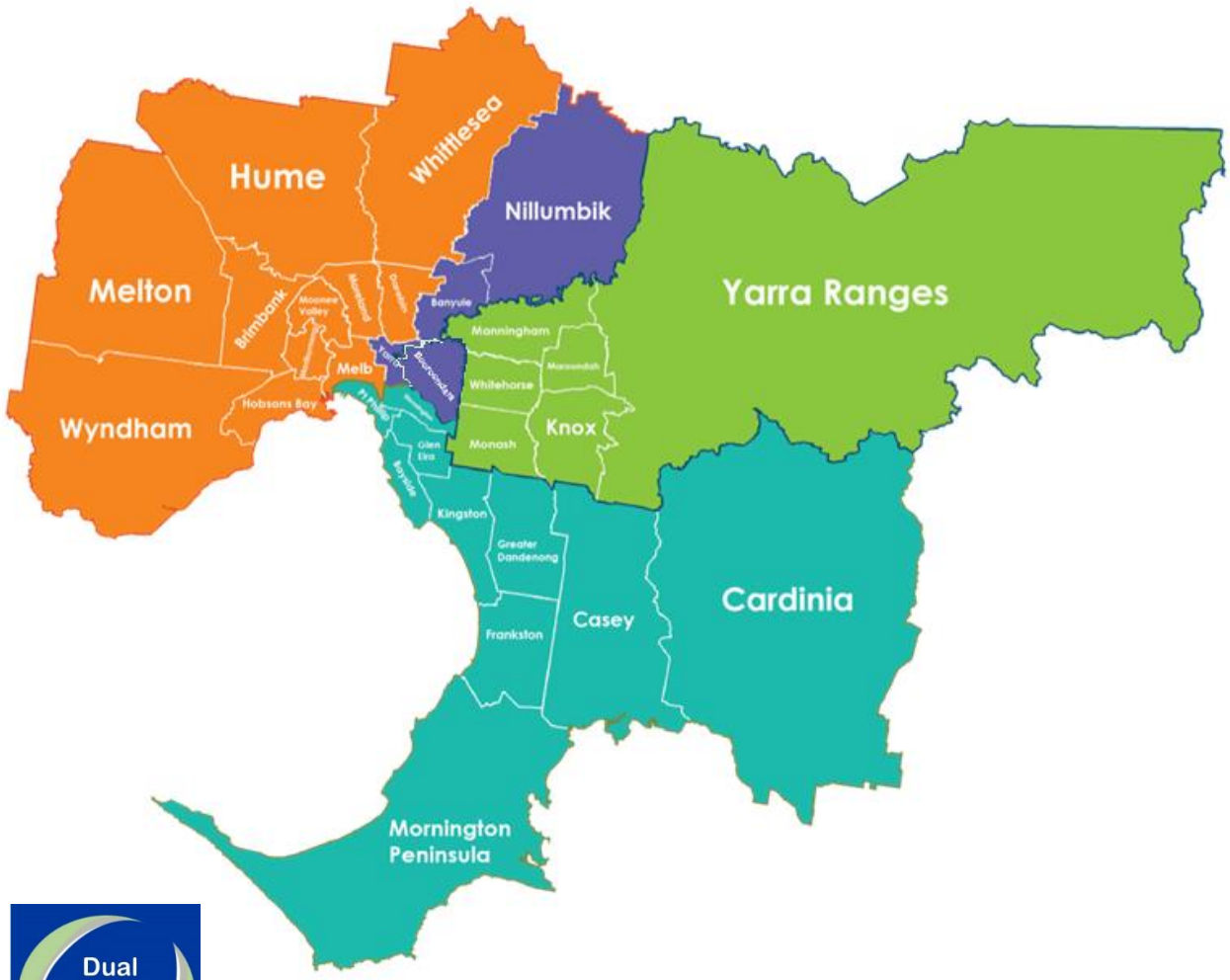
6.5.3 Key service requirements

The initiative includes the following functions.

- Develop co-operative working relationships between mental health and AOD treatment services within the relevant area service catchment. This should particularly address areas of access, assessment and the development of effective treatment planning.
- Provide training and consultation to all community mental health and AOD treatment services within the catchment with a strong focus on building capacity within the services to respond more effectively to people with a dual diagnosis.
- Provide direct service to clients with a serious mental illness and substance use problems with a focus on developing and modelling good practice. This may be by providing a limited direct service and intensive support/consultation to case managers on specific cases.

VDDI Contacts

Contacts: Victorian Dual Diagnosis Initiative METRO



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Dual Diagnosis
Victorian Dual Diagnosis Initiative

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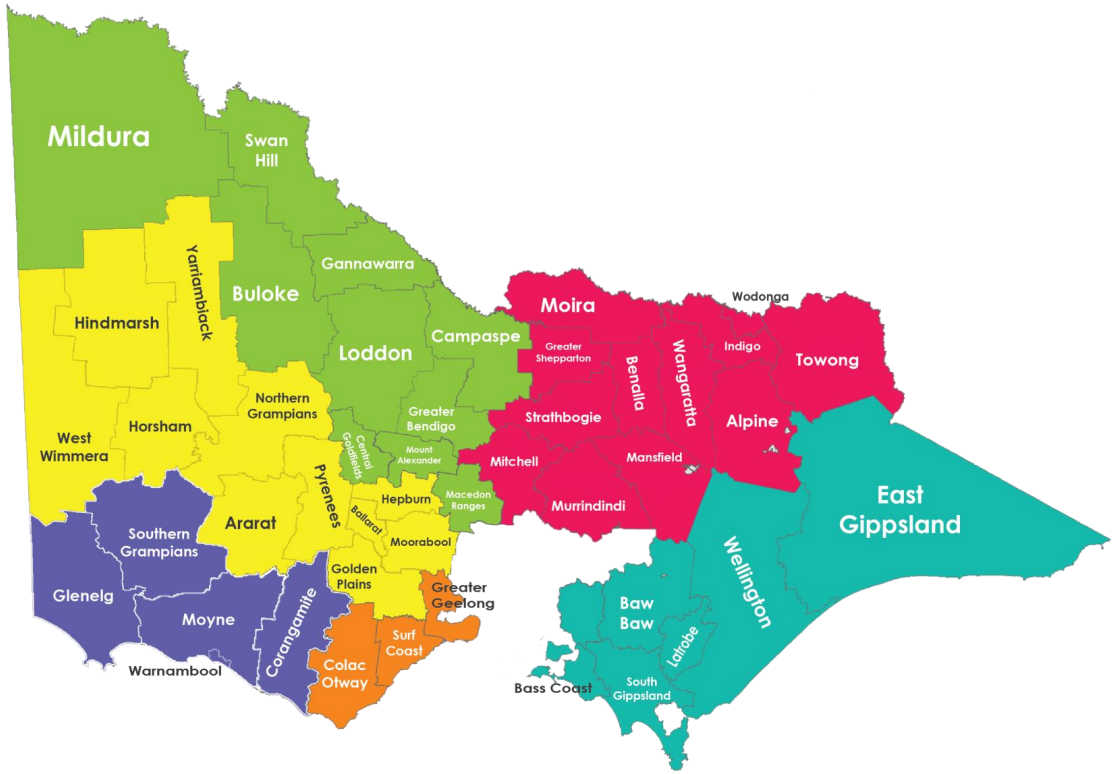
VDDI Rural Contacts

Contacts: Victorian Dual Diagnosis Initiative RURAL



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Dual Diagnosis
Victorian Dual Diagnosis Initiative

VDDI Inquiries: 03 9231 2083

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-8

This is the attachment marked '**GJC-8**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

Queensland Mental Health Commission

Options for reform

Changing attitudes, changing lives

Options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use

March 2018

Queensland Government

Authority

The Queensland Mental Health Commission was established under the *Queensland Mental Health Commission Act 2013* to drive reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.

One of its key functions in achieving reform is to undertake and commission research in relation to mental health and substance misuse issues (section 11(1)(f)) and to review, evaluate, report and advise on the mental health and substance misuse system (section 11(1)(d)).

The report will be provided to the Minister for Health and Minister for Ambulance Services, the relevant Directors–General of State Government Departments, and made publicly available.

Feedback

We value the views of our readers and invite your feedback on this report. Please contact the Queensland Mental Health Commission on telephone 1300 855 945, fax (07) 3405 9780 or via email at info@qmhc.qld.gov.au.

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the report, you can contact us on 1300 855 945 and we will arrange an interpreter to effectively communicate the report to you.

Published by the Queensland Mental Health Commission, March 2018

Queensland Mental Health Commission
PO Box 13027, George Street QLD 4003
Phone: **1300 855 945**
An electronic copy of this document is available on the Queensland Mental Health Commission's website at **www.qmhc.qld.gov.au**

2018/1275

Contents

Acknowledgements

We pay respect to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander people, their culture and customs across Queensland.

We also acknowledge people experiencing mental health and alcohol and other drug problems, as well as those impacted by suicide, and their families, carers and support people. We can all contribute to a society that is inclusive and respectful, where everyone is treated with dignity and able to focus on wellness and recovery, and have fulfilling lives.

The Commission would particularly like to acknowledge the people who generously shared their personal experiences to help inform ways to reduce stigma and discrimination.

Commissioner's message

Most Queenslanders, most of the time, experience good mental health and wellbeing and can contribute to, and participate in the community. Queenslanders from all walks of life use alcohol, tobacco and other drugs. While not everyone who uses alcohol or other drugs will experience harms, when harms do occur they can have a wide-ranging impact on the mental and physical health of the person, their family, friends and the broader community.

As this report demonstrates stigma, and discrimination, causes significant harms. It acts as a barrier to people seeking help and support in order to make changes in their lives. For some of our most vulnerable Queenslanders, stigma and discrimination can lead to and compound socio-economic disadvantage through unemployment and social isolation.

A multi-layered and multi-level response is required to eliminate stigma and discrimination, and to support people on their journey to recovery and reconnection to the community. This report outlines options for reform that can guide actions to reduce the harms experienced by many people experiencing problematic alcohol and other drug use.

I sincerely thank the people who generously shared their personal stories to inform this report. Through interviews and consultation, they poignantly illustrated how stigma and discrimination is experienced: for some on a daily basis. Regardless of how frequently or where stigma and discrimination is experienced it ultimately devalues people and takes away their dignity. I hope that this report can support the voices of people with a lived experience to bring about long-term change.

I also thank the wide range of people and agencies that have contributed to this report. They include the Drug Policy Modelling Program who informed the evidence base with their detailed research, the Queensland Network of Alcohol and other Drug Agencies and the alcohol and other drug treatment services who supported their clients to participate in the research, members of the Project Advisory Group that guided the project, the Queensland Mental Health and Drug Advisory Council, and the State Government agencies who provided important feedback throughout the development of the options for reform.

I look forward to continuing our collective effort towards building a healthy, inclusive and connected community for all Queenslanders.

Ivan Frkovic
Queensland Mental Health Commissioner

About this report

This report has been prepared by the Queensland Mental Health Commission (the Commission) to examine ways to reduce stigma and discrimination which has a negative impact on the mental health and wellbeing of people experiencing problematic alcohol and other drug use.

The work contained in this report is a commitment within the Queensland Government's *Queensland Alcohol and other Drugs Action Plan 2015–17* (the AOD Action Plan). The findings and the options for reform outlined in this report support the AOD Action Plan's overarching goal—which is to prevent and reduce the adverse impact of alcohol and other drugs on Queenslanders.

This report outlines 18 options for reform regarding systemic issues to address stigma and discrimination for people experiencing problematic alcohol and other drug use, and their families. It is intended to encourage policy discussion and enhance understanding of the prevalence and impacts of stigma and discrimination. It also seeks to inform services, and the community about ways to address the attitudes, policies and practices that may directly or indirectly manifest stigma and discrimination.

This report also sets out evidence-informed advice to reduce the harms caused by stigma and discrimination. It is informed by a range of sources, including independent research undertaken by the Drug Policy Modelling Program, National Drug Research Centre at the University of New South Wales on behalf of the Commission; the views of people with a lived experience of problematic alcohol and other drug use, their families and friends; Queensland government agencies; non-government organisations; and consultation with the Queensland Mental Health and Drug Advisory Council.

The options for reform are based on the following policy principles:

- **Harm minimisation approach**: A harm minimisation approach, in line with the *National Drug Strategy 2017–2026,* has been adopted to prevent and reduce the adverse impact of alcohol and other drugs on the health and wellbeing of Queenslanders. Stigma and discrimination is an avoidable harm that impacts negatively on the mental and physical wellbeing of individuals and families experiencing problematic alcohol and other drug use.
- **Recovery-oriented approach**: Recovery from problematic alcohol and other drug use is possible. Many people, with the right support, can and do recover and live a life with purpose and hope. Stigma and discrimination hinders recovery.

  In Queensland, government and non-government alcohol and other drug treatment agencies define recovery as "any approach that seeks to identify and achieve goals that are meaningful to the client, which may include safer using practices, reduced use or abstinence. For many people, recovery describes a holistic approach that offers greater opportunity for positive engagement with families, friends and communities"[1]**.**
- **Social inclusion**: Stigma and discrimination underpin actions that socially exclude people experiencing problematic alcohol and other drug use. Social inclusion is critical as it is strongly associated with quality of life factors that protect against problematic alcohol and other drug use. This includes, but is not limited to, economic security, being and feeling safe, access to services, equity and fair treatment, self-esteem and confidence, good physical health and social support with family and friends.
- **A balanced approach**: There is a need for balance between individual rights and responsibilities, and those of others including families and the broader community.
- **Health–focused approach:** Addressing problematic alcohol and other drug use as a public health and wellbeing issue, not a moral or criminal justice issue can lead to better outcomes for individuals, families and communities. Reducing stigma and discrimination can have a positive impact on the physical and mental health and wellbeing of Queenslanders.

Executive summary

Societal values toward problematic alcohol and other drug use inform stigma and discrimination. These values are reflected in the cultural acceptance of some substances such as alcohol, alongside the criminalisation of others. This distinction informs stigmatisation and discrimination, particularly against people who use illicit drugs. There is strong evidence that intoxication or dependence is behaviour that is considered immoral, illegal, and deviant. The World Health Organisation indicates that illicit drug dependence is the most stigmatised health condition in the world[2]. People who are dependent on drugs are viewed as more blameworthy and dangerous compared to people living with mental illness or physical disability[3]. Frequently, society neglects to separate the person experiencing problems from the alcohol and drug use itself, which can result in negative labelling: reinforcing the stigma and furthering alienation.

Experiences of stigma and discrimination are a common occurrence in the everyday lives of people with a lived experience[i] of problematic alcohol and other drug use. These experiences are distressing and can result in people feeling shame, anger, rejection and a sense of worthlessness and hopelessness. This in turn can trigger further alcohol and other drug use.

Stigma and discrimination can create barriers to people seeking and receiving help to address problematic alcohol and other drug use and can also hinder their ability to reconnect with the community, and access opportunities such as employment. Additionally, it can further compound social disadvantage and can lead to social isolation and exclusion which can have negative impacts on mental and physical health. It can also have a significant negative impact on the families and friends of people experiencing problematic alcohol and other drug use, and can affect people long after problematic use has ceased.

Stigma is complex and can be expressed as ‘felt’ or ‘perceived’ stigma (real or imagined fear of discrimination); ‘enacted’ stigma (experiences of stigma and discrimination); and ‘self’ stigma which is the internalisation of negative thoughts and feelings arising from identifying as part of a stigmatised group. Structurally, stigma and discrimination may arise in policies or laws.

In the uncommon but important instances where people report an absence of stigma and discrimination, they felt understood and cared for as a ‘normal’ individual. Inclusion fostered greater connection to families and the community more broadly and contributed to improved wellbeing.

Stigma and discrimination have been found to be most pervasive in five settings:

1. Health care and public health
2. Welfare and support services, including housing
3. Police, public order and criminal law
4. Employment
5. Society at large.

In these settings stigma and discrimination negatively impact people’s access to services (including health care), fair treatment in the justice system, employment opportunities, relationships with family and friends, their feelings of social inclusion, and their drug use.

An analysis of Queensland legislation highlighted the potential for discrimination in a wide range of provisions, mainly through the need for clarity of definitions, which influences their application by decision makers. The need for overarching human rights protections was also identified.

[i] Lived experience refers to people who have a direct personal experience of problematic alcohol and other drug use.

To effectively address stigma and discrimination, a multifaceted approach that addresses individual attitudes and behaviours, in tandem with strategies focused on societal structures and systems is required.

To shift community attitudes and to decrease stigma associated with accessing information about alcohol and other drugs and treatment services, it is essential to challenge the pervasive negative stereotypes of people who experience problems with alcohol and other drug use. It is also essential to convey hopeful messages that support, services and a variety treatment types are available.

Options for reform

The Queensland Mental Health Commission identified 18 options for reform under six key domains.

Domain 1: Human rights

Option 1. The Queensland Government progress the introduction of a Human Rights Act for Queensland.

Domain 2: Social inclusion

Option 2. The Queensland Mental Health Commission identify and promote effective anti-stigma training activities and resources, including examination of the 'Putting Together the Puzzle' anti-stigma program that has been delivered in Queensland.

Option 3. All social service sector workforces, including health, housing, child safety and justice, build staff capacity to recognise and reduce stigma and discrimination by providing ongoing training and professional development opportunities. Anti-stigma training should be:

- delivered in partnership with people with a lived experience of problematic alcohol or other drug use
- targeted to the relevant audience/s.

Option 4. To contribute to decreasing stigma and discrimination in help-seeking, Queensland Health explore implementation of strategies to ensure that credible, factual and positive information about alcohol and other drugs and how to access support and treatment, is readily accessible to the general public. Information should be tailored for:

- population groups at higher risk of problematic alcohol and other drug use
- families and friends of people experiencing problematic alcohol and other drug use
- the general population to counteract stigmatising attitudes and normalise help seeking from available services.

Option 5. The Department of the Premier and Cabinet ensure that Queensland Government mass media campaigns are based on evidence and reinforce positive messages that people can and do recover from problematic alcohol and other drug use.

Option 6. The Department of the Premier and Cabinet and Queensland Health, in partnership with key stakeholders, explore options for the development of evidence-based mass media campaigns to reduce stigma and discrimination experienced by people who use alcohol and other drugs.

Option 7. The Queensland Mental Health Commission, in partnership with key stakeholders, will investigate development of an evidence-based media resource designed to improve media coverage of issues related to alcohol and other drug use.

Domain 3: Engaging people with a lived experience and their families

Option 8. To improve and increase the meaningful engagement of people with a lived experience of problematic alcohol and other drug use, their families and significant others, the Queensland Mental Health Commission will pilot and evaluate the Stretch2Engage framework in partnership with alcohol and other drug services.

Option 9. To support stigma reduction, Queensland Health explore a range of strategies to enhance the engagement of individuals and families with a lived experience of problematic alcohol and other drug use in policy and service planning.

Option 10. Health care service providers identify the rights and responsibilities they have adopted, and how they are promoted to people accessing their services, their staff, and their organisation as a whole. Should gaps be identified, develop and promote a statement of rights and responsibilities, ensuring that they are inclusive of people experiencing problematic alcohol and other drug use. An active awareness and promotion campaign should accompany the statement of rights and responsibilities to ensure that people who access the service can enact their rights.

Domain 4: Access to services (health care and social services)

Option 11. Health care and social services, across a range of settings, work to ensure that a welcoming environment that respects the dignity and worth of all clients, including people with a lived experience of problematic alcohol and other drug use, is provided. This may include:

- funding bodies identifying and promoting opportunities for services to seek funding for design and infrastructure improvements
- services undertaking, or applying a risk analysis to service environments, including the physical design, to meet the relevant standards of safety and amenity for staff and clients
- input from service users and their families to identify and implement strategies to improve service environments.

Option 12. To enhance integration and improve pathways across the care continuum, the Department of Health, Hospital and Health Services and Primary Health Networks increase joint planning and investment activities, across the full spectrum of alcohol and other drug services including family support.

Option 13. Queensland Health and the Queensland Police Service give further consideration to the development of new, evidence-based, innovative harm reduction strategies in Queensland.

Domain 5: The justice system

Option 14. The Queensland Government introduce processes that require an assessment of potentially discriminatory provisions as part of law reform and legislative review projects, for example by including a requirement in the Queensland Legislation Handbook.

Option 15. Relevant Government agencies introduce or include processes and/or training programs for policy makers and legislators to ensure the potentially stigmatising and discriminatory effects of legislation, and suitable ways to achieve stigma reduction in laws, are considered.

Option 16. The Queensland Mental Health Commission initiate discussions about the risks and benefits of decriminalisation for personal use and/or possession of illicit drugs, similar to other countries.

Option 17. The Queensland Police Service develop and deliver anti-stigma awareness training for frontline police officers in collaboration with alcohol and other drugs subject matter experts.

Domain 6: Economic participation

Option 18. Employers, across all sectors, should ensure that support is available for people in the workplace who are experiencing problematic alcohol and other drug use. This includes:

- having information about options for assistance and support readily available for both employees and managers dealing with alcohol and other drugs in the workplace
- promotion of, and confidential access to, counselling and support services
- provision of flexible workplace policies and practices such as leaves of absence to seek help, reasonable adjustment of duties and return to work programs.

Background

Many Queenslanders, from all walks of life, regularly use alcohol, tobacco and other licit and illicit drugs. The 2016 National Drug Strategy Household Survey[4] indicates the following proportions of Queenslanders aged 14 years and over had used alcohol and other drugs in the previous 12 months:

- 19.5 per cent drank alcohol at life time risky drinking levels
- 15.6 per cent drank alcohol at risky levels on single occasions at least weekly (had more than 4 standard drinks at least once a week)
- 14.8 per cent smoke tobacco daily
- 16.8 per cent used at least one illicit drug
- 11.9 per cent used cannabis
- 1.5 per cent had used meth/amphetamine.

While not everyone who uses alcohol and other drugs experiences harm, when harms do occur they can have a significant impact on the health and wellbeing of the individual, their families and the broader community. The type of harm can also vary from immediate risk of physical injury to long-term disability, and in some cases death. Harms also include social isolation, stigma and discrimination. Problematic alcohol and other drug use, particularly illicit drug dependency, is recognised as one of the most stigmatised health conditions in the world[5].

Stigma related to problematic alcohol and other drug use can negatively affect a person's self-esteem and engender feelings of worthlessness and hopelessness. This in turn can trigger further alcohol or other drug use or giving up on seeking positive life changes. It can impact on a person's recovery by hindering their ability to participate in the community and be engaged in opportunities such as employment, education and training. Critically, it can create barriers to people seeking and receiving help to address their problematic alcohol and other drug use or their social welfare needs.

Stigma and discrimination can also lead to, or compound existing social disadvantage, especially where other forms of discrimination exist. Co-stigmas associated with health conditions such as hepatitis C and HIV/AIDS, mental illness, or homelessness, cultural background, socio-economic status, or sexuality and gender identity are examples where stigmas can become conflated and lead to additional barriers to care, support and social inclusion. For some population groups existing stereotypes can be reinforced, for example with Aboriginal and Torres Strait Islander peoples.

Stigma associated with having, or having previously experienced problematic alcohol and other drug use can impact for a lifetime, in multiple areas of a person's life.

While the effects of stigma and discrimination have been well documented there is limited research into the most effective way of reducing stigma and discrimination. This includes the ways it impacts on the ability of people to be socially connected and to participate in education, training and employment, or how it acts as a barrier to seeking help when needed.

There is considerable variation in the definition of stigma and discrimination found in literature. The definitions of stigma and discrimination employed by the Drug Policy Modelling Program and adopted by the Commission are:

- **Stigma** is the labelling and stereotyping of difference, at both an individual and structural societal level, that leads to status loss (including exclusion, rejection and discrimination).
- **Discrimination** is the lived effects of stigma—the negative material and social outcomes that arise from experiences of stigma.

- **Drug/s** includes alcohol, tobacco, illegal (also known as illicit) drugs, pharmaceuticals and other substances that alter brain function, resulting in changes in perception, mood, consciousness, cognition and behaviour. This is in line with the National Drug Strategy.

Developing options for reform

In 2015, the Queensland Government released the AOD Action Plan which aims to prevent and reduce the adverse impact of alcohol and other drugs on Queenslanders. The AOD Action Plan supports implementation of the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan) which aims to improve the mental health and wellbeing of Queenslanders. The Strategic Plan takes a collective impact approach for whole-of-government action to achieve its goal.

The AOD Action Plan adopts a harm minimisation approach and contains actions focused on demand reduction, supply reduction and harm reduction. It commits to 54 actions that will be implemented by agencies across the State Government, many in partnership with the non-government sector. The Commission is lead agency for Action 15 which is a commitment to:

Commence research to identify effective ways of reducing stigma and discrimination which has a negative impact on the mental health and wellbeing of people experiencing problematic drug use.

To progress this commitment the Commission sought to undertake research that would examine:

- how stigma and discrimination presents and manifests, including where it is not experienced
- the settings and sectors in which stigma and discrimination occurs, including but not limited to health services, housing, justice, education and employment, other social support services and in the broader community
- the impacts of stigma and discrimination on mental health and wellbeing and on recovery and the ability to reconnect with the community
- the commonalities and differences across varying types of drug use (for example alcohol versus illicit drug use)
- the commonalities and differences experienced by different groups who experience higher levels, or at greater risk, of problematic alcohol and other drug use, for example Aboriginal and Torres Strait Islander peoples
- the evidence of what works to address stigma and discrimination.

Research

In December 2016, the Commission engaged the Drug Policy Modelling Program, National Drug and Alcohol Research Centre at the University of New South Wales to undertake this research. The research team was led by Professor Alison Ritter, Director, Drug Policy Modelling Program with Dr Kari Lancaster, Research Associate, Drug Policy Modelling Program; and Dr Kate Seear, Australian Research Council Discovery Early Career Researcher Award Fellow and Senior Lecturer, Faculty of Law, Monash University.

In early discussions with the researchers and key stakeholders it was agreed that a separate project, specifically focused on the experiences and needs of Aboriginal and Torres Strait Islander peoples, would be undertaken. The Commission has committed to conduct research to identify the impact of stigma and discrimination related to problematic alcohol and other drug use, and the effect of related negative stereotypes, on the mental health and wellbeing of Aboriginal and Torres Strait Islander communities, families and individuals. This work commenced in July 2017 and is a commitment under Action 6 in *Proud and Strong: Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016–18*.

Additionally, early in the research it became apparent that poly-drug use (use of more than one type of drug) was very common. Therefore it was agreed that the researchers would not be able to include an examination of the commonalities and differences across varying types of drug use in their report (for example alcohol versus illicit drug use).

The final research report, *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use* (the research report) is available on the Commission's website at www.qmhc.qld.gov.au.

The Commission has accepted the research report, however, it does not necessarily reflect the views of the Commission or the Queensland Government.

Research methodology

The Drug Policy Modelling Program researchers' methodology included three inter-related elements:

1. A **literature review** involving analysis of international and Australian research relating to definitions of stigma and discrimination; manifestations and experiences of stigma; how stigma is experienced by people with a lived experience of problematic alcohol and other drug use; stigma and the law; and effective interventions to reduce stigma.
2. **Analysis of Queensland legislation** examining the stigmatising and/or discriminatory potential of legislative provisions that deal with alcohol and other drugs.
3. **In-depth qualitative interviews** with 21 people with a lived experience of problematic alcohol and other drug use, and analytical case studies based on the interviews. Interview participants were recruited through treatment services and needle and syringe programs across Queensland.

Consultation

This report is informed by the views expressed to the Commission by people experiencing problematic alcohol and other drug use, their families and friends, State Government and non-government organisations, and the Queensland Mental Health and Drug Advisory Council.

The Commission consulted the following State Government agencies to seek their views on the issues raised in the report:

- Anti-Discrimination Commission Queensland
- Department of Aboriginal and Torres Strait Islander Partnerships
- Department of Child Safety, Youth and Women
- Department of Communities, Disability Services and Seniors
- Department of Education
- Department of Employment, Small Business and Training
- Department of Health
- Department of Housing and Public Works
- Department of Justice and Attorney-General
- Department of the Premier and Cabinet
- Department of Transport and Main Roads
- Office of the Health Ombudsman
- Public Service Commission
- Queensland Corrective Services
- Queensland Police Service.

The Commission established a Project Advisory Group to provide advice and guide the Drug Policy Modelling Project's research project and development of this report. Membership included:

- Anti-Discrimination Commission Queensland
- Multicultural Development Association
- Queensland Indigenous Substance Misuse Council
- Queensland Injectors Health Network
- Queensland Health representatives from the Preventative Health Unit, the Mental Health Alcohol and Other Drugs Branch and Statewide Clinical Support Services
- Queensland Network of Alcohol and Other Drug Agencies.

Members were consulted at key milestones during the Drug Policy Modelling Program's research and on the draft of this report.

Key findings

Multifaceted and multilevel approaches are required to reduce stigma and discrimination. To bring about meaningful change there is a need to focus on changing the attitudes and behaviours of *individuals*, as well as *structural factors* that contribute to stigma and discrimination. Interventions that target only one element at a time are unlikely to bring about change because they fail to address broader contextual (and social) factors.

Different types of stigma can be experienced differently. It can be:

- felt (real or imagined)
- enacted (real experience for example job loss or social exclusion)
- internalised or self-stigma (negative attitudes or feelings arising from identification with a stigmatised group).

'Within group' stigma is another form of stigma, that is, where stigma is attached to different drug types or methods of use. This can result in stigmatising and discriminatory attitudes between people who use drugs. People who inject drugs are identified as the group most stigmatised. Stigma associated with heroin use is significantly higher that stigma associated with cannabis use.

Experiences of stigma and discrimination

Many people experiencing problematic alcohol and drug use also have other complex social needs. They may also experience issues such as, but not limited to, homelessness, mental health problems, health conditions such as hepatitis C and HIV/AIDS, or involvement with the criminal justice and/or child protection systems. Stigmas are associated with each of these areas and can compound to further marginalise people from their families and communities and entrench social disadvantage.

The Drug Policy Modelling Program researchers interviewed 21 people with a lived experience of problematic alcohol and other drug use. Experiences of stigma and discrimination were a common occurrence in their everyday lives. Multiple, specific examples of being treated badly, looked down upon and feeling judged were described by interview participants. The experiences had profound negative effects and often lead to exclusion and marginalisation. Stigma and discrimination made many people feel degraded, embarrassed, shamed and angry. Feelings of worthlessness and hopelessness were also common. For many, these feelings triggered further use of alcohol or other drugs or contributed to giving up on seeking changes in their lives, especially if it was experienced at the time of seeking help.

Research participants described experiences of stigma and discrimination across a range of settings: including family and social; health care; employment; police/public order; child services/legal/courts; other services; and in society at large.

Stigma and discrimination were found to be most pervasive in five settings:

1. Health care and public health
2. Welfare and support services, including housing
3. Police, public order and criminal law
4. Employment
5. Society at large.

Particularly stigmatising and discriminatory assumptions were reported by some participants who presented for medical care of a physical health condition. Stigmatising views of health care staff created barriers to appropriate pain management or diagnosis of physical ailments.

Participants had come to expect stigma and discrimination in many areas of their lives. However, the ways in which it stymied their careers or prevented them from getting work was reported as particularly distressing. Criminal histories related to past drug use was a difficult barrier to overcome for some: even when it wasn't relevant to the employment they were seeking.

A lack of understanding about problematic alcohol and other drug use led to negative stereotypes becoming dominant in interactions with families, friends and communities. Negative assumptions, such as people who use drugs being untrustworthy, violent or erratic, led to experiences of social exclusion, isolation and estrangement. This was reported as particularly hurtful when being excluded from significant social gatherings such as birthdays and weddings. These assumptions often continued after a person had stopped using alcohol or other drugs. Negative stereotypes were often reinforced by the media.

> ***"Constant experiences of exclusion, marginalisation, and discrimination impacted on participants' access to health care (including treatment) and other services, fair treatment in the justice system, employment opportunities, and impeded connection to family, friends and community. Importantly, these experiences shaped participants' sense of self-worth, and how they saw their place in the world."*** [6]

Where stigma and discrimination was not experienced

Few participants could describe situations where they had not experienced stigma or discrimination. However, interactions where stigma was not experienced were characterised by the provision of services in an understanding, inclusive, non-judgemental manner. In families, unconditional support was highly valued as a way of enhancing positive feelings of self-worth.

In health care settings it was characterised by feelings of 'being understood' and being cared for as a 'normal' person not as 'just a drug user' or 'just an alcoholic'. In workplace settings the provision of practical, empathic responses from employers that supported help seeking (such as granting leaves of absence or access to confidential counselling through employee assistance programs) were positively experienced.

Using stigma to create change

It is a common misconception that stigma and discrimination could be used in a positive way to discourage people from using drugs or as a public health 'tool'. However, there is no evidence to support that it is an effective deterrent to alcohol or other drug use. On the contrary, the harmful effects of stigma and discrimination are well documented and can impact different population groups disproportionately. An unintended consequence is the further marginalisation of some people or groups. This in turn can reinforce stigma and further entrench negative self-beliefs and barriers to supports.

The use of stigmatising imagery across a variety of media may further entrench stigmatising attitudes and inadvertently create barriers to people seeking help. Campaigns or resources that aim to stigmatise drug use and create fear to deter drug use, can lead to further separation and stigmatisation of people who use drugs. Extreme and stigmatising images may have the unintended effect of preventing people from seeking help, or distance people from the key message of harm reduction.

Legislative analysis

Queensland law was analysed by the Drug Policy Modelling Program with a view to assessing its stigmatising and/or discriminatory potential, which was defined for the purposes of this study as: *the enabling conditions for the manifestation of stigma and/or discriminatory practices*.

It was found that:

- A total of 222 provisions across 11 different areas of law were identified as relevant in some way to people who experience problematic alcohol and other drug use.
- The domains of substantive criminal law, employment law and professional regulation, public health, and public order contained the most provisions.
- The provisions convey decision-making powers and/or authority to a wide range of decision-makers, bodies and authorities. In some instances, these decision-makers are familiar, highly trained and regulated (for example, police) but in others, powers are conferred upon private citizens and organisations who may be less familiar, trained or versed in the exercise of power (for example: mining operators, employers, sellers of goods).
- 67 per cent of the provisions did not clearly define the targeted practice, activity or behaviour. The absence of clear definitions may allow for highly subjective and variable assessments to be made by decision makers. Approximately one third (30.9 per cent) of the provisions were found to not include clear legal protections.

Options for reform

The Commission identified 18 options for reform designed to reduce experiences of stigma and discrimination by people experiencing problematic alcohol and other drug use in Queensland.

The options for reform are divided into six key domains:

Domain 1: Human rights

Human rights belong to everyone and respect for human rights is fundamental to supporting recovery of people experiencing problems with alcohol and other drug use. Those rights include, but are not limited to: a right to respect and dignity as an individual, prohibition of inhuman or degrading treatment, and equitable access to health care of appropriate quality. A Human Rights Charter is one mechanism through which widespread structural stigma and discrimination can be alleviated.

On 3 December 2015, the Queensland Legislative Assembly directed the Legal Affairs and Community Safety Parliamentary Committee to inquire into whether it is appropriate and desirable to legislate for a Human Rights Act in Queensland. Following extensive public consultation, the committee delivered the Legal Affairs and Community Safety Committee's Report No. 30, *Inquiry into a possible Human Rights Act for Queensland* on 30 June 2016. The committee was unable to agree on whether it would be appropriate and desirable to have a Human Rights Act in Queensland.

On 29 October 2016, the Honourable Annastacia Palaszczuk MP, Premier and Minister for Trade announced the Queensland Government's commitment to introducing a Human Rights Act to protect the rights of all people in Queensland, including the most vulnerable.

The Queensland Government is working to deliver this commitment and will be continuing to consult with stakeholders on the content. It is anticipated the legislation will be modelled on the Victorian *Charter of Human Rights and Responsibilities Act 2006.* Once legislation for a *Human Rights Act* is introduced into the Queensland Parliament, it will be referred to a Parliamentary Committee for consideration and members of the public will be able to provide further comment.

What is needed

There is a need to better protect the human rights of people experiencing problematic alcohol and other drug use. The Commission has advocated for a Human Rights Act that better enables people to enforce their human rights; one that includes economic, social and cultural rights, such as adequate health care, education and housing; and one that applies to organisations funded by Government to deliver services, as well as government agencies.

The introduction and passage of human rights legislation will send a message that Queensland values and protects the rights of all members of the community. This is an important and significant step towards greater human rights protections for all Queenslanders. It may alleviate or reduce potential for stigma or discrimination in the implementation of laws that do not clearly define the targeted practices, activities or behaviours.

> **Option 1: The Queensland Government progress the introduction of a Human Rights Act for Queensland.**

Domain 2: Social inclusion

Social connectedness and strong positive social identities have profound protective effects on individual health and wellbeing[7]. Conversely, loss of social identity and social status through experiences of stigma and discrimination can affect individual sense of belonging, self-esteem, agency and purpose.

Positive experiences of services or engagement with family, friends and the broader community were characterised by a sense of 'inclusion' by individuals consulted as part of the Drug Policy Modelling Program's research. Positive experiences with service providers made people feel 'normal' and that they were treated with dignity and respect.

Actions that change stigmatising and discriminatory attitudes can enhance the social inclusion of people experiencing problematic alcohol and other drug use. They can support people to access the social supports and services they need and can improve the outcomes of a person's experiences and treatment, as well as improve their mental and physical health.

Changing professional behaviours that may stigmatise people can be accomplished by:

- increasing awareness of stigmatising aspects of clinical or organisational practice
- meaningfully involving service users and family members
- taking on a public advocacy role in challenging stigma (and seeing this as part of the profession)
- campaigning at a policy level for adequate clinical resources and research in the field. The existing evidence on effectiveness of these interventions shows that workplace education, without organisational support is ineffective.

Community-based interventions that are designed to reduce stigma among family members and others closest to those affected by stigma and discrimination can help increase knowledge, equalise the relationships and promote closer connections. Programs in the HIV field have been shown to reduce experiences of stigma for people living with HIV by changing the attitudes of those close to them.

What is needed

Anti-stigma awareness training

Anti-stigma awareness training across all relevant workforces has been identified as key to increasing knowledge and reducing stigmatising attitudes. To be most effective training needs to be supported by organisational change and leadership.

The Australian Injecting and Illicit Drug Users League (AIVL) developed the 'Putting Together the Puzzle' national anti-stigma training package for use within health care contexts. The training module and supporting resources have been rolled out by state and territory drug user organisations. In Queensland, training has been delivered to a wide variety of government and non-government agencies, including the Pharmacy Guild by the Queensland Injectors Health Network and the Queensland Injectors Voice for Advocacy and Action. Some government agencies, including the Queensland Police Service and the Department of Child Safety, Youth and Women (child safety staff) undertake alcohol and other drug-related training developed within their departments.

A training package that combines the provision of information with skill-building will increase workforce capability to work with people experiencing problematic alcohol and other drug use and their families: it will also increase capability of those who are developing policies or legislation. There is an identified need for a structured training package that can be developed and delivered in partnership with people with a lived experience; be delivered via a variety of modalities; and can be tailored to unique audiences, settings and drug types. A detailed needs assessment is required to identify the unique needs of each service sector workforce and what type of training package is required. The development of a

Queensland Government endorsed workforce training package could be incorporated into existing agency training programs and professional development strategies.

Option 2: The Queensland Mental Health Commission identify and promote effective anti-stigma training activities and resources, including examination of the 'Putting the Puzzle Together' anti-stigma program that has been delivered in Queensland.

Option 3: All social service sector workforces, including health, housing, child safety and justice, build staff capacity to recognise and reduce stigma and discrimination by providing ongoing training and professional development opportunities. Anti-stigma training should be:

- delivered in partnership with people with a lived experience of problematic alcohol or other drug use
- targeted to the relevant audience/s.

Information and marketing resources

The development and promotion of information materials can help to reduce stigma associated with alcohol and drug use and accessing treatment services. Factual and credible messages targeted to people experiencing problematic alcohol and other drug use, their family and friends and the broader community can help to increase awareness that can foster greater inclusion and reduce stigmatising attitudes.

Stigma can also be experienced by the family members of people experiencing problematic alcohol and other drug use and result in negative effects on their health and wellbeing. People have reported that some family members hold stigmatising attitudes that have led to estrangement and status loss within the family structure.

Increasing access to and expanding the range of alcohol and other drug service options for family support programs and services is a priority in Queensland Health's *Connecting care to recovery 2016–2021: A Plan for Queensland's State funded mental health, alcohol and other drug services (Connecting Care to Recovery)* [8].

Family Drug Support Australia is a non-government organisation providing support to family members impacted by alcohol and other drugs. The Queensland Government has recently provided new funding to Family Drug Support to expand their support services for Queensland families, including those in the child protection system to overcome issues associated with crystal methamphetamine use. Workforce education and training in family-inclusive practice for alcohol and other drug treatment services is being implemented in 12 locations across Queensland by Dovetail, an initiative funded by Queensland Health.

However, there continues to be a need to explore how to better support family members with information resources that help negate negative stereotypes and increase their knowledge and understanding of support that is available to them.

Option 4: To contribute to decreasing stigma and discrimination associated with help-seeking, Queensland Health explore implementation of strategies to ensure credible, factual and positive information about alcohol and other drugs, and how to access support and treatment is readily accessible to the general public. Information should be tailored for:

- **population groups at higher risk of problematic alcohol and other drug use**
- **families and friends of people experiencing problematic alcohol and other drug use**
- **the general population to counteract stigmatising attitudes and normalise help seeking from available services.**

Media

For individuals, stigma reduction interventions can be universal (whole-of-population approach) or targeted and delivered in specific settings. The media, including social media, can play an important role in conveying messages that increase knowledge and understanding about alcohol and other drugs, dependency and recovery: thus reducing levels of fear, blame and stigmatisation.

Universal prevention messages are an important prevention and early intervention strategy to reduce harms from alcohol and other drug use. However, research [9] indicates that fear-based campaigns and shock-based imagery can reinforce stigmatising attitudes in the general population. The potential for campaigns to contribute to stigma and discrimination, and consequently exacerbate the negative effects on people who use drugs, requires careful consideration in the design of a campaign.

Reducing stigma associated with media reporting, including social media, was identified as a key issue. Educating the media on responsible reporting of information was identified as a strategy to reduce stigma and discrimination. Mass media campaigns should use images and messaging that promote hope and portray people who use drugs as everyday human beings. Frightening and stigmatising imagery is ineffective and presents a significant risk that the target audience do not relate to, or see these images as relevant to their personal experience.

Wherever possible, individuals and family members who have a lived experience of problematic alcohol and other drug use, and subject matter experts should be consulted in the development of media campaigns.

> **Option 5: The Department of the Premier and Cabinet ensure that Queensland Government mass media campaigns are based on evidence and reinforce positive messages that people can and do recover from problematic alcohol and other drug use.**
>
> **Option 6: The Department of the Premier and Cabinet and Queensland Health, in partnership with key stakeholders, explore options for the development of an evidence-based mass media campaign to reduce stigma and discrimination experienced by people who use alcohol and other drugs.**
>
> **Option 7: The Queensland Mental Health Commission, in partnership with key stakeholders, will investigate the development of an evidence-based media resource designed to improve media coverage of issues related to alcohol and other drug use.**

Domain 3: Engaging people with a lived experience and their families

Stigma and discrimination are specific barriers to engagement with people who use alcohol and other drugs. The illegal nature of some drugs acts as an additional barrier to engagement and participation.

The involvement of people with experience of problematic alcohol and other drug use, as well as their families and supporters is an important consideration for organisations. The levels or types of involvement may vary, from seeking feedback, to full participation in the organisation's decision-making and governance processes. Meaningful, quality engagement at strategic and operational levels can help challenge discriminatory or ill-informed opinions and reduce stigma. Meaningful engagement may include the adoption of the principle of 'co-design' involving people with a lived experience in developing, implementing and evaluating policies, programs and services. The participation of people with a lived experience should be part of the core business for services that regularly engage with people experiencing problematic alcohol and other drug use.

A number of policies and procedures, including the *National Safety and Quality Health Service Standards*[10], require public health services to engage with people who use their services. There have been limited resources available to guide services on how to engage effectively.

In 2016, Queensland Health published *Project Gauge alcohol and other drugs client engagement and participation toolkit*[ii]. The toolkit provides specific online training modules targeted to Queensland public health alcohol and other drugs services. It aims to support services to create partnerships with their clients and improve the safety and quality of care.

What is needed

In 2017, the Commission published the *Stretch2Engage Service Engagement Framework for Mental Health and Alcohol and Other Drug Services*[11]. The Stretch2Engage framework was developed on behalf of the Commission by the Queensland Alliance for Mental Health, in partnership with the Queensland Network of Alcohol and other Drug Agencies and Enlightened Consultants. It sets out draft best practice principles to guide agencies about meaningful engagement with people with a lived experience, their families and friends. Stretch2Engage is founded on values which acknowledge engagement of people with lived experience, their families and friends, as a human right fundamental to citizenship. It also sees engagement as being important in its own right while acknowledging the benefits to services who engage effectively.

> **Option 8: To improve and increase the meaningful engagement of people with a lived experience of problematic alcohol and other drug use, their families and friends, the Queensland Mental Health Commission will pilot and evaluate the Stretch2Engage framework in partnership with alcohol and other drug services.**

Peer workforce

The development of a peer workforce has been identified as an effective strategy to help to reduce stigma and discrimination. Peer workers can assist those seeking help to navigate service systems, provide a 'lived experience' perspective that can engender trust and engagement and help reduce self-stigma by providing positive role modelling and non-judgemental supportive professional relationships. Pockets of good practice exist in Queensland, for example, the Queensland Injectors Health Network's peer-led service and the Queensland Injectors Voice for Advocacy and Action, a peer-based drug user organisation that employs people with a lived experience. However, there is need to adopt a systemic approach across the whole service system.

There is a clear need to increase and strengthen the peer workforce by including a focus on organisational cultures and policies that acknowledge the role of peers in supporting recovery and provide access to training for their specific needs.

Further analysis and scoping of the concept of peer involvement in the context of the alcohol and other drug sector is needed. There is a necessity for adequate safeguards and protections of the rights of people who choose to use illegal drugs and who wish to contribute to breaking down stereotypes and stigma. Identification as a peer may unintentionally place people at risk of further stigmatisation and/or discrimination which may impact on their workplace or private lives.

Queensland Health is progressing work to establish and enhance mechanisms for the engagement and participation of people with a lived experience of problematic alcohol and other drug use in policy and service planning, including any actions designed to reduce stigma and discrimination. The *Mental Health Alcohol and Other Drug Workforce Development Framework 2016–2021*[12] released in October 2017 provides an opportunity to further consider development of the alcohol and other drug peer workforce. Peer workforce development activities should encompass the views of current peer workers, people with a lived experience of problematic alcohol and other drug use and their families.

> **Option 9: To support stigma reduction, Queensland Health explore a range of strategies to enhance the engagement of individuals and families with a lived experience of problematic alcohol and other drug use in policy and service planning.**

[ii] The Project Gauge alcohol and other drugs client engagement and participation toolkit is available online at http://insightqld.org/project-gauge/

Rights and responsibilities

Clear and accessible information about an individual's rights and responsibilities when receiving a service would support them to exercise those rights. Provision of a clear guide about rights and responsibilities in relation to that service would reinforce for people, especially those who hold self-stigmatising attitudes, that they are entitled to seek and receive appropriate care and treatment.

Consumer rights are protected in the Queensland Health system and are set out in the Australian Charter of Healthcare Rights. The Charter was developed by the Australian Commission on Safety and Quality in Healthcare and describes the rights of patients and other people using the Australian health system. It articulates, among other rights, that all participants in the healthcare system are entitled to be treated with respect and not be discriminated against in any way. The individual accessing the healthcare system, the healthcare provider and the health service organisation all have a role to play in ensuring that care is provided in a respectful, non-discriminatory manner.

Robust safeguards that enable people to make complaints about stigmatising or discriminatory practice need to be in place. Importantly, individuals need to be aware of their rights and, where needed, be supported to understand and enact their rights.

Stigma (real or imagined) and self-stigma contribute to people with a lived experience not making formal complaints. Peer workers can have an important role in informing others about their rights and responsibilities, including helping individuals to exercise those rights by, for example, assisting them to navigate formal complaint mechanisms. An example of good practice is the Queensland Pharmacotherapy Advocacy and Mediation Service (QPAMS) which is a peer based service supporting Queenslanders who are on opioid treatment to address any issues or complaints they have with the opioid treatment system.

The development of the *Statement of Rights* for patients of Queensland mental health services, their families, carers and other support persons outlines information about rights under the *Mental Health Act 2016*[iii]. The Statement sets out rights and responsibilities and how people can access support through Independent Patient Rights Advisors.

> **Option 10: Health care service providers identify the rights and responsibilities they have adopted, and how they are promoted to people accessing their services, their staff, and their organisation as a whole. Should gaps be identified, develop and promote a statement of rights and responsibilities, ensuring that they are inclusive of people experiencing problematic alcohol and other drug use. An active awareness and promotion campaign should accompany the statement of rights and responsibilities to ensure that people who access the service can enact their rights.**

Domain 4: Access to services (health care and social services)

As addressed in the human rights section, all people who experience problematic alcohol and other drug use have a right to respect and dignity as an individual, and a right to services that support their recovery.

Frontline service providers (such as emergency services, child protection, housing service centres, correctional services and domestic and family violence services) are often the first point of contact for people experiencing problematic alcohol and other drug use. The quality of the interactions between the staff and an individual is critical to supporting them in their recovery and for enabling access to a range of services across the continuum of care.

[iii] The Mental Health Act 2016 is available online at https://www.legislation.qld.gov.au/view/html/asmade/act-2016-005

This includes the:

- quality of the service provision (including an absence of stigma and discrimination)
- quality of the service environment
- quality of referral processes
- ability of a person using a service to be able to report their experience (positive or negative) back to the agency to support ongoing service improvement.

The provision of anti-stigma awareness training, as outlined in option for reform number two, is intended to support greater access to health care and social services by addressing stigma and discrimination with a wide range of frontline service providers. Training is intended to change individual attitudes and behaviours as well as to positively influence organisational culture. Training should not be considered a solution in isolation from broader organisational change.

Alcohol and other drug services

Alcohol and other drugs services delivered by Queensland's public health service system are guided by the *Alcohol and Other Drug (AOD) Services Model of Service (Companion Document)*[13] published by Queensland Health in 2016. The Model of Care is informed by the *Queensland Alcohol and Other Drugs Treatment Service Delivery Framework*[1] (the Treatment Service Delivery Framework) which was developed in 2015 by a partnership of statewide alcohol and other drugs government and non-government agencies, and the *Queensland Health Clinical Services Capability Framework v3.2*[14][iv] (2016).

The model of service provides a detailed description of the alcohol and other drug services to be delivered. It includes a commitment that the Hospital and Health Services alcohol and other drug service functions will work towards decreasing stigma and discrimination within the local community, as well as reducing barriers to social inclusion. Additionally, it states that the Hospital and Health Services alcohol and other drug services will be able to, among other things:

- provide information, advice and support to families and significant others
- establish a detailed understanding of local resources for the support of people directly and indirectly affected by substance use
- appropriately involve individuals and their families and/or significant others in all phases of care, and support them in their navigation of the alcohol and other drug system
- convey hope, optimism and education in the management of substance use issues and harm reduction to clients, their significant others and the wider community
- promote and advocate for improved access to general health and the primary health network for people experiencing problems related to substance use.

The Treatment Service Delivery Framework explicitly notes that effective alcohol and other drug treatment services are safe, welcoming and non-stigmatising. The sector's practice values include non-discrimination, respect and dignity, compassion, non-judgement, empowerment, client-centred practice, strengths-based practice, holistic care, inclusivity, accessibility, flexibility and responsiveness. Challenging current stigma around the alcohol and other drug client population is identified as a future direction for the alcohol and other drug sector in Queensland.

[iv] The Queensland Health Clinical Services Capability Framework v3.2 (2016) outlines minimum requirement for the provision of health services in Queensland public and licensed private health facilities. This includes ambulatory, emergency and inpatient alcohol and other drug services. For more information see: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/about

Additionally, the Treatment Service Delivery Framework outlines shared objectives, including:

- Build the client's capacity to better understand and manage their own health and wellbeing
- Improved physical and mental health
- Improved resilience, confidence, self-esteem and sense of self-worth.

What is needed

Service environments

Many agencies put effort into making their services appealing and welcoming spaces that reflect how their clients are valued. The Commission encourages agencies to actively consider how they can improve the physical environment of treatment service settings to reduce the stigma often associated with these spaces. Provision of physical settings of a standard at least equivalent to other specialist health care settings can help reduce self-stigma and discriminatory community attitudes.

> **Option 11: Health care and social services, across a range of settings, work to ensure that a welcoming environment that respects the dignity and worth of all clients, including people with a lived experience of problematic alcohol and other drug use is provided. This may include:**
>
> - **funding bodies identifying and promoting opportunities for services to seek funding for design and infrastructure improvements**
> - **services undertaking, or applying a risk analysis to ensure service environments, including the physical design, to meet the relevant standards of safety and amenity for staff and clients**
> - **input from service users and their families to identify and implement strategies to improve service environments.**

Understanding barriers to services

To drive service quality improvement and identify barriers and solutions to issues such as stigma and discrimination, there is a need to regularly capture information from the people who use the services.

Effective and accessible complaint processes are very important to identify individual and systemic issues. A systematic audit of complaint mechanisms in health care settings is impractical, especially for non-government agencies that may lack the resources to undertake an audit. A focus on client satisfaction measures and meaningful feedback mechanisms may be more likely to identify client complaints and help shape formal complaint mechanisms.

The Queensland Alcohol and Other Drug Sector Network, in partnership with alcohol and other drug treatment services, is developing a treatment and harm reduction outcomes framework (the Outcomes Framework) to support: continuous improvement of interventions delivered; organisational improvements that make alcohol and other drug services more accessible; and system-level investment decisions to reduce alcohol and other drug related harm. The Outcomes Framework is due to be released in 2018 and will provide guidance to alcohol and other drug treatment services in Queensland. It will complement the Treatment Service Delivery Framework.

Access to more and different alcohol and other drug treatment services

Primary health care providers such as general practitioners may be the first point of contact for people experiencing problematic alcohol and other drug use, or their families. They may provide ongoing care in partnership with specialist alcohol and other drug service providers, particularly for people living in rural and remote areas. For some, an increase in drug treatment through primary care settings can reduce stigma associated with specialist alcohol and other drug treatment services. Greater integration between

primary care, specialist care and social services, with continuity of care across service types, may help to address stigmatising views held by some workers.

The Queensland Department of Health, Hospital and Health Services and the Primary Health Networks all have significant roles to play in planning, funding and delivering alcohol and other drug services in Queensland. Queensland Health's *Connecting Care to Recovery* seeks to invest in building the capacity of the alcohol and other drug service system to better meet the existing demand and expand access to integrated, flexible treatment options across the care continuum. Hospital and Health Services design and deliver specialist alcohol and other treatment services in the Queensland public health system. Each Hospital and Health Service works collaboratively with a range of local partners, including primary health care. The Primary Health Networks have a significant role in coordinating primary health and non-government services at a regional level, including the commissioning of further drug and alcohol treatment services to meet local need. Better coordination and integration of these parts of the system will support greater investment in, improved accessibility to, and greater visibility of, alcohol and other drug treatment services.

> **Option 12: To enhance integration and improve pathways across the care continuum the Department of Health, Hospital and Health Services and Primary Health Networks increase joint planning and investment activities, across the full spectrum of alcohol and other drugs services including family support.**

The provision of innovative harm reduction strategies, particularly in relation to illicit drugs, is a strategy to reduce stigma and discrimination. There have been calls internationally, nationally and within Queensland to consider new and innovative harm reduction strategies to prevent overdoses and save lives. Examples include drug testing at events or early warning systems. These types of harm reduction activities enable practical and non-judgemental engagement, and opportunities for brief interventions or referrals to treatment.

Evidence suggests that safe injecting facilities do support reduced harms[16, 17] however, this type of intervention is best introduced where there is evidence of high levels of street based injecting drug use or high levels of overdose deaths. The Medically Supervised Injecting Centre was established in 2001 in Sydney, New South Wales, and the Victorian government will trial a medically supervised injecting room in Richmond in 2018.

The introduction of these types of measures is not current Queensland government policy.

There is a need for further in-depth discussions on the most effective, innovative and least stigmatising strategies to reduce harms associated with illicit drug use in Queensland.

> **Option 13: Queensland Health and the Queensland Police Service give further consideration to the development of new, evidence-based, innovative harm reduction strategies in Queensland.**

Domain 5: The justice system

Policy and legislation

Structural factors that influence stigma and discrimination include legislation, and organisational policies and practices.

The law articulates societal values and norms. The Drug Policy Modelling Program's report notes that policy and law have an important role in both protecting people from stigma (for example anti-discrimination legislation) and in producing stigma (by "branding certain practices as deviant or illegal").

The legislative analysis component of the Drug Policy Modelling Program's research highlighted that laws have the potential to be stigmatising and/or discriminatory, especially where practices, activities and behaviours are not clearly defined. Where clear definition is lacking there is usually a requirement for a judgement to be made by a decision-maker or authorised person. The training and skills of those empowered to make decisions can vary greatly, from those who are highly trained and regulated, to those who have received little training or guidance.

When developing policy and legislation it is important that the target of the legislation, the activity and the behaviours are very clearly defined. This may reduce the potential for inconsistent interpretation and application of the law. This clarity will aid in the operationalising of policies and legislation and mitigate risks associated with individual interpretation in their implementation.

There is a need to assess existing legislative provisions in view of their potential to be stigmatising and discriminatory as part of legislative reviews. The drafting of new policy and legislation should include mechanisms to avoid stigmatising effects.

In Queensland, the Office of the Queensland Parliamentary Counsel has a statutory function to advise on the fundamental legislative principles, including the rights and liberties of individuals, in the context of legislative proposals. The Queensland Legislation Handbook outlines the legislative processes and explains what is needed in drafting instructions for Acts of Parliament and subordinate legislation. It is designed primarily for use by policy or instructing officers to help them work effectively with the Office of the Queensland Parliamentary Counsel.

> **Option 14: The Queensland Government introduce processes that require an assessment of potentially discriminatory provisions as part of law reform and legislative review projects, for example by including a requirement in the Queensland Legislation Handbook.**
>
> **Option 15: Relevant Government agencies introduce or include processes and/or training programs for policy makers and legislators to ensure the potentially stigmatising and discriminatory effects of legislation, and suitable ways to achieve stigma reduction in laws, are considered.**

Legal reform

Drug law reform is a contentious issue in Australia. Drug law reform advocates identify that the criminalisation of drugs, especially in small quantities for personal use, has been unsuccessful in reducing harms, and that involvement in the criminal justice system is a social harm in its own right[18] .

The Drug Policy Modelling Program reports that much of the stigma and discrimination documented through their research is associated with the fact that the personal consumption of drugs is a criminal offence. Many people report that a past criminal record for drug use/possession reduces their chances of reintegration into society, for example by limiting opportunities for work.

Decriminalisation of personal use/possession provides the opportunity for a health—rather than criminal justice—response and facilitates greater treatment seeking and opportunities for recovery. It is noted that the stigma of a criminal record can continue through life, long after treatment has been sought and drug use has stopped. Reconnection to work and family is often a motivator in treatment, and is key to enhancing social inclusion, however motivation can be impeded by the legacy of a criminal history.

The Queensland Government currently does not intend to change the existing laws contained in the *Drugs Misuse Act 1986* in relation to the personal use and possession of dangerous drugs. The Government does however, where appropriate, seek to divert minor drug offenders from the criminal justice system through several court and non-court based diversion programs, such as the Queensland Police Service's cautioning program for minor cannabis offenders. In keeping with a harm minimisation approach, the commitment to increase diversion of minor drug offenders away from the criminal justice

system and into health-based services is positive. Strong partnerships between the health and justice systems have been key in reducing harms associated with alcohol and other drug use in Queensland.

These strong partnerships are also reflected in the re-establishment of the Queensland Drug and Alcohol Court which commenced operation on 29 January 2018. Based in Brisbane, the Court provides an intensive and targeted response to adults with severe alcohol and other drug use directly associated with their offending. The Court works with a network of referral and support services in Brisbane with a view to improving community safety. The Court provides a therapeutic environment where people can be diverted from the criminal justice system to treatment for their alcohol or drug dependency, and be supported in their recovery.

Additional to the establishment of the Queensland Drug and Alcohol Court, the Courts Innovation Program within the Department of Justice and Attorney-General, is undertaking several projects relevant to reducing stigma and discrimination. They include commitments to:

- Continue to divert minor or moderate illicit drug offenders from the criminal justice system to assessment, education and treatment programs through the Police Diversion Program and the Illicit Drugs Court Diversion Program.
- Provide assessment and education sessions to people over 18 on bail offences committed in a public place while being adversely affected by an intoxicating substance through the statewide Drug and Alcohol Assessment Referral Program.
- Reinstate the Murri Court and the Special Circumstances Court Diversion Program (commenced in 2016).
- Continue to support the Queensland Magistrates Early Referral into Treatment (QMERIT) Program in Maroochydore and Redcliffe.

Public health

Laws relating to public health were identified as potentially stigmatising for people experiencing problematic alcohol and other drug use, especially those who also have acquired notifiable conditions such has hepatitis C or other blood borne viruses.

The potential for stigma and discrimination increases where an individual is identified as being an injecting drug user within the 'notifiable conditions' sections of public health law. However, provisions related to public health are necessary in the interest of broader public health. In the administration of public health legislation, Queensland Health employees are bound by information confidentiality provisions under the *Public Health Act 2005*[v] and the *National Code of Conduct for Health Care Workers*. Option for reform number two relates to anti-stigma awareness training would serve to reduce the risk of stigmatising behaviour by health professionals. The promotion of complaint mechanisms would support individuals to make complaints where stigma or discrimination occurs or where the *Public Health Act 2005* or the Code of Conduct is breached.

Similarly, there is a need to address the *transmission of serious diseases with intent* in the Queensland *Criminal Code 1899*[vi] to provide protection to people from grievous bodily harm. The potential stigmatising effect of provisions in the Criminal Code (for example section 317(b)) is limited to potential offenders who intentionally transmit their illness to others. The provisions are necessary as they describe offences that can carry significant risks for the general public. The *Public Health Act 2005* manages people living with blood borne viruses under the *Guideline for the Management of People Living with HIV who Place Others at Risk of HIV*. Anti-stigma training can help address the potential for stigma and discrimination against any person who is within the criminal justice system.

[v] The *Public Health Act 2005* is available at https://www.legislation.qld.gov.au/view/html/inforce/current/act-2005-048

[vi] The *Criminal Code 1899* is available at https://www.legislation.qld.gov.au/view/html/inforce/current/act-1899-009

Police interactions

Frontline police have thousands of interactions with community members each year and many of these interactions are with people who experience problematic alcohol and other drug use, both as victims of crime and offenders: and many are in distress. Positive interactions with police can make a big difference to connecting people to assistance and support, and diversion from the criminal justice system. People who use drugs have reported both positive and negative (stigmatising and discriminatory) interactions with police arising from a wide-range of interactions.

The Queensland Police Service utilises the Police Referrals System to refer people to health and social support services including those that offer drug and alcohol treatment, community support, disability services, domestic violence, family and youth services, health and wellbeing, homelessness, legal, seniors and victim support. Locally-led partnerships between the Queensland Police Service and social service providers are in place throughout the state. The relationships may vary in each location.

Queensland Police must comply with a range of accountability and transparency measures which include the use of body worn cameras and a requirement to abide by all relevant legislation, awards, certified agreements, subsidiary agreements, directives, whole-of-government policies and standards.

The Queensland Police Service Client Service Charter[19] outlines that police will:

- treat people fairly
- deliver services professionally, ethically and with integrity
- recognise and respect individual rights and needs
- refer to an appropriate agency if they cannot deal with a matter themselves.

Complaints about harassment or discrimination can be made by the public at a local police station, or for serious matters related to police misconduct, oversight is provided by the Police Ethical Standards Command and the Crime and Corruption Commission Queensland.

Queensland Police Service have advised that they do not target or conduct surveillance on needle and syringe facilities or health care services, unless a public safety risk is identified: for example, where people have arrived or attempted to leave needle exchange facilities in-charge of a motor vehicle whilst intoxicated. Police are instructed not to detain or search people utilising needle exchange facilities and there is widespread awareness of the role of needle exchange facilities as part of broader harm reduction strategies. The Queensland Police Service Operational Procedures Manual addresses the targeting of individuals using needle exchange facility services. Where it is identified that police are potentially in breach of policy, officers are provided guidance and education in relation to the policy and the intent of the harm reduction strategy. The Queensland Police Service prioritises serious and organised crime, including drug trafficking and supply offences.

What is needed

The Commission has heard widespread agreement that there needs to be a continued focus on criminal justice diversion programs that appropriately divert people to the health care system.

Further, the Commission would like to open a dialogue in Queensland about the benefits, disadvantages and implications of the decriminalisation of the personal use or possession of illicit drugs. The conversation would consider current models in operation, such as in Portugal, and the elements that may be relevant to Queensland's context.

To support appropriate referrals and inter-agency work there is a need for continued development of locally-led interagency partnerships between non-clinical and clinical supports, including the Queensland Police Service, to reduce alcohol and other drug-related harms and to support a person's recovery goals.

The Commission supports the continued utilisation of the Police Referrals System to strengthen the broader system of support for police and people with a lived experience. The building of relationships between police and people with a lived experience of problematic alcohol and other drug use can be supported by anti-stigma awareness training and enhanced relationships with local peer led organisations.

Option 16: The Queensland Mental Health Commission initiate discussions about the risks and benefits of decriminalisation for personal use and/or possession of illicit drugs, similar to other countries.

Option 17: The Queensland Police Service develop and deliver anti-stigma awareness training for frontline police officers in collaboration with alcohol and other drug subject matter experts.

Domain 6: Economic participation

Economic security is a key protective factor from harms associated with problematic alcohol and other drug use. Being able to find and maintain a job is an integral part of recovery for many people. However, stigma and discrimination can have a significant impact on people experiencing problems with alcohol and other drug use finding employment or gaining a promotion, particularly if they disclose their history of problematic drug use. For some, their criminal history associated with previous drug use is a barrier. For others, fear of employment problems and legal penalties were reported as a barrier to disclosing problems with alcohol or other drug use to employers.

Self-stigma shapes the way a person sees themselves and their sense of value and worth, and can impact negatively on an individual's behaviour: for example, by not actively engaging in seeking employment. Alcohol and drug related barriers to securing employment can discourage people from making positive life changes and reinforce self-stigmatising views.

Improved collaboration and coordination between the private sector, government and non-government agencies to enhance pathways to employment for people who are exiting treatment services would enable greater participation in the workforce. For people who are accessing treatment through publicly funded alcohol and other drug services, active treatment and discharge planning should include aftercare and post treatment support, which includes services to support engagement in education, training and employment.

The Queensland Government's *Skilling Queenslanders for Work*[vii] initiative supports disadvantaged Queenslanders to get back into the workforce through targeted skills and training programs. The initiative focuses on individual skill development and addresses barriers to getting and maintaining employment.

Many people experiencing problematic alcohol and other drug use are employed and participate meaningfully in the workforce, across a wide range of sectors. Some professions and sectors have clear regulations related to workplace health and safety which encompass alcohol and drug related issues. These regulations are clearly needed and are important measures to protect the safety and wellbeing of individuals and communities. For example, the *Mining and Quarrying Safety and Health Regulation 2001*[viii] contains a provision that prohibits a person carrying out operations at a mine, or to enter an operating part of a mine, if the person is under the influence of alcohol, or is impaired by a drug, to the extent the alcohol or drug impairs, or could impair, the person's ability to safely carry out their duties at the mine. Employers have a duty to: provide a safe and supportive workplace that does not create a risk

[vii] Information about Skilling Queenslanders for Work is available online at https://training.qld.gov.au/community-orgs/funded/sqw

[viii] The *Mining and Quarrying Safety and Health Regulation* is available online at https://www.legislation.qld.gov.au/view/pdf/inforce/2016-07-01/sl-2001-0017

of harm to employees; manage the work performance of their employees; and ensure they are fit for duty. There is a need to balance workplace health and safety obligations, employee privacy and supportive workplace practices.

What is needed

Where an employee is identified as experiencing problematic alcohol or other drug use or self-discloses, workplaces can be an avenue for support and help. Employers can play a positive role by implementing workplace laws, policies and professional regulations in a non-stigmatising, non-discriminatory way.

This includes using factual language in conversations and personnel files, and maintaining the privacy and confidentiality of the employee's difficulties. The delivery of anti-stigma awareness training to employer groups and human resource practitioners would build capability to identify and appropriately support employees experiencing problematic alcohol and other drug use.

Where pre-employment screening is conducted, employers should consider whether the past offence/s are relevant to the employment being offered. Stigmatising attitudes toward criminal histories for personal use or possession of drugs can act as a barrier to employment and economic participation in society.

To support employees to retain their employment throughout their recovery journey, employers can actively promote access to information and support, and provide flexible workplace practices such as leaves of absence to seek help, reasonable adjustment of duties and return to work programs. Information materials for employee assistance programs should clearly identify that they can assist with alcohol and drug related issues, should employees wish to access them confidentially: a range of support options should be promoted to employees.

Option 18: Employers, across all sectors, should ensure that support is available for people in the workplace who are experiencing problematic alcohol and other drug use. This includes:

- **having information about options for assistance and support readily available for both employees and managers dealing with alcohol and other drugs in the workplace**
- **promotion of, and confidential access to, counselling and support services**
- **provision of flexible workplace policies and practices such as leaves of absence to seek help, reasonable adjustment of duties and return to work programs.**

Conclusion

The Drug Policy Modelling Program have provided the Commission with a report that gives an evidence-based analysis of experience of stigma and discrimination for people experiencing problematic alcohol and other drug use in Queensland. The report shows that stigma and discrimination does not support individuals to positively change their behaviours and reduce the harms experienced by themselves, their families, friends and the community. In fact, stigma and discrimination is a harm in its own right.

Through the 2017 state-wide consultations to renew the Strategic Plan, the Commission has heard from hundreds of Queenslanders. Stigma and discrimination has been consistently raised as an issue. In keeping with the renewal of the Strategic Plan, the Commission will work with other agencies: to reduce stigma and discrimination by shaping a service system that puts people first; balance investment in services that reduce harms and promote recovery as well as treatment; focus on better coordination, collaboration and integration; tailor responses for vulnerable groups and communities; and adopt a whole of population approach.

The Commission will continue work to fulfil its role to drive on-going reform towards a more integrated, evidence-based, recovery-oriented mental health and alcohol and other drug service system. This will only be achieved by continuing to bring together lived experience and professional expertise by partnering with the community, government, and industry across a range of areas including health, employment, education, housing and justice.

Consistent with its role, the Commission will publish an update report outlining progress made towards implementing the options for reform, 12 months after the publication of this report.

Collective action to reduce the harms from stigma and discrimination related to problematic alcohol and other drug use will enable vulnerable Queenslanders to be socially included, valued members of our communities.

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Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-9

This is the attachment marked '**GJC-9**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
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Assessment #8

Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?

August 2019

Alexandria, Virginia

Eighth in a Series of Ten Briefs Addressing—Beyond Borders:
International and National Practices to Enhance Mental Health Care

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Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What Now?

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Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What Now?

Kenneth Minkoff and Nancy Covell

Introduction – Historical Context for this Review: What's Known

Individuals with co-occurring mental health and substance use disorders (COD) were first identified as a population of significance in the 1970s and 1980s, at a time when mental health (MH) services and practitioners and substance use disorder (SUD) services and practitioners were far more divided than is the case today. At that time, the so-called "dual diagnosis" population were recognized as a group of individuals who were associated with poor outcomes and high costs in multiple domains (1-5), as well as being surprisingly prevalent in both MH and SUD service settings.

Beginning in the late 1980s, researchers in a variety of settings began describing and studying programmatic approaches and specific intervention strategies for what was termed "integrated treatment" - addressing both types of disorders at the same time, in the same place, by the same team (6). During the next decade and one-half, there was a steady accumulation of materials, manuals, guidelines, and research findings directed at "COD". Many of these materials will be described later in this review article.

By the late 1990s, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services (CMHS) had released an evidence-based practice toolkit on Integrated Dual Disorder Treatment (IDDT) for individuals with serious mental illness and co-occurring substance use disorder (7), and a few years later, the Center for Substance Abuse Treatment (CSAT) released *Treatment Improvement Protocol(TIP) #35, on Assessment and Treatment of Individuals with SUD and Co-Occurring Mental Illness* (8), which was designed mostly to provide guidance for addressing individuals with COD who were being serviced in SUD settings, although much of the manual could be applied in any setting.

The emergence of these sets of organized clinical materials helped to generate a wave of energy directed at implementation of integrated services and integrated systems of care at the federal, state, and local (county and regional) level across the country. SAMHSA's CMHS Managed Care Initiative, as early as 1998, commissioned a report entitled: *Individuals with Co-Occurring Mental Health and Substance Use Disorders: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula* (9-11). Massachusetts (12), New Mexico (13) and Arizona implemented statewide consensus building and implementation processes (in New Mexico) regarding universal implementation of what were termed "Dual Diagnosis Capable (DDC)" services. The American Society of Addiction Medicine (ASAM) issued updated *Patient Placement Criteria (Second Edition, revised)* incorporating standards for DDC and Dual Diagnosis Enhanced (DDE) addiction services (14). In 1999, the national organizations representing the National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD) issued a combined consensus statement supporting the use of the "Four Quadrant Model" for service planning for individuals with COD across state systems (15).

SAMHSA's Report to Congress on Co-Occurring Disorders (2002) declared (based on an accumulation of epidemiologic data from the Epidemiologic Catchment Area survey (16) and the National Comorbidity Survey and NCS-R (17) that "Co-occurring disorders are an expectation,

not an exception" in all settings, thus indicating a need for universal application of strategies to develop integrated or "dual diagnosis capable" services and integrated systems to support those services (18). In 2003, SAMHSA funded the Co-Occurring Center of Excellence (COCE) to coordinate national technical assistance and implementation efforts, and also initiated a multi-year wave of five-year Co-Occurring State Infrastructure Grants (COSIGs), which were ultimately awarded to 19 states, with a first wave of seven states in 2004, and the last two states in 2009. The goal of the COSIGs were to assist states in developing, implementing, and evaluating statewide approaches to integrated service delivery for the COD population.

In 2006, COCE produced a series of technical assistance papers to provide guidance to the field (19-26). Numerous states (*e.g.,* Ohio (27), Michigan, New York) embarked on their own implementation activities without receiving COSIG grants. Many states and counties proceeded to "integrate" their MH and SUD divisions or departments into single "Behavioral Health Departments". SAMHSA developed a train-the-trainer series on implementing *TIP #42*, *Treatment Improvement Protocols* and increasingly emphasized implementation of evidence-based practices (EBPs) such as IDDT in its MH Block Grant requirements. In addition to the EBP Toolkit for IDDT, to be discussed in more detail later in this paper, toolkits with broader applicability were developed by Kenneth Minkoff & Christie Cline (*e.g., Comprehensive Continuous Integrated System of Care* (28-32), and by McGovern *et al.,* (33) to guide the implementation of "dual diagnosis capability" or "co-occurring capability" more universally at the program and practice level; these toolkits were used in most of the COSIG states, and many of the non-COSIG states and counties to support an organized implementation process for integrated services. (28-31). Most states adopted one or the other toolkit, but some states, like Maine, used both (34).

There was a lot of progress apparently being made. And then, suddenly, it all slowed down. The COSIG program stopped, COCE was de-funded, and the energy and effort dedicated to COD was apparently sidelined.

What happened?

First, beginning in 2006, as the appropriate result of the emergence of dramatic data on the 25- to 30-year life expectancy gap for adults with serious mental illness (SMI) (35), and the simultaneous accumulation of research on evidence- based approaches for treatment of common behavioral health conditions in primary care (*e.g.,* Collaborative Care models such as IMPACT (36) and DIAMOND (37) for depression, and Screening Brief Intervention and Referral to Treatment (SBIRT) for SUD (38)) there was an upswing of effort shifting the focus on "integration" from Mental Health and SUD integration to Primary Health and Behavioral Health Integration (PHBHI).

Notably, most of the health conditions contributing to the mortality gap are caused or exacerbated by a co-occurring nicotine addiction resulting in high smoking rates in the behavioral health population (39). Beginning in September 2009, SAMHSA and the Health Resources and Services Administration (HRSA) began funding PHBHI implementation grants. Over the past several years, those grants have reached more than 100 recipients (mostly MH agencies) across the nation and have been evaluated as producing success in building integrated, multidisciplinary teams offering an array of services and demonstrated improvement in some medical, but not behavioral health, outcomes (40). SAMHSA and HRSA also established and funded the Center for Integrated Health Solutions (under the auspice of the National Council for Behavioral Health) to support "bidirectional" implementation efforts nationwide, and a panoply of tools and toolkits emerged to

achieve PHBHI at multiple levels of system design and service delivery (https://www.integration.samhsa.gov/).

As the focus on PHBHI became more prominent, it became natural to assume that the "BH" (that is MH and SUD) integration had been completed. At the same time, there was somewhat less energy for continuing to work on COD. The prevailing perspective was: "We did that already; we need to move on." This was likely related to limitations in understanding how to measure "MH and SUD integration", and limitations in the ability to apply best practices of implementation science to the achievement of MH/SUD integration.

For example, if integration is "measured" by "administrative reorganization" – the creation of a BH Department instead of separate MH and SUD departments –by increasing co-located MH and SUD services, or increasing numbers of staff who had received some type of COD training, then progress was indeed visible. If, however, MH/SUD integration was measured by the number of individuals or families with both MH and SUD conditions who were screened and identified, and received integrated assessment and appropriately matched integrated treatment, then progress (as will be discussed below) was far more inconsistent, less firmly grounded, and less sustainable. Indeed, people with COD continued receiving treatment for both at alarmingly low rates; in the 2017 National Survey on Drug Use and Health (NSDUH), only 12% of adults with co-occurring SMI (8% with any mental illness) and substance use disorder received both MH and specialty SUD treatment (41).

A fully applied implementation science framework applied at the system level would have more routinely focused attention on the importance of aligning policies, procedures, practice supports, and ongoing supervision to ensure that individual COD clients receive the services they need, and that progress is continually measured to ensure that, in fact, individuals with COD are receiving appropriately matched services. However, in the past few years, as a result of newly emergent areas of concern, there has been a growing re-focus on achieving MH and SUD integration, and improving services for individuals with COD.

What's New?

1. **The opioid epidemic:** The emergence of the national opioid crisis has been a stark reminder of the need for integration of MH/SUD services. Among significant data that have emerged are:
   - The high prevalence of co-occurring MH conditions (including trauma) among individuals with opioid use disorder (OUD) (42), especially women (43), requiring integration of MH services into OUD treatment settings, and
   - The high prevalence of OUD among adults with SMI (42, 44), and the need for integrated services, including medication-assisted treatment (MAT), to be delivered within MH settings to meet their need.

   It is also important to note that the visibility of the opioid epidemic has partially obscured the continued impact of methamphetamine—which is also associated with a high prevalence of COD—across the nation. Many states are currently reporting more deaths related to methamphetamine (possibly due to a mixture with fentanyl) than due to opioids. (45)

2. **Certified Community Behavioral Health Centers (CCBHCs):** The implementation of the CCBHC demonstrations, starting with 24 states with planning grants, 8 states currently in year two of implementation, and the likelihood of expanded funding for more states to come on line, has led to a focus on this new model of funding and service delivery as an emerging model for the system as a whole. Part of CCBHC implementation has been the dissemination of a set of federal standards of practice that CCBHCs have to meet, one of which is the ability to respond effectively to the needs of individuals with COD (45). For the National Council for Behavioral Health and for many providers, this has brought renewed awareness that co-occurring services had not been well-developed, even in these "front running" CCBHC provider organizations, and that more consistent attention to this population is warranted.
3. **PHBHI Progression:** Over the past decade, steady progress in implementing integrated services in primary care has made it even more clear how much disconnection remains between treatment for MH and SUD, even within primary care integration efforts. There have been numerous national projects studying implementation of SBIRT in primary care (37), and implementation of Collaborative Care models in primary care (36) (usually with a focus on the use of PHQ-9 to screen for depression), but primary care organizations have not commonly been focused on integrating services for BOTH MH and SUD conditions. (47); the Veterans Administration (VA) is arguably an exception to this finding. Nonetheless, progress in PHBHI has begun to circle back to recognizing that both MH and SUD need to be integrated with each other AND integrated into primary care in order to maximize population health impact.
4. **Criminal Justice Diversion:** During the past decade as well, there has been renewed focus on developing system and service approaches to diverting individuals with BH needs out of the criminal justice system wherever possible. Sequential intercept mapping (48) has been a guiding approach, and the Stepping Up initiative (49-50) has led to hundreds of counties nationwide to commit to these efforts, with support from a variety of federal grant programs, the National Gains Center, MacArthur and Arnold Foundations (https://stepuptogether.org/what-you-can-do). The data on individuals with BH needs in the criminal justice system report on the striking prevalence of comorbidity (51) yet communities attempting to implement diversion efforts indicate that there is limited access to effective program models (52) that can respond effectively to these individuals. This has led once again to the need to implement what is known about effective integrated treatment approaches for this population, in order to effectively respond the strengthening demand for diversion services.

What Now?

The revival of attention to this issue requires that we move forward, pick up where we left off as a field, and build upon what we already know, not start over. The main purpose of this review article is to bring together information that will help the field do just that, in each of the following sections.

Understanding and Planning for the Population – This section will review definitions of COD, integration, and other key terms, will look at the most current data on epidemiology and frameworks for population mapping (e.g., the Four Quadrants), and then look at where we need to go in these areas.

What's Known

Over 10 years ago, the SAMHSA Co-Occurring Center of Excellence (COCE) issued a set of "Overview Papers" to clarify terms and concepts concerning co-occurring disorders (19-26). These papers, although somewhat dated, still represent the best available consensus understanding of definitions, epidemiology, and approaches for population mapping. Here is a summary of key points:

Definition of COD: COCE recommends using a "service definition" (individuals who need both MH and SUD services at any point in time) for co-occurring disorder service planning, rather than a narrower "diagnostic" definition, since many individuals require integrated services but may not meet independent diagnostic criteria for mental illness and SUD. (19). COCE also recommends inclusion of gambling and nicotine as addictive issues of concern. This might be stated as follows: "Any person, of any age, with any combination of a mental health condition (including trauma-related symptoms) and a substance use or addictive condition (including nicotine or gambling addiction), whether or not that person has already been diagnosed." This definition also can include individuals with serious and disabling mental illness, or youth with serious emotional disturbance, who are using substances in moderate amounts that are nonetheless harmful because of the vulnerability of their brains, but who may not meet the diagnostic threshold for a SUD.

Epidemiology of COD: COCE's review of COD epidemiology (26) captures general household survey prevalence data from three sources: The National Comorbidity Survey – Replication (NCS-R), conducted 2001-03, the annual SAMHSA NSDUH, and the National Epidemiologic Study on Alcohol and Related Conditions (NESARC), conducted 2001-02. The review discusses the variations in methodology of these various surveys, and concludes that somewhere between 5 million and 7 million Americans suffered from COD (at that time). With regard to prevalence in treatment settings, COCE summarizes data indicating between 20% and 50% of individuals served in MH settings have lifetime co-occurring SUD, and between 50% and75% of individuals in SUD treatment settings have a lifetime co-occurring mental health condition. The prevalence of comorbidity is higher in populations with higher levels of instability and need (*e.g.*, homelessness, criminal justice involvement, child welfare populations, crisis settings.) (53-61)

COCE concludes: *Persons with COD are found in all service populations and settings. These clients will never be served adequately by implementing a few programs in a system with scant resources. Rather, COCE takes the position that co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming. (See COCE Overview Paper 3 (21), Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders, p. 2; CSAT, 2005).*

Systems integration is one important mechanism for reaching this goal. COCE has papers dedicated to discussion of both "services integration" (24) and "systems integration" (25), each of which utilizes the following definitions:

- ***Integration:*** *As used in this paper, integration refers to strategies for combining mental health and substance abuse services and/or systems, as well as other health and social services to address the needs of individuals with COD.*

- ***Services Integration:*** *Any process by which mental health and substance abuse services are appropriately integrated or combined at … the level of direct contact with the individual client with COD ….. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients.*
- ***Systems Integration****: The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with COD and their families. (*24-25*)*

Note that COCE emphasizes that simply merging MH and SUD "departments" at a provider organization or delivery system level does not automatically produce either systems integration or services integration. Whether or not "departments" are administratively merged, there needs to be an organized and collaborative effort across all relevant service domains to implement routine delivery of integrated services at the level of individuals served.

Definition of Co-Occurring Capability: COCE (24) utilizes the original ASAM definition of Dual Diagnosis Capability, as follows:

Dual Diagnosis Capable (DDC): This term is used to designate programs that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (14 p. 362). A more recent version of The ASAM Criteria (Third Edition, 2013), utilizes the "service definition" of "co-occurring conditions" (above) and updates its terminology to "co-occurring capability," as follows:

Co-Occurring Capability: *For any type of program, and as defined by the mission and resources of that program, recovery-oriented co-occurring capability involves integrating at every level the concept that the next person "coming to the door" of that program is likely to have co-occurring conditions and needs. This approach emphasizes that such people need to be welcomed for care, engaged with empathy and the hope of recovery, and provided what they need in a person-specific and integrated fashion…..For any type of addiction and MH program, co-occurring capability can be achieved within existing program resources….Progress…includes addressing…(a range of) indicators, through policy, procedure, practice improvement, and workforce development over time (pp. 26-29). (See also Minkoff & Cline, Compass-EZ 2.0, 32)*

Tools for measuring program co-occurring capability include the COMPASS-EZ 2.0 for both MH and addiction programs (32), and the DDCAT (for addiction programs) (33) and DDCMHT (for MH programs) (61).

The ASAM Criteria also discuss **Co-Occurring Enhanced programs** (formerly termed Dual Diagnosis Enhanced), describing them as "**special programs**" that are not merely programs that have made more progress in being COD-Capable. Examples include addiction programs with enhanced resources that specifically and preferentially serve individuals with more severe psychiatric disabilities, or specialized mental health programs that focus on individuals with severe mental health conditions and active SUD, such as acute COD-specialized inpatient units or specialized IDDT or ACT programs (14, p. 29; 24).

What's New?

Very little has changed in the past decade, other than the evolution of terminology from Dual Diagnosis Capable to COD-Capable, described above. Several areas of importance are worth noting, however:

Epidemiology of Co-Occurring OUD and MI: Using 2015–2017 NSDUH data, one study estimated the prevalence of co-occurring substance use and mental disorders and receipt of mental health and substance use treatment services among adults with opiate use disorder (42). More than three-quarters (77%) of adults with opiate use disorder had co-occurring other substance use disorders or nicotine dependence in the past year, and many had co-occurring mental health issues (64% with any MI and 27% with SMI (42). Less than one-third of people with a co-occurring mental health and OUD received treatment for both (25% of those with any MI and 30% of those with SMI; 42).

Epidemiology of Co-Occurring Trauma and SUD: Although it has been well known since the late 1990s that the presence of a history of trauma (emotional, physical, sexual abuse) is both predictive of the development of SUD, often the result of having an SUD, and in either case commonly correlated with SUD (62), this issue has received even greater attention because of the increasing awareness of the connection between combat-related trauma, SUD, and mental illnesses (notably depression and suicide) among returning combat veterans. (U.S. Department of Veterans Affairs). This has led to important progress in knowledge (discussed further later in this article) regarding integrated interventions for SUD and trauma-related disorders (*e.g.*, PTSD) and symptoms.

Epidemiology of Co-Occurring SUD, MH and Intellectual and Developmental Disabilities (I/DDs) and Acquired Brain Injury (ABI): There has similarly been significant advance in knowledge of the risk of initiation of both MI and SUD following ABI (combat-related and non-combat related), as well as the risk of SUD in causing ABI (*e.g.*, resulting from motor vehicle accidents caused by driving under the influence) (63). This has resulted in awareness of the need for brain injury support services to integrate co-occurring disorder services. Further, increased efforts to identify individuals with a wider range of I/DDs (including fetal alcohol syndrome and autism spectrum disorders) and support them living in the community, has resulted in a greater prevalence of individuals in I/DD services who have both mental health and substance use disorders which need integrated attention within I/DD support services (64).

Importance of Addressing Co-Occurring Nicotine Dependence:

> Tobacco-related illness is the highest-ranking cause of death among people with SMI. (65) People with a diagnosed mental health and/or substance use disorder, other than nicotine, have smoking rates higher than the general population (66) and are responsible for over one-third of all cigarettes smoked (39). Dr. Jill M. Williams and colleagues have made a strong argument for behavioral health providers to treat tobacco dependence like any other co-occurring mental health and substance use disorder (67).

Increased Recognition of Risks of Marijuana and "Synthetic Cannabinoids" in COD Populations.

> Cannabis use has been associated with an increased risk for psychosis (68) and co-occurring use of cannabis has been related to poorer outcomes for people with psychosis, major

depressive disorder, and bipolar disorder (69). The rates of synthetic cannabinoids are increasing with similarly negative impact for people with COD. In one study, over one-half of 101 people admitted to a psychiatric inpatient unit for co-morbid substance use in Australia reported use of synthetic cannabinoids during their lifetime (70). In a separate study of a similar population in the United States, among 594 people admitted to an inpatient unit for co-occurring mental health and substance use, synthetic cannabis use was associated with higher rates of psychosis and agitation than marijuana use (71).

Description of System Integration Planning Frameworks: COCE describes two system integration frameworks that are in common use today.

- **Four Quadrant Model:** The Four Quadrant model was developed as a consensus for system planning among state mental health and SUD commissioners (NASMHPD and NASADAD) in 1999 (15). This planning framework divides the population into four quadrants based on severity (applied to acuity and/or chronic impairment) associated with each condition. The High-High (Quadrant IV) and High-Low (Quadrant II) clients are generally served in acute or long-term mental health settings; the Low-High (Quadrant III) clients and some types of Quadrant IV clients are served in SUD settings. Low-Low (Quadrant I) clients are more likely to be seen, and served, in primary care. This is clearly only a rough heuristic, but it has proven valuable for describing the focus of population planning for MH/SUD service integration that is most relevant for each type of system and service delivery setting.
- **Comprehensive Continuous Integrated System of Care (CCISC):** First described by Paul Barreira *et al*., (12), this approach has been developed and applied in multiple systems by Kenneth Minkoff and Christie Cline (28, 29), and was described as an emerging practice for systems integration by COCE (25). The framework of CCISC builds on the idea that individuals and families with co-occurring conditions occur in all settings (including, in child MH settings, where parents of children with serious emotional disturbance abuse substances) and therefore systems integration requires an organized systemic Continuous Quality Improvement-driven implementation process by which all processes, programs, and staff become co-occurring-capable. This approach has been applied and described in multiple state and regional systems (13, 30-31), with individual evaluations of system progress (*e.g.,* Maine) (34), but has not been subject to formal implementation research. Experiences with CCISC implementation will be discussed later in this paper.

What Now?

It is striking to realize that the most recent national epidemiologic survey addressing co-occurring disorders (NCS-R) is nearly 20 years old. There is an urgent need for more current and reliable data on the epidemiology of all MI and SUD, including COD. That is an effort for which SAMHSA is currently seeking to obtain funding.

Further, it is also striking to realize that there has been little further progress in the delineation, evaluation, and research of system and services integration efforts, including concepts like co-occurring capability, co-occurring enhancement, the 4 Quadrant Model, and CCISC. Indeed, significant structural barriers still exist in access to evidence-based treatments for people with co-occurring disorders, including service availability, identification of the co-occurring disorder,

provider training, service provision, racial/ethnic disparities, and insurance/policy barriers. (72) There is much more known about "what works" (as shall be seen in the next section of this paper) than about sustainable and systematic implementation of "what works". This will be discussed in more detail in the final section of the paper.

Understanding What Works

This section will first review the array of treatment interventions that have been identified as helpful for individuals and families with COD, the data that support those interventions, the various ways that the interventions that work have been packaged into "integrated interventions" and "integrated treatment program" models, and the data that support the effectiveness of various packages of integrated services. Following that, there will be discussion of what's new in terms of emerging clinical interventions, and what's next in terms of application in the field.

What's Known: Overarching Principles: COCE (21) articulated 12 overarching principles for integrated COD treatment, the first six for systems, and the second six for providers of care. The latter principles include:

> **Principle 7**: Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.
>
> **Principle 8**: Within the treatment context, both co-occurring disorders are considered primary.
>
> **Principle 9:** Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes. In all behavioral interventions, the quality of the treatment relationship is the most important predictor of success.
>
> **Principle 10:** Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.
>
> **Principle 11:** The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.
>
> **Principle 12:** The contribution of the community to the course of recovery for consumers with COD and the contribution of consumers with COD to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy.

These principles can inform our understanding of "what works". Each person with co-occurring conditions is unique, and interventions must be matched appropriately to what that individual needs, within the context of an ongoing treatment relationship that is matched to the level and type of service that the individual needs and wants and is able to successfully engage the individual over time.

To summarize this:

- **Each person requires interventions that are appropriately matched to EACH primary co-occurring condition.** This requires attention not just to diagnosis, but to acuity, severity, chronicity, and level of impairment associated with each condition, as

well as to the individual's personal preferences and capabilities (developmental or cognitive status) for participating in treatment. Just as this is variable for any single condition, it is similarly variable for any combination of conditions.

- **Each person requires interventions that are matched to his/her individual recovery goals and his/her stage of change (73) for <u>each</u> condition.** In addition to services being properly matched to the disorders or conditions, the services must be matched to the individual's stage of change. If the person does not acknowledge that they have an MH or SUD condition – or that they want to address it – offering them treatment for it will not be properly matched. For many people, this means that they are engaged in service for one type of problem or condition, while receiving motivational interventions to help them progress with one or more co-occurring conditions. This may be further complicated by the needs of individuals (usually youth) who are being served in the context of their family or caregivers who may have their own needs, goals, and preferences. This leads to "stage-matched" or "stage-wise" treatment, which will be discussed below.

- **Each person (or family) is likely to benefit from "integration" of treatment or services to the degree that they are unable to integrate services for themselves.** The above definition of "integration" references the ability to integrate appropriately matched services at the level of the individual (or family). Thus, "integration" is not a single type of program or activity, so much as a range of strategies for helping individuals receive services that are integrated in accordance with their needs. Everyone must integrate multiple services or interventions for any co-occurring conditions in his or her own life; the question becomes how much assistance is needed to do that. The need for integration to be externally provided increases when the conditions are more complex, chronic, and disabling, or when the individual or family is more impaired. Further, this can require a higher level of external integration during an acute decompensation (e.g., hospitalization or crisis episode) than during ongoing continuing care. Thus, for some individuals, ongoing integration can be provided by an individual clinician coordinating care among multiple settings; at the other extreme, some individuals require a high degree of integration and coordination over time such as might be provided by an Assertive Community Treatment team, IDDT Team, or Modified Therapeutic Community. Similarly, for adolescents and families, program models based on wraparound principles that incorporate both high intensity services and integrated attention to COD have been developed, such as Multi-Systemic Therapy (MST) (74) which was designed to address co-occurring conduct disorder, SUD, and juvenile justice involvement.

Interventions That Work

For individuals with COD, there is considerable evidence indicating that interventions that work with any single condition will "work" with individuals who have a co-occurring "other" condition, with some degree of modification as needed based on the characteristics of the condition (*e.g.,* severity or chronicity) and the individual's cognitive capacity or disability.

These interventions can be divided into pharmacologic and non-pharmacologic interventions, and, within the latter, can be subdivided into specific treatment interventions and recovery supports. The following is an intentionally brief summary of the most salient points.

Pharmacologic Interventions for MI for Individuals with COD

What's Known

Based on a range of available studies, including important research on IDDT, SAMHSA established principles for psychopharmacologic interventions for individuals with COD (75). These were further elaborated by Minkoff (76). The following are highlights of "what's known":

- Necessary non-addictive medication for known mental illness is effective, and must be continued, even for individuals who continue to use substances. In general, risky behavior requires closer monitoring and more support, not treatment extrusion or medication discontinuation (29, 75).
- Adults and adolescents respond to appropriately matched medications for their mental illness, even when they continue to use substances. (77).
- Although there are medications that have indications for MI (*e.g.,* certain anticonvulsant mood stabilizers such as gabapentin (78), valproate (79), and topiramate (80) that may have benefit for helping individuals reduce substance use, there are no data indicating that any specific medication is a "magic bullet" for any combination of comorbid conditions.
- There is considerable research suggesting that clozapine may have a direct effect helping individuals with psychotic illness reduce substance use, beyond its direct impact on their mental illness (81-82).
- Individuals with diagnosable ADHD (adults or children) are recommended to start treatment with non-stimulants, but once they are reasonably stable, they may benefit from, and safely be prescribed, continuing long-acting stimulants for their ADHD (83). There is no evidence that treatment with stimulants of individuals with ADHD produces higher incidence of SUD; in fact, pharmacotherapy of ADHD is associated with a reduced risk for substance use (84).

What's New?

There is a regular flow of research attempting to identify medications for psychiatric illness that may also impact co-occurring SUD (76). Often, initial findings that show promise do not hold up in subsequent studies. In a very recent report that shows promise, three people with longstanding substance use disorder reported a rapid and dramatic decrease in substance use when treated with cariprazine for bipolar I disorder (85).

What Now?

Despite the fact that the COD psychopharmacology practice guidelines are over 20 years old, there is still a lack of consistent training and implementation among prescribers. This is an important standard of care issue that needs to be addressed.

Pharmacologic Interventions for SUD for individuals with COD

What's Known

Research on the effectiveness of "Medication-Assisted Treatment" for SUD for individuals with co-occurring mental illness dates back more than 40 years. Early studies demonstrated the success of combining tricyclic antidepressants with methadone for co-occurring OUD and (86-87). Success using disulfiram for individuals with schizophrenia and alcohol use disorder (AUD) was demonstrated as early as 1986 (88). Steven L. Batki *et al*. demonstrated the effectiveness of naltrexone in reducing alcohol use among individuals with schizophrenia in 2007 (89). This research leads to the converse principle in co-occurring psychopharmacology practice guidelines (76).

For individuals with co-occurring MI, MAT for SUD will be as effective as for individuals without SUD who do not have co-occurring MI. These interventions may be used both to assist with "harm reduction" as well as with achieving abstinence, depending on the appropriate patient-centered goals.

What's New? In the past decade, the emergence of research and awareness of the value of MAT for AUD and OUD has expanded considerably, most recently as a result of the opioid epidemic. At this point, it is considered a standard of care that ALL individuals who may have conditions that would respond to MAT should have the opportunity to receive it (90). This represents a major culture shift in addiction treatment. Although there are still no approved medications for treatment of stimulant use disorders, hallucinogen use disorders, or so-called "synthetic cannabinoids," there is a continuing effort to identify those. N-Acetyl cysteine (NAC) has been found to be helpful with reducing cannabinoid use (91).

There has been an explosion of research looking at new medications (including "vaccines" (92), and delivery methods (sublocade for long acting buprenorphine administration; (93), and procedures (rapid initiation of MAT in emergency rooms; (94-95). Recently, the National Institute on Drug Abuse (NIDA) released a "ten most wanted list" for medication developments to treat OUD (96). All of these are likely to have value for individuals with COD.

There has been expansion of research on medications to treat nicotine addiction among individuals with SMI. Jill M. Williams *et al.* (97) have asserted, based on recent reviews, that prior concerns about MH side effects with varenicline are not so serious and therefore varenicline should be considered the treatment of choice, with bupropion and nicotine replacement interventions being considered as ancillary interventions.

The opioid epidemic has led to increased pressure and expectation for the development of MAT capacity in mental health settings of all kinds. This is reinforced by the standards of care in CCBHCs (45). There are increasingly reports and descriptions of such implementation efforts in the literature (98).

What Now?

In spite of these recent efforts, the number of individuals with COD who receive MAT for AUD or OUD is dramatically low, mirroring treatment rates overall. For example, in 2013, only 2.5 million persons (11%) of 22.7 million persons aged 12 or older needing treatment for an illicit drug or alcohol use problem actually received such treatment. In a national study, of 623 people who had a diagnosis of prescription OUD at any time in their life, only 11% sought treatment within the first year, 24.5% within 10 years, and 42% in the course of their lifetime (99). Similarly, data from 156 community-based addiction treatment organizations participating in the

ongoing National Treatment Center Study (NTCS) found that only an average of 9.6% (SD=24.1%) of people with OUD received MAT (100). In a survey of 170 psychiatrists in North Carolina, close to one-half of the people seen in a primary psychiatric setting had comorbid alcohol use disorders, yet only one-fourth were prescribed MAT (101). Therefore, the next wave of effort will be in expansion of implementation for MAT in all types of settings, including in MH settings, to be a standard part of care for individuals with COD, as well as SUD alone

Psychosocial Interventions for MI for individuals with COD

What's Known: As with psychopharmacologic interventions, it has been established for some time that effective psychosocial interventions for psychiatric illnesses and disabilities are usually effective for those same conditions in individuals who have co-occurring SUD.

Case Management and Care Coordination: Although the level of intensity may vary (ranging from standard case management to Intensive Case Management (ICM) to Assertive Community Treatment (ACT) or IDDT based on individual need) the benefit of this intervention for complex populations is well known (102-103). Of most interest are recommendations for continuing case management among individuals with severe SUD and co-occurring MI who are NOT SMI, and therefore not eligible for usual SMI case management services (104).

Cognitive Behavioral Therapy (CBT): CBT for anxiety and mood symptoms has been demonstrated effective in individuals with COD (provided SUD is sufficiently stabilized) (105-106).

Symptom Management Skills Training: Numerous tools have been made available, particularly for use in SUD settings, to assist with teaching COD clients the skills to manage symptoms of mental illness without using substances, including both self-management skills and help-seeking skills. One of the most robust of these efforts has been Seeking Safety (62, 107), which has been demonstrated to be helpful in managing trauma-related pathology in early SUD recovery for both men and women.

Psychoeducation: Efforts to educate individuals with COD about their mental illnesses as well as teaching them skills for using medication properly and working effectively with prescribers (e.g., 108), along the lines of Illness Management and Recovery (IMR), have been utilized in a wide range of SUD programs.

What's New?

Although research in this arena has been limited in the past decade, there have been significant advances in the treatment of trauma-related pathology (including PTSD) (109), and in the application of those "trauma-specific treatments" to individuals with severe mental illness (110) and substance use disorders (111). While the application to people with serious mental illness still needs high-quality research evidence (110), there is evidence supporting that the position that the use of trauma-focused interventions alongside treatment for substance use disorder can help reduce PTSD symptom severity (111). Increasingly, research on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and exposure therapy has been conducted that has demonstrated benefit for individuals when PTSD treatments are integrated in the earliest stages of sobriety, challenging the longstanding notion that trauma-specific treatment must wait until an extended period of sobriety has been achieved (107, 112-116).

What Now?

Consistent implementation of these interventions in settings providing SUD services for individuals with COD is still quite limited, so that more focus on consistent implementation of what's known is the challenge ahead.

Population health efforts--including addressing both the OUD epidemic AND addressing individuals with high medical and/or BH utilization in health systems attempting to implement value-based payment methodologies—are beginning to more regularly identify individuals with severe SUD (usually with COD, but often not with identified SMI) as a high priority population for continuing care coordination and/or case management (117-118). Given that the traditional approach to SUD treatment has been episodic, the recognition that these individuals need the same types of continuing interventions as other complex populations may result in a significant redesign of services for this population.

Psychosocial Interventions for SUD for individuals with COD

What's Known

As with the converse, it has been known for some time that effective psychosocial interventions for SUD are also effective for individuals with COD, if there are appropriate modifications for the presence of psychiatric disability that may affect cognitive processing ability.

Examples of such interventions include: Motivational Engagement or Motivational Interviewing (MET or MI); CBT (including relapse prevention, and skill building); and Contingency Management.

In a review that included 43 research trials and 24 reviews to illuminate treatment of people abusing substances who also have a co-occurring mental health diagnosis, among behavioral strategies, MI, CBT, and Contingency Management (CM) proved the most effective (106). Notable examples of cognitive-behavioral skill building interventions that have been adapted into modules for individuals with SMI include the Substance Abuse Management Module (SAMM) created as part of their social skills training (119), and the BTSAS modules created by Allan S. Bellack and associates (120). CM interventions have been studied in SMI individuals for over two decades, beginning with work by Andrew Shaner *et al.,* (121-122) and Richard K. Ries *et al.* (123) (related to using disability payments as incentives) in addition to the more recent dissemination of CM interventions for all types of SUDs with and without COD (124-126).

Another category of psychosocial intervention that has been applied to individuals with COD is the Therapeutic Community (TC). Stanley E. Sacks and others have described how traditional TC's can become Modified TCs for COD (127), which have demonstrated positive outcomes after extended lengths of stay, particularly for individuals with correctional involvement (128). Modified TCs embed many of the specific interventions listed above (*e.g.,* medication, skill building, etc.) into the context of the "therapeutic community" which emphasizes peer-based social learning as a key change element.

What's New?

There has been no notable new research in this area during the past decade. The previous skill-building modules remain the most relevant for current practice.

What Now?

As with other types of interventions, the need for more consistent implementation of what's known remains a consistent challenge.

Stage-Matched Interventions for Each Condition:

What's Known

The early research on the implementation of IDDT articulated the concept of Stagewise Treatment, defining Eight Stages of Treatment (129), moving from Pre-Engagement through Remission, and emphasizing the importance of interventions (individual and group) and outcomes being stage matched. This work was an extension of the earlier work of Prochaska and Di Clemente on the Transtheoretical Change Model for SUD, which articulated five stages of change, along with, again, the concept of stage matched interventions and outcomes (73). The relatively simultaneous dissemination of the science and technology of motivational interviewing (or Motivational Enhancement Therapy (MET)) by William R. Miller and Stephen Rollnick (130), has led to the recognition that while MET strategies are important in the change partnership at any stage of change, they are particularly relevant for helping to engage individuals in the earliest stages of change to make progress through the subsequent stages. Some studies have demonstrated effectiveness of modifying MET for individuals with SMI (131). This is particularly relevant for COD, where individuals may be engaged actively in working on one issue (MI or housing) and still be in an earlier stage of change for SUD (or vice versa).

What's New?

More recent work has delineated a conceptual framework for expanding the application of stages of change and stage-matched interventions (and application of MET) from SUD to a multiplicity of other co-occurring conditions, including MI, housing, criminal justice, trauma, health and so on. Kenneth Minkoff & Christie Cline articulated the concept of stage of change being issue specific (28, 29), and recommended that all interventions be both integrated and stage-matched. Further, the Transtheoretical Change model has similarly expanded in the past decade or more to expand its application and research to other conditions, finding that the same concepts are applicable as were applicable to SUD (*cf* , 132-133).

What Now?

As with other types of interventions for individuals with COD, even though the recognition of the effectiveness of stage-wise treatment or stage-matching has been apparent for over two decades, there is very little consistent implementation of this framework in standard practice. It is very rare that treatment providers routinely identify the stage of change for each of multiple issues to ensure that all interventions and outcomes are stage-matched.

Residential Treatment and Supported Housing for Individuals with COD

What's Known

Just as for either condition separately, individuals with COD may benefit from episodes of residential treatment. The literature has examples of how co-occurring services and interventions can be embedded into residential settings ranging from psychiatric inpatient facilities (134),

residential SUD facilities (135), TCs (127), and psychosocial rehabilitation settings (136). However, because individuals with COD have not one but at least two chronic relapsing conditions, there is no data that suggest that a single episode of residential care is sufficient to produce long lasting recovery without provision for continuing services for each condition. In addition to what's known about residential treatment, there is considerable literature on various types of housing interventions, both to engage individuals with COD who are homeless, as well as to provide various levels of engagement and recovery support for individuals who may be further along in their recovery process. The extensive "Housing First" literature has emphasized the value of engaging homeless individuals with COD in scattered-site housing environments (sometimes termed "wet housing") with supports to help them succeed in the housing while making better decisions over time about managing their various challenges (137-138).

Similarly, literature on group "Housing First" environments (or "damp housing") has indicated success in using integrated psychosocial interventions for engaging individuals who initially are unable or unwilling to completely discontinue substance use to ultimately be engaged by the community to be more willing to commit to sobriety (139). Finally, there is a growing literature on sober housing or "recovery residences" as a valuable element of the continuum of support for individuals (including those with COD) who may wish to live in a supportive sober environment to help them maintain abstinence (140-141). Further research indicates that some individuals with serious mental illness come to recognize that choosing supported sober group living to help them establish sobriety will help them achieve their ultimate recovery goal of living independently (142).

What's New?

More recent work continues to refine these approaches. Recent Housing First research has been more purposeful about studying impact on individuals with more severe SUD (143). Researchers have begun to explore how to more accurately delineate who will do well in scattered-site vs. single-site (group) Housing First environments. For example, Susan E. Collins *et al.* (144) identified a cohort of homeless individuals with severe alcohol use disorders (almost all with co-occurring mental health conditions) who appeared to do better in a single site environment, noting however that those with psychotic or violent symptoms appeared to do better in scattered-site environments. Finally, there has been a major effort by the National Association of Recovery Residences to establish standards for recovery homes, including a basic equivalent of co-occurring capability that creates minimum expectations of policies and procedures for residents who are receiving psychotropic medication (145). These standards have been promulgated and are in the process of adoption by some states.

What Now?

In spite of the robust literature on these various approaches, it is still the exception rather than the rule that communities design housing continua to fit the varying needs of individuals with COD rather than continuing to expect these individuals to fit into abstinence-oriented group living even when it is not their preference. Further, the movement to establish standards for recovery homes is still in its infancy, and much needs to be learned about what standards are most appropriate and how they can be most effectively disseminated without limiting availability of recovery homes for those who need them.

Supported Employment and Education for Individuals with COD

What's Known

Multiple reviews including randomized controlled trials have established the effectives of supported employment for people with SMI (*e.g.,* 146-147). This evidence-based practice emphasizes that all people who want to work are eligible for services, including those who are actively using substances (148). Indeed, a co-occurring condition of substance use is not predictive of employment outcomes (146). Further, people with COD are successful in supported employment programs, and employment can be critical to their recovery (149). More recently, in a secondary analysis of a random controlled trial comparing supported employment to conventional vocational rehab programs, of the 106 people with COD, those who participated in the Individual Placement and Support Model (IPS) of supported employment had cumulative employment rates of 60%, compared to 24% of those in a conventional program; those receiving IPS were more likely to work 20 or more hours per week (47% vs. 10%) at some point during the 18-month follow-up, worked more weeks and hours, had a longer job tenure, and earned more wages than control clients (150).

When SAMHSA developed a toolkit for supported education (151), the evidence base was promising but far from rigorous (152), and the field has advanced little since that time. In a recent review of supported education for people with mental health disorders, Heather Ringeisen and colleagues (153) concluded that, while the evidence base is growing, there is a significant need for more rigorous studies using larger sample sizes and long-term follow-up. Notably, studies to date do not mention co-occurring substance use and its interaction with supported education.

What's New?

The recent attention to Coordinated Specialty Care (CSC) for people experiencing first episode psychosis is driving an increased focus on supported education and employment (*e.g.,* 154-157). Because young adults almost always have work- and school-related goals, it is imperative that services for people experiencing first episode psychosis include supported education and employment specialists (158). To date, results have been promising. For example, in a sample including 325 individuals ages 16–30 with recent-onset nonaffective psychosis who were enrolled in the OnTrackNY CSC program, including 144 (44%) with co-occurring substance use, education and employment rates increased from 40% to 80% by six months of program participation (157). It is notable that substance use was not a predictor of any study outcome, including employment and education (157). In parallel, the definition of recovery is increasingly focusing on community integration, including attention to education and employment as they relate to dimensions of wellness (159).

What Now?

With the importance of education and employment to long-term recovery, there is a significant need for more rigorous studies and long-term follow-up of supported education. As many supported education efforts are currently packaged as an extension of supported employment, it will be important to understand the unique contribution of each of those services separately on outcomes. While it is hopeful that people with COD seem to benefit from both supported education and employment, understanding which aspects of these services are most helpful and identifying what modifications strengthen their impact for people with COD would be useful.

Recovery Supports for Individuals with COD

Within the broad array of "recovery supports", this section focuses on peer recovery support, including non-professional "self-help" recovery support services and programs, and peer support provided by formally trained and commonly certified and employed "peer specialists" or "recovery coaches."

What's Known

Although it has been difficult to conduct formal research on the benefits of various self-help recovery programs for people with SUD (*e.g.*, 12-Step programs like Alcoholics Anonymous (AA), Narcotics Anonymous; and Smart Recovery) or people with mental illness (Emotions Anonymous; Schizophrenia Anonymous), there is an established literature indicating that these activities are beneficial for many if not all individuals who have these disorders (160-161), including those with co-occurring mental illness (162). Twelve-Step Facilitation (as a formal treatment intervention) has been found to have some level of supportive evidence of being effective for individuals with SUD, including those who may have lower severity COD (161).

At the same time, many individuals with COD have found difficulty to participate in these types of programs, both because individual groups (*e.g.,* AA groups) may be less accepting of people on psychiatric medications than the formal AA literature would suggest, and because some individuals with more significant psychiatric challenges (psychotic illnesses; PTSD) may find the group process overwhelming rather than helpful. For this reason, beginning over two decades ago, efforts emerged to create "dual diagnosis" oriented self-help "programs", such as Dual Recovery Anonymous and Double Trouble in Recovery (163), and some literature emerged suggesting the benefits of these types of self-help recovery supports for individuals with co-occurring disorders (164-165).

Also in the past two decades, there has been more focus on formal training, certification, and employment of individuals with lived experience of mental illness (many of whom may have COD) to work as "certified peer specialists (CPS)" (166). In the past decade, there has been a similar effort in the SUD system to move away from relying only on non-professional recovery supports to the training and certification of what are usually termed "recovery coaches" (RC), many of whom are recovering from various mental health conditions in addition to having the lived experience of recovering from SUD. Two rigorous systematic reviews examined the body of published research published between 1995 and 2014 on the effectiveness of peer-delivered recovery supports. Both concluded there is a positive impact on participants. (167-168) In spite of the fact that a recent review indicated that many studies had methodologic limitations making it difficult to draw conclusions (169), specific studies demonstrate benefit for individuals with co-occurring disorders (170-172).

What's New?

In relatively short order, it have become an increasing expectation that employed peer supporters for individuals with either MI and/or SUD be available, even though there is still a lot of work to be done to train and employ those individuals in sufficient numbers. Almost all states now have a process for the certification of peers. However, while it is intuitive that individuals trained to be peer supporters for one condition can be helpful for those with both, there is little if any research exploring the degree to which that applies. In fact, in many states, although the majority of peer supporters might have COD, peer support training tends to be siloed--CPS learn about MH recovery but not about integrated COD treatment or dual recovery, and vice versa for RCs.

With regard to self-help programs, the expansion of dual recovery programs appears to have plateaued, and more recent survey data indicate a significantly increased likelihood that any "self-help" program for any single disorder will be much more purposeful about integrating some level of attention to COD. For example, AA updated its pamphlet entitled The AA Member: Medications and Other Drugs in 2011 to include much more explicit support for using medications to address co-occurring disorders (173). Conversely, Wellness Recovery Action Plan (WRAP) materials - which originally were focused on mental illness – have now added a specific booklet for addictions (174).

What Now?

The continuing evolution of recovery peer support needs to be designed and studied with the assumption that individuals both receiving and providing peer supports will have co-occurring MH and SUD (in addition to other concerns, including medical issues). This will affect future training packages, certification expectations, and materials development. Further, the "peer movement" is beginning to coalesce and even "integrate" in many communities as more peers discover that "co-occurring disorders" are an expectation in their own lives. One example of this effort involves the implementation of what are termed Recovery-Oriented Systems of Care (ROSCs), in which (in many, but not all ROSC communities) the addiction recovery community reaches out to partner with the MH recovery community to create a community collaborative designed to build recovery support throughout the combined community (175-177). Finally, the opioid epidemic has led to an erosion of the barriers to peer support for individuals receiving MAT. A new 12 Step Program, Medication Assisted Recovery Anonymous, has recently emerged (www.mara-international.org). In addition, there is a growing movement to provide both counselors and peer supporters training and certification in "Medication Assisted Recovery Support" (MARS) (178).

<u>Integrating</u> Interventions for Co-Occurring Conditions

What's Known

As indicated previously, there are a substantial number of interventions for either SUD or MH conditions (including trauma) that "work" when properly matched to individuals who may also have COD. Further, individuals are likely to do better when they receive properly matched interventions for each disorder at the same time, and over time. Finally, individuals benefit from these interventions being "integrated" into a single program, team, or provider, to the extent that the person is unable to successfully integrate "parallel" interventions on his or her own (which is common, particularly for more serious issues).

What's known about how to do that? The earliest investigations (25-30 years old) of how to provide "integrated treatment" started with the development and evaluation of special "integrated treatment" programs. The most well-known example of this is IDDT which, in spite of its very generic name, actually refers to a particular evidence-based package of interventions encapsulated within a reasonably intensive treatment team program model specifically designed for individuals with very serious and disabling mental illnesses and serious SUDs. SAMHSA has identified IDDT as one of its core EBPs for the SMI population, and the toolkit is available for implementation (179).

There is research indicating the benefit of the IDDT approach, as well as describing the incremental progress of these individuals through stages of treatment over a period of years (6,180-181). Other studies have challenged whether "integrated treatment" is substantially beneficial, but all studies raise methodological challenges because (as previously noted) integrated treatment cannot be researched as if it is a "single intervention" compared to "treatment as usual": Integrated treatment means that an individual receives appropriately matched interventions (including correct matching for stage of change as well as for specific diagnosis and level of severity) for EACH condition at the same time, provided by a well-coordinated team. Consequently, research on whether "integrated treatment" is helpful has to account for proper individualized matching of services for each condition as well as measuring progress individually (e.g., movement through stages of change or stages of treatment). Any research that does not ensure that the integration AND the matching AND the outcomes expected are properly comparable to what is being provided to – and measured for - controls will not be able to reliably demonstrate differential results for the "integrated" condition vs the "non-integrated" condition.

As an illustration, a recent systematic review of IDDT concluded there is some evidence that IDDT can improve psychiatric symptoms and substance use, but no research supporting whether it is more effective than standard treatment (181). Specifically, the authors found six studies, only one of which was a randomized controlled trial (two were non-randomized studies, and three were pre-post studies) which included a variety of outcomes making comparison difficult (181). The authors confirmed that the lack of research in this area is remarkable, particularly given that integrated treatment is considered the standard clinical practice for people with co-occurring disorders (181).

A recent randomized controlled stepped-wedge cluster trial, with 6 functional assertive community treatment teams that included 154 people, demonstrated a significant decrease in the number of days a person used drugs or alcohol after 12 months but no effects on mental health, therapeutic alliance or motivation to change (182). However, the authors also did not observe a change in clinician knowledge, attitudes. or motivational interviewing skills, which may have indicated poor implementation (the intervention focused on a three-day training of clinicians with one booster session) rather than any lack of impact of the evidence-based treatment on outcomes (182).

Other specialized program models have been explored for individuals with severe SUD whose co-occurring mental illness might not meet the criteria for SMI. One such model, previously mentioned, is the Modified TC. As previously mentioned, MST is one example of a specialized program model for adolescents with certain co-occurring mental health and substance use issues (specifically, conduct disorder, SUD, justice involvement, as well as other challenges) that has

had some degree of dissemination (183). By contrast, many widely disseminated SUD program models for both adults (*e.g.,* Matrix Model for SUD, particularly methamphetamine) (184) and adolescents (*e.g.,* Adolescent Community Reinforcement Approach or ACRA) (185), address emotional issues and mental health symptoms, but do not integrate specific attention to co-occurring disorders within their researched program materials.

In the past 20 years, there has been progressive exploration of how to "integrate interventions" without necessarily defining a special program model (9-10). For example, there were investigations of how to "unpack" some elements of the IDDT toolkit and use those elements in residential (135, 139) or hospital (134) settings. The literature on dual diagnosis capability (33, 61) and co-occurring capability (32) involves descriptions of how any program can organize itself to routinely provide a package of appropriately matched and integrated interventions as part of its routine service for individuals with COD who routinely attend. This package includes elements of the list of "interventions that work", either provided directly or through collaboration and in-reach, to create an integrated experience for the clients. This package looks different for a program providing psychiatric inpatient services compared to a program providing residential substance abuse treatment, ICM for adults with SMI, or school-based outreach for teens with SED, or compared to a veteran's court. But the general approach is the same (186).

In an extensive review spanning 30 years of psychosocial interventions for people with schizophrenia and co-occurring substance use disorders, Lisa Dixon and colleagues (105) recommended offering integrated treatment for both disorders using motivational enhancement (ME) and behavioral strategies that focus on engagement in treatment, coping skills training, and relapse prevention training. Their research suggested that ME and cognitive-behavioral interventions improved treatment attendance, substance use and relapse, symptoms, and functioning (105). While the evidence for "integrated treatment" was not definitive, there was a suggestion that people with co-occurring schizophrenia and substance use disorders receiving appropriate integrated interventions participated more in treatment, reduced substance use, spent more days in stable housing, and experienced fewer hospitalizations and arrests (105). Notably, many of the studies reviewed reported that more than half of the sample were people with diagnoses other than schizophrenia, suggesting that these results may apply more broadly to people with serious mental illness and co-occurring substance use disorders.

Another review of 45 controlled studies (22 including random assignment and 23 quasi experimental) conducted by Robert E. Drake and colleagues concluded that group counseling, contingency management, and residential treatment for co-occurring disorders reduced substance use, while other interventions (*e.g.,* case management improving time in community and legal interventions increasing treatment participation) impacted other areas related to recovery. No interventions consistently impacted mental health outcomes; however, the authors noted that the review was limited by lack of standardization, diversity of participants and outcomes, absence of fidelity assessment, and varying lengths of intervention (187). The authors also noted a lack of research specific to stages of treatment (6).

Similarly, in a review including 43 research trials and 24 reviews to illuminate treatment of people abusing substances who also have a co-occurring mental health diagnosis, Thomas M. Kelly and colleagues (106) concluded that the combination of evidence-based treatments (both behavioral and pharmacological) provides the most effective treatments for co-morbid conditions. In a controlled trial, people receiving methadone maintenance who were randomly assigned to receive on-site integrated substance use and psychiatric care (n=160) were

significantly more likely to initiate psychiatric care, attend more psychiatrist appointments, and have greater reductions in global severity of symptoms than were those who received off-site and non-integrated care (n=156). However, there were no group differences in drug use (188).

An observational study conducted by Van L. King and associates examining referral of people on methadone maintenance to a community psychiatry program that was co-located on the same campus concluded that such referrals are often ineffective and that integrated models can improve attendance and retention. In that trial, 156 people receiving methadone maintenance were referred to the co-located psychiatric service and, while about 80% initiated care, they attended only one-third of scheduled appointments and most (84%) did not complete a full year of care. However, they did display modest reductions in psychiatric distress over time (189).

What's New?

In spite of the continuing limitations of research methodology (*e.g.,* the above reviews referring to "integrated treatment" as a "thing"), there has been continued progress in recognition of the importance of providing integrated interventions routinely in a variety of settings.

The American Society of Addiction Medicine Patient Placement Criteria (PPC) Second Edition, Revised (PPC 2R 2001; 14) was the first version that incorporated language defining "dual diagnosis capability" and creating the expectation that all addiction programs at any level of care should be moving from an addiction-only service design to becoming DDC. This was enhanced further in PPC 3 (2013; 190) with the inclusion of the term "complexity capability", referencing the need to routinely engage in integrated attention on multiple issues in addition to SUD and MH (health, housing, criminal justice, learning, etc.).

The opioid epidemic – and associated data showing the prevalence of high-risk opioid misuse and addiction among individuals with SMI (many of whom are served in MH settings) has created a nationwide effort to implement integrated MAT in MH settings. This is very much a work in progress and has required recognition of the fact that these individuals generally need a suite of interventions available, not just medications.

The federally mandated CCBHC standards include very specific language requiring capability to provide integrated MH and SUD interventions to people with co-occurring conditions. Although this was viewed as a logical standard when first developed, it raised recognition that many Community Mental Health Centers that had been approved as CCBHCs did NOT have this capacity and needed to develop it.

Parallel efforts to implement MH care in primary care (usually with a focus on depression screening), and SUD care in primary care (usually termed as "implementing SBIRT") has led to an awareness of the fact that PHBHI implementation efforts for the past decade have been largely "non-integrated" (i.e. parallel, if combined at all) with regard to MH and SUD. This has led to understanding that PHBHI cannot ultimately be successful without integrating attention to both MH and SUD within the primary health care setting.

Another area of emerging concern relates to the challenge of workforce development. In the past decade, expansion of specialist certifications (*e.g.,* addiction psychiatry, COD-certified addiction counselors) has been striking, and there is some evidence that more individuals are seeking dual credentials, but it is also clear that there will never be enough specialists with either two credentials (mental health AND substance use disorder certification) or with a specialized "co-

occurring disorder credential" to meet the need. This has led to the launch of efforts to develop clearer instructions for how any individual provider (whether with no license (as a peer supporter), one license/certification, or multiple certifications) can receive appropriate guidance (within their job and level of training) to know how to appropriately provide properly matched integrated interventions to the individuals they are helping.

Kenneth Minkoff & Christie Cline have described a suggested scope of practice for singly trained SUD counselors (191), and rehabilitation counselors (192), but there has been limited implementation of these recommendations by state registration boards. One of the best descriptions of "integrated team" development is in the detailed description of implementation of IDDT in mental health settings by Kim Mueser *et al.* (193). However, although there are individual "organizational case stories" about developing integrated co-occurring capable services throughout a system (30-31, 34), these descriptions have not provided detailed guidance for how to move beyond having "parallel" MH and SUD specialists vs having an integrated team where everyone is cross trained to be "co-occurring competent" and mutually supportive. This is in striking contrast to the level of detail that has been provided on culture changes required for the integration of primary health and behavioral health (194).

What's New:

The drivers mentioned at the beginning of this article and earlier in this section have led to renewed awareness that progress in learning how to provide integrated treatment or integrated interventions within a wide array of programs has essentially stopped or slowed in the past decade, and much more needs to be done. This requires more clearly articulating what co-occurring capability looks like in any service (in terms of explicitly defining the helpful interventions), as well as researching how individuals with various levels of severity respond to properly matched and integrated interventions vs. non-matched and/or non-integrated interventions. The prevalence of COD has (as far as we know) not been reduced, though the prevalence has not been recently measured, and the importance of providing guidance for how to implement what is known, and then steadily improve it, is more important than ever.

What Now?

Implementation of What Works – Programs and Staff, Systems and Services

What's Known:

A review of psychosocial treatments for people with co-occurring disorders conducted by Robert E. Drake and colleagues noted a significant need for evidence-based approaches to changing systems of care and implementing integrated treatments (187). Integrated treatment requires changes at multiple levels ranging from developing individual practitioner skills to developing policies and procedures that integrate, or at least coordinate, multiple systems of care (*e.g.,* treatment for mental health, addictions, and primary care; criminal justice; social services). The developing field of implementation science offers several frameworks that can guide this work (see, for example, the Consolidated Framework for Implementation Research (CFIR) (195); and the National Implementation Research Network implementation drivers (196-197).

Outside experts, also called purveyors, when supporting one evidence-based practice, or intermediaries, when supporting multiple evidence-based practices (198), can use these frameworks to support programs and agencies that seek to provide evidence-based integrated treatment for co-occurring mental health and substance use disorders.

Existing implementation strategies have attempted to apply this multi-level implementation framework in real world systems. Some of those strategies have focused on the specific implementation of the IDDT program model, using implementation techniques described in the most recent update of SAMHSA's IDDT Toolkit (7). Other strategies have been more broadly focused on implementing integrated services on a system-wide basis, through efforts to implement universal co-occurring capability.

One such strategy, developed by Mark P. McGovern and others, has utilized a set of tools (DDCAT) (33), (DDCMHT) (61)) to formally assess and improve (using multi-layered training and technical assistance strategies) to formally improve DDC in large state and local systems. This process involves alignment between state leadership efforts, program improvement activities, and provision of training, consultation, and technical assistance to the targeted programs. This approach was adopted by several of the 19 states receiving Co-Occurring State Incentive Grants (COSIG) during the period 2005-2013 (e.g., Oregon, Missouri, South Carolina, Minnesota, Connecticut), as well as in several non-COSIG states (*e.g.,* New York, Michigan), some states with statewide application, and others with subsystem pilots.

Another such strategy, the Comprehensive Continuous Integrated System of Care (CCISC), described and implemented by Kenneth Minkoff and Christie Cline (28-29), involves a multi-level implementation approach that combines program self-assessments using the authors' toolkit (*e.g.,* COMPASS-EZ and other tools) to assess and improve baseline co-occurring capability (or "complexity capability"), aligned with overarching system leadership attention, to: providing direction: creating integrated capacity for leading the implementation process via an integration steering committee; continual improvement of data, policies, procedures, protocols, and practices; recruitment and support of a boundary spanning team; system-wide team of change agents or champions; and continual attention to integrated practice improvement at the front line level. Tools in the CCISC toolkit include tools for staff competency evaluation, system of care improvement, integrated system oversight improvement, and attention to co-occurring/complexity capability in intellectual/developmental disability services, health services, and prevention services.

CCISC implementation was utilized to varying degrees in many of the 19 states receiving COSIG grants (*e.g.,* Alaska, Maine, Vermont, District of Columbia, Oklahoma, South Dakota, Pennsylvania, Virginia) as well as many other state and local systems in the U.S. and Canada (*e.g.,* California, Florida, Iowa, Nebraska, Montana, Michigan, Maryland, Manitoba, Prince Edward Island). (*cf.* 30, 31, 34)

Results of COSIG implementation efforts have been described in individual state evaluation reports, only one of which has been formally published (Maine) (34), but there has never been a formal cross-site evaluation of the COSIG process, nor formal evaluation research comparing approaches or tools for system-wide integrated services implementation.

With regard to implementation research, a review of research exploring implementation of IDDT at the program-level concluded that successful implementation takes considerable time and effort, longer than what is needed to implement many other psychosocial interventions (199). Most of the research in this area occurred as part of the National Implementing Evidence-Based Practices Project where, of the 11 programs attempting to implement IDDT, only 2 (18%) met the high fidelity benchmark, 6 (56%) met the moderate fidelity benchmark, and 3 (26%) did not exceed the low fidelity threshold after two years. However, 9 of these programs had sustained

the practice at four years (199). The authors noted that the longer time frame was likely related to the aforementioned complexity of implementing integrated services, which requires culture change (within programs and across separate systems of care), skill development, shifts in staff, clinical process changes, and outcomes monitoring (199), a complexity underscored in a more recent study by Martin Kikkert and colleagues (182).

A large study related to utilization of DDCAT and DDCMHT in New York state demonstrated (not surprisingly) the likely value of technical assistance in improving DDC scores. In a study of technical assistance provided to 603 behavioral outpatient programs throughout the state of New York, Michael Chaple and Stanley Sacks (200) measured capability to provide treatment for co-occurring disorders at baseline (n=603) and at follow-up (n=150 randomly selected programs). Programs received technical assistance focusing on site visit feedback (including key strengths to build on and immediate opportunities to improve capability based upon the baseline self-assessment in which items reflecting the presence of co-occurring capability are rated on a scale from a low of 1 to a high of 5), assessment report (including recommendations for improvement in each dimension and links to training and other available resources), implementation support (quick guides to summarize most common recommendations; guidelines to improve scores), and workshops (reinforcing feedback from assessments and guidance to develop implementation plans (200). Programs demonstrated significant improvements from baseline to follow-up overall, in each domain, and for a majority of individual items (at baseline, the average program score was 2.68 out of 5, and, at follow-up, the average score was 3.04 out of 5 (200). Further, the percentage of programs with average scores of 3 and higher more than doubled, from 22% to 52% (200). The authors note that, given the significant New York state policy directives and other training/technical assistance (TA) initiatives in the state at the time, it was difficult to decipher the unique impact of the TA provided in this study (200).

Recent research on system implementation of integrated service delivery was reported by a group in Sydney (New South Wales), in which a team of researchers set out to apply "implementation science" to the use of a "multimodal" training process, along with "clinical champions", to improve co-occurring service delivery in SUD programs across New South Wales. These efforts did not utilize any of the tools or materials utilized in the North American implementation efforts referenced above, but nonetheless represent the most recent published work on this topic (201).

In conclusion, despite the availability of considerable practical experience, and a wide range of tools and measures for implementing integrated co-occurring services in all types of programs, there is little universality in the implementation of these strategies, very little evidence of sustainable effort over time, and almost no research continually evaluating, comparing, and refining various approaches to implementation. A recent review by Mark McGovern and colleagues across multiple states indicated that only a very small percentage of a sampling of selected MH or SUD providers were able – at baseline - to demonstrate even moderate progress toward co-occurring capability (202).

Conclusion

Although there has been little substantially new in the development, evaluation, or research of strategies for large scale implementation of integrated MH/SUD services, the past decade has led

to important new knowledge and opportunities for implementation of integrated services, as follows:

- **Substantial knowledge about implementation of integrated PH/BH services:** There is substantial literature that has accumulated describing the details of implementation of sustainable culture shift and practice improvement in both primary health and behavioral health settings working on PHBHI. One of the best descriptions of the level of detail involved in this challenge has been described in "A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration" (194). Further, the concept of "bidirectional" integration has made it clear that integrated services occur in multiple forms and in multiple settings. (*See* SAMHSA_HRSA Center for Integrated Health Solutions at https://www.integration.samhsa.gov/). This knowledge can contribute to our next steps of implementation of MH/SUD integration.

- **Increased recognition of the importance of MH/SUD integration for a wide array of populations.** Because of the opioid epidemic, the need to provide integrated criminal justice diversion services, and the importance of integration of both MH and SUD in health settings, implementation efforts have now included the importance of incorporating medication assisted treatment (which of course applies to both MH and SUD) in all settings, as well as building opportunities for integrated continuity of care for all individuals with severe SUD, including those with co-occurring conditions that do not meet the criteria for SMI.

- **Increased understanding of how to integrate MH/SUD services with other complex challenges.** The state of Iowa engaged in a five-year project from 2008 to 2014 to develop "multi-occurring capability" involving MH, SUD, I/DD, and Brain Injury services statewide, using the CCISC approach. The Council on State Governments has released a system design model which overlaps MH/SUD severity (high low) with criminogenic risk severity (high low) to provide opportunities for mapping services (using the sequential intercept model) to the expectation of various combinations of high or low MH, SUD, and criminogenic risk comorbidities at each intercept (203).

- **Increased recognition at the state and county system level that "integration of MH and SUD services" is not "complete".** Although many states have engaged in internal reorganization and "integration" of their MH and SUD departments and divisions, and many states have engaged in some type of practice improvement activity to improve co-occurring services, there are very few places that have embedded sustainable system MH/SUD integration improvement efforts at all levels. As the opioid epidemic has progressed, associations representing state and county leaders (*e.g.,* NASMHPD, NASADAD, NACBHDDD) have become increasingly aware of not only the lack of integrated services for individuals with co-occurring MH and OUD conditions, but of the lack of MH/SUD integration generally. As a result, there is now a re-emergence of interest and commitment to incorporate what is known into state and local system improvement efforts for complex populations. This becomes more urgent as more and more states are seeking to invest limited resources in population health models in which integrated services for individuals with complex co-occurring MH/SUD needs are essential for success.

Recommendations

The short answer is simple:

It's time for state and local systems (and their partner provider agencies and programs) to begin to *systematically implement what is known* to routinely provide integrated MH/SUD services for the high risk, high volume, poor outcome population with complex needs. It is also time for federal, state, and local research funders (the National Institute of Mental Health, SAMHSA, foundations, etc.), academic institutions, and other entities which routinely evaluate population health efforts to make the same level of investment in the study of systematic MH/SUD integration efforts as has already been done for PHBHI.

For any individual state (or county) leader, we recommend the following policy steps. These steps are relatively simple, not terribly costly, and can be highly productive in improving integrated MH/SUD services in your system**.**

1. **Establish the goal of universal availability of integrated MH/SUD services in all settings for all populations ("universal co-occurring capability").** Ensure that this goal is communicated by all divisions overseeing service provision. (Note that only establishing the goal of health/behavioral health integration will NOT automatically imply that MH/SUD integration will be addressed.)
2. **Routinely measure and report the prevalence of co-occurring MH/SUD conditions (whether or not they have both been diagnosed or billed) in *all* settings in which service or population data are reported.** Expect over time to have data collection match expected prevalence in that setting. Include reporting on co-occurring families in children's services. Include specific attention to gathering data on opioid users in all settings. Developing baseline data collection enables ongoing data-driven performance improvement at the individual, program, and subsystem level.
3. **Identify a sustained state-level "steering committee' with empowered leadership from all relevant state agencies - and broad stakeholder involvement - to oversee MH/SUD integration improvement efforts.** Replicate such steering committees at the level of key intermediaries (regions, counties, etc.). Ensure participation of managed care organizations and other funding intermediaries. This should be viewed as an ongoing (10-year) effort, not as a short-lived project. The end point should be that routine monitoring and improvement of integrated service provision is sufficiently embedded into all state oversight operations and services to the degree that no further "special leadership" is required.
4. **Identify a formal process (tool) for measuring co-occurring capability and ensure all programs utilize that tool to establish a baseline for improvement.** Encourage initially and then ultimately expect that all agencies and programs demonstrate continuous improvement. Do not settle for achievement of a "partial score" on the fidelity scale; emphasize the need for continuous improvement within available resources. Utilize other tools for measuring and improving co-occurring system performance and staff competency.
5. **Make provision for cost-effective statewide (and local, when appropriate) support of the change processes, including training/consultation/TA, identification of champions, support of learning communities and continuing measurement of**

progress. At present, there is no one right way to do this, but the presence of sustainable support will result in better outcomes. Intensity is less important than sustainability. Some states (*e.g.,* Ohio) have created a formal Center of Excellence for this purpose.

6. **Make provision for ongoing evaluation and improvement of the system-wide implementation process.** Ensure that the evaluators are familiar with large-scale implementation science methodologies and can translate effort into measuring progress across the total population, rather than just in narrowly selected practices or pilot programs.
7. **In the context of the opioid epidemic, specifically target routine implementation of MAT for OUD and AUD in community mental health programs, as well as in primary care settings.** Similarly, emphasize access to MAT for SUD and access to medications for co-occurring mental health conditions in SUD programs as a routine feature of services throughout the system. This can be done through direct provision of psychopharmacology in SUD programs, or through proactive collaboration of SUD programs with MH programs and/or MAT programs.
8. **Review and improve internal state and local policies and regulations regarding the following issues:**
    a. **Ensure all program descriptions in regulation include the expectation that the programs will be addressing individuals with co-occurring disorders and providing integrated services.** Ensure this occurs in the crisis continuum as well as at all levels of care in routine services. Ideally, crisis services should be designed as an integrated (rather than parallel) continuum of services for people in crisis, using LOCU.S. (204) or a similar set of guidelines for integrated measurement of appropriate service intensity.
    b. **Review and adjust all access rules that create barriers for individuals with co-occurring conditions.** Every door is the right door to get help, and the job of every program should be to bring you in quickly and help you get connected to what you need.
    c. **Review billing instructions and codes to ensure that appropriate co-occurring services can be provided and billed within each *individual* MH or SUD funding stream.** This would include appropriate instructions regarding progress note and treatment plan documentation. Numerous systems have begun to develop these policies, but they have not been widely disseminated.
    d. **Redefine outcome measures to emphasize continuity of small steps of progress across multiple disorders, including harm reduction efforts, rather than emphasizing "treatment completion" and short-term episodes of care.**
    e. **Identify mechanisms that reimburse and reinforce cross-consultation and in-reach services provided by MH practitioners/agencies in SUD programs, and vice versa.** Include attention to implementation of MAT services in MH and other settings, as well as psychiatric input into methadone programs.
9. **Establish a plan for "co-occurring competent" workforce development system-wide. This might include the following issues:**

a. **Provision of continuing support for co-occurring MH/SUD practice improvement strategies at the subsystem and provider level.** This should involve alignment of system leadership, agency managers, supervisors, and staff to move beyond "training alone" to ensuring that any training is associated with routine practice supports on the job.

b. **Review and improve existing workforce development activities (*e.g.,* state-funded training programs, scopes of practice of state licensing boards, job descriptions).** The goal is to clarify that all BH providers will need to be prepared to have clear instructions and basic competency for providing integrated services to the people with co-occurring needs that regularly appear in their caseloads.

c. **Incorporate co-occurring training into certification of peer support specialists and recovery coaches.** Remarkably, even though most peers have co-occurring issues, they are commonly trained on providing peer support for only one area of lived experience.

10. **Over time, work with partner systems to support identification and integrated interventions for individuals and families with co-occurring needs as a routine feature of service design.**

    a. **Criminal justice and juvenile justice services.** All diversion services should have the expectation of addressing co-occurring needs, including trauma.

    b. **Primary health services.** All "health homes" should be able to implement appropriate measurement-based screening and intervention for common MH disorders (not just depression) and SUD (through SBIRT) (38), with access to consultation or teleconsultation if appropriate, as well as referrals for more challenging situations.

    c. **Housing services.** Include attention to the design of housing support services that can accommodate individuals who may be making different choices about substance use, necessitating services that are matched to preference as well as need, and are "dry", "damp", or "wet".

    d. **Child protective services.** Child welfare regularly deals with co-occurring families, as well as parents who themselves have co-occurring issues, including trauma. Aligning evidence-based and trauma-informed family intervention approaches for traumatized and complex families with the specific BH services available is an appropriate goal.

    e. **Aging and disability services.** Individuals with cognitive disabilities are at high risk for both MH and SUD, and often both.

    f. **Employment and vocational services: Supported employment and education.** Emphasize that the evidence base for IPS does not require sobriety before employment or education.

These policy recommendations will permit each state and county system to review what's known, take advantage of what's new, and organize to use the existing knowledge and current energy for change to implement substantial and sustainable improvements in co-occurring services within existing resource limitations.

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Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-10

This is the attachment marked '**GJC-10**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

EACH Service Principles

health . hope . opportunity

each

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The success and rich learning gained through these workshops, would not have occurred without the following support:

- EACH community members who participated in the Service Principles workshops to provide feedback on their experiences of welcome, empathy and hope.
- EACH Service Managers and Team Leaders who shared their experiences with Head Office staff in the service of developing an 'internal customer' mindset.
- IDEO.org (Individual Design and Consulting organisation) for generous launch of free Field Guide to Human Centred Design and related Tool Kit.
- Lead workshop facilitators; Jenni Thompson, Annette Rudd with the operational support of Monika Osmanagic.
- Change Agent co-facilitators who enthusiastically shared their time and expertise in the delivery of Orientation workshops and supported ongoing iteration of the workshop: Jane Ludtke, Michelle Egan, Rhianna Perkins and Tim Pitt.
- EACH staff members who engaged with enthusiasm to explore using new and creative ways to have conversations with customers, and who worked together to create prototypes that would improve service response.
- EACH Managers and Team Leaders who supported staff to attend a full day workshop in the context of competing demands.

PHOTOGRAPHS

The photographs included in this report have been used with permission of workshop participants.

EVALUATION METHOD

Workshops were evaluated using the following data:

- Post workshop surveys
- Individual staff feedback
- Customer engagement and feedback
- Prototypes

Data analysis and interpretation has been Thematic (synthesizing patterns, themes of text and spoken) and Content (coding and quantifying survey responses) analysis.

DEFINITIONS

Throughout this report the following terms/acronyms will be used.

Customers: EACH is committed to being a customer centric organisation. Our broad definition of customer means we are inclusive of all people who interact or engage with us, either externally or internally. Our customers include consumers, clients, participants, patients, carers, the community, stakeholders, partners, staff, personnel, volunteers and members.

Human Centred Design: (HCD) is a method of co-design that develops solutions to problems by involving human beings most affected by the problems to be part of the solution finding process. This approach enhances effectiveness and efficiency as well as user satisfaction.

NDIS: National Disability Insurance Service

3 Points of Difference: Social model of health, Co-design, Service principles.
EACH differentiates itself through these points of difference.

"If EACH gets this right,
it will get everything right"

- EACH customer

FOREWORD

EACH is operating in a time of unprecedented change. New funding models and increased choice and control is empowering customers like never before. These are values and principles EACH fully supports. At the same time these changes bring significant challenges to previous ways of working, increased competition, increases in regulation and compliance around quality, safety and funding as well as skill shortages in some areas.
These factors combine to create a very challenging environment for EACH, as well as the not-for-profit sector as a whole.

EACH is committed to meeting these challenges. The Service Principles described in this Report respond to the need to develop a consistent approach to 'the way we work' at EACH, regardless of the actual service we provide. We believe that 'how' we work is as important as 'what' we do and a consistent set of principles that underpin all of our work needed to be described.

Initial exploration of existing service models identified two things. Firstly, that no other comparable organisations had anything resembling a whole-of-organisation service model. Secondly, that the Comprehensive Continuous Integrated Systems of Care model pioneered by American Psychiatrists, Dr Ken Minkoff and Dr Christie Cline. (CCISC), seemed to capture the values and principles that resonated with EACH.

The CCISC model is an evidence-based service model guiding best practice service provision to individuals and families with complex challenges. It appeared to share the same values and principles that we would want to see embedded in the EACH culture, such as being non-judgmental, empathic, strengths-based and promoting a growth /recovery mind-set. However, there was also an acknowledgement that the model would need to be tested with our diverse customer population, re-designed and adapted for a better fit with EACH.

And so we launched a series of Innovation Labs over February 2016 to inform the development of a new set of EACH Service Principles, co-designed with customers and providing a consistent way to deliver the diverse programs of EACH across the organisation. The CCISC model was tested through the Innovation Labs using Human Centred Design methods. The engagement with customers helped us to develop evidence based service principles in language that resonated with customers and aligned with exceptional staff service provision.

As a key component of **EACH 2020: A National Strategy** the Service Principles define our values and purpose, guiding the way we provide our services to our customers, forming a key component of our 'points of difference' that distinguishes us from our competitors.

Peter Ruzyla
CEO

CUSTOMER EXPERIENCE IS VARIED

"This restores my hope and faith in EACH"

"EACH treats me like a human being, other providers treat me like a transaction"

"EACH has lost its way"

"EACH no longer cares about me as a human being"

"EACH doesn't treat its staff well"

EXECUTIVE SUMMARY

Imagine a health and wellbeing service designed for customers, by customers.

The EACH Service Principles philosophy – "we welcome you with empathy and hope" has been voted the most important EACH cultural experience for both staff and clients based on feedback throughout orientation to the Service Principles.

To orient all EACH staff to the Service Principles organisation-wide the following work was undertaken:

- The Development of an Orientation module that incorporated both Service Principles and co- design.
- A pilot project to test the module with both staff and clients at Patterson Street, and with leaders and managers.
- 40 Orientation Workshops were conducted.
- 700 staff and 165 customers participated in the Orientation Workshops.
- Staff demonstrated over 100 prototypes to improve the ways we "welcome you with empathy and hope" were developed.

The purpose of the workshops were to socialise the Service Principles across the organisation. Evaluation of the pilot workshop indicated:

- a 95.8% increase in participants knowledge and understanding of EACH's service principles.
- a 96 % increase in confidence of participants to apply the service principles to their daily work.
- 100% agreement that the workshops were an appropriate method for orienting to the service principles.
- Staff demonstrate a high level of enthusiasm, endorsement and engagement with both the Service Principles and the mindset and methods of co-design to improve service.

Qualitative data indicated that the workshops generated a high level of inspiration for staff in regard to their philosophical alignment with both Service Principle philosophy and the using of HCD mind sets and methods. Staff expressed these points of difference position EACH well for the competitive market and demonstrate a commitment to innovation.

Despite this strong expression of endorsement from staff, the most common concern raised in response to the strategic aspiration to create a culture of welcome, empathy and hope was the experience of "incongruence". Staff reported the aspiration was incongruent with internal culture and incongruent with the emerging NDIS transactional model of service as they experience more "clinical" and "transactional" "medical model" language and procedures that are in conflict with social model of health. Their experiences of internal customer service was also incongruent with aspirations of exceptional customer centric co-design.

Interstate customers reported strong alignment and validation of the Service Principles, the philosophy of welcome, empathy and hope, with many stating that their experiences of EACH demonstrated a more "human interaction" when compared with other service providers, increasing customer loyalty to EACH as a service provider. One NDIS customer reported, "EACH treats me like a human being, other providers treat me like a transaction". However this was not always the experience of clients impacted by the mental health reform and transition to NDIS in Victoria.

A number of customers in Victoria had very different experiences with a change to what they once received from EACH being impacted by NDIS. Customers in Victoria reported "EACH has lost its way", "EACH no longer cares about me as a human being", "EACH doesn't treat its staff well". Customers in the mental health services in Victoria reported awareness of staff feeling "stretched" and unsure of job security. Some customers reported that programs ceased abruptly without explanation or transition.

Universally customers expressed appreciation for being asked their view and reported this was the first organisation who had deliberately engaged their opinion in the exploration of improving services. Customers felt heard by staff and appreciated the demonstration of genuine desire to "walk a mile" in their shoes. Customers were paid for their time and expressed this was deeply respectful and acknowledged them as the experts of their experience and consultants to EACH.

Orientation workshops conducted with Corporate Services engaged EACH Service Managers and staff as the "internal customer". The concept of the internal customer highlighted the need for a mindset of internal customer service and that taking this approach improves relationships between corporate and operations as well as creates a culture of respect and exceptional service efficiencies and experiences for both staff and clients. Complaints about internal customer experience from operational areas in relation to IT, infrastructure and HR onboarding were essentially universal. Complaints revolved around timeliness of getting what was needed just to do their basic work, inability to access the right person to discuss concerns, tone of incivility from corporate services staff towards questions and complaints. Co-design encourages a culture of welcoming complaints in the service of getting better at all that we do. This was acknowledged as an aspiration that needs to be a mindset of all staff at all levels.

SUMMARY RECOMMENDATIONS

To address the issues raised as a result of this work the following capacity building activities are recommended:

- Resource and Support Design Teams to integrate HCD methods and Service Principles in model development.
- Incorporating the Service Principles and HCD methodology into key organisational policies, procedures.
- Ensure all programs allocate budget to co-design and facilitate regular customer engagement activities.
- Customer-centricity demonstrated through commitment to HCD methods and follow through
- All prototypes to be reviewed for identification of ideas to be further tested and implemented.

STAFF CAPACITY BUILDING AND MONITORING

- Develop Capability Framework and Baseline Measures for individuals and programs.
- Integrate Service Principles into Recruitment Processes and Position Descriptions.
- Align Code of Conduct with Service Principles.
- Ongoing Leadership Development that is aligned with Service Principles.
- Orientation to Service Principles and Co-Design mandatory training for all staff.
- All employee IPDR's to include review against capability matrix and identification of workforce.

EVALUATION AND IMPACT MEASURES

- Analyse customer feedback against Service Principles Eg. Align compliments and complaints against the principles to identify key areas for improvement and training needs.
- Develop internal customer feedback processes that identify pain points, and measures for turnaround times, particularly in regard to internal customer satisfaction.
- Identify and liaise with key personnel to assist in trouble shooting and problem solving when urgent needs are unmet or post a risk to business.

Our Co-design Principle:

"Nothing about us without us!"

INTRODUCTION

This report aims to:

- Detail the development and implementation of a workshop model used to introduce Human Centred Design and Service Principles to EACH Staff.
- Share the key lessons and learnings that were identified through the quantitative and qualitative feedback from participants.
- Provide an overview of the prototypes developed in response to the customer interviews carried out during each workshop.

PROJECT BACKGROUND AND CONTEXT

Innovation Labs - Phase 1

In February 2016, 13 Innovation Labs were facilitated across EACH nationally.

Almost 200 customers and 50 staff worked together to test and co-design a set of Service Principles in response to an expressed need for a consistent approach to 'the way we do business'. This was following a period of EACH growth through merges, acquisitions and establishing services nationally. HCD methods were used to train a Creative Team made up of customers and staff to co-facilitate the Innovation Labs and to research customer opinion and expectation.

The Innovation Labs ensured our Service Principles were co-designed with customers through a process of testing and iterating. The result established a benchmark for highest quality care and service. (See the Development of EACH Service Principles Report 2016)

SERVICE PRINCIPLES AND STRATEGY 2020

The EACH Service Principles aim to provide cohesive and a consistent service delivery experience across EACH's diverse programs and locations. They provide EACH with a shared language that clearly articulates our shared values and philosophy with the aim of uniting the organisation through a common approach to service provision, where all customers, external and internal, will experience a consistency of engagement and a high quality of service.

As a key component of EACH 2020: A National Strategy the Service Principles define the EACH 'heart and soul', 'how we do business', guiding the way we provide our services to customers, and form a key component of our 'points of difference', distinguishing us from other services.

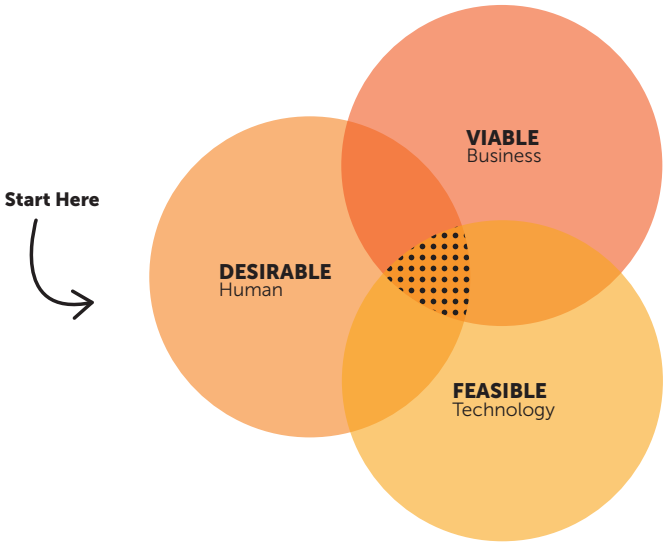
PROJECT SCOPE

This project aimed to increase staff knowledge and engagement with the new EACH Service Principles and EACH's method of co-design: Human Centred Design.

We decided to integrate both the Service Principle philosophy and the methods and mind sets of HCD to develop an Orientation Module for staff via a full day workshop engaging staff and customers in a co-design activity that would support customer engagement to improve real time issues for customers. The workshop involved relevant clients to the audience and a hands on co-design experiential process exploring a relevant Service Principle implementation issue: How might we improve your experience of welcome at this site? How might we demonstrate empathy? How might we demonstrate hope?

METHODOLOGY

Co-design is one of our Points of Difference in the EACH 2020 National Strategy. As part of being a customer centric organisation we are committed to engaging with individuals and communities as the end users of our service system to actively understand, explore and ultimately improve the service system together. We start with customer desire, exploring viability and feasibility in the pursuit of innovation and service improvements.



The term 'co-design' is used a lot in the Service Sector and needs to be clarified as it can often be misused. We need to be clear in the language we use and make sure that when we are communicating, consulting and collaborating we are not using the term "co-design". Whilst these are elements of co-design, co-design is the deliberate engagement of end users of a service system to co- design change as highlighted by the work of Huddle NDS Project definitions. To genuinely co-design we approach the engagement with no agenda for outcome, we use the mindsets of empathy and creative confidence as well as a robust welcoming of complaint to genuinely hear what is not working without defensiveness.

Whilst communicating, consulting, collaborating and coordinating can be aspects of co-design, to genuinely co-design we need to deliberately engage the end user of a system to help us solution find together.

Table 1: Co-Design Definitions

Communicate	Informing people what is going to happen
Consult	Engaging with people to indirectly influence outcomes
Co-ordinate	Bringing together different and multiple elements for consolidation toward a shared outcome
Collaborate	Multiple people working together in a mutually beneficial and well defined relationships to achieve a common goal
Co-design	Deliberately engaging users of the system, deliverers of services and other experts to actively understand, explore and ultimately change a system together

Source: Huddle NDS Project

UNDERSTANDING THE TRUTHS AND MYTHS OF CO-DESIGN IS KEY

There are some concerns and misunderstandings about co-design expressed by managers and leaders across EACH. These are highlighted in the co-design myths by Huddle NDS project.

Whilst co-design encourages "out of the box" thinking, it is not always viable or feasible to take on ideas generated by a co-design activity, nor is co-design appropriate for every problem-solving situation. One of the myths that is not included in the Huddle Project learning is the myth of co-design being time consuming. Co-design can bring about prompt information about current opinions and supports engagement and ownership in end user. This can often take much longer through the usual working group methods that often have top down decision making approaches that do not get buy in. Serious errors of judgement may also be made through lack of engagement with the end user involved in the process.

Table 2: Truths and Myths of Co-design (Huddle NDS project)

Co-design TRUTHS	Co-design MYTHS
Is person-centred	Customers are always right
Is inclusive and draws on many perspectives	We should give people what they want
Focusses on desired outcome	If we've engaged users, that's co-design
Develops practical real life solutions	If I'm part of a co-design approach I get to determine the results
Makes ideas, experiences and possibilities visible and tangible	Co-design can be applied to anything

CHALLENGES AND LIMITATIONS

There are some concerns and misunderstandings about co-design expressed by managers and leaders across EACH. These are highlighted in the co-design myths by Huddle NDS project. Whilst co-design encourages "out of the box" thinking, it is not always viable or feasible to take on ideas generated by a co-design activity nor is co-design appropriate for every problem-solving situation.

Time

"Time competing responsibilities. Fear of others judgement."

"Busy seeing clients, lots of change happening at the moment. No barriers to strategy but maybe barriers to implementing."

"I'm flat out with my caseload, too busy, more clients but at the cost of reduced quality."

Management/Leadership

"Managers don't see the value of co-design."

"Management not listening. Not enough employees speaking up."

"Leadership are not on board."

Culture

"Culture is not safe to fail."

"Inconsistent expectations and culture across the organisation."

"Mindset that we already do this, already do enough."

Funding Model

"Limitations of NDIS."

"Budget Constraints."

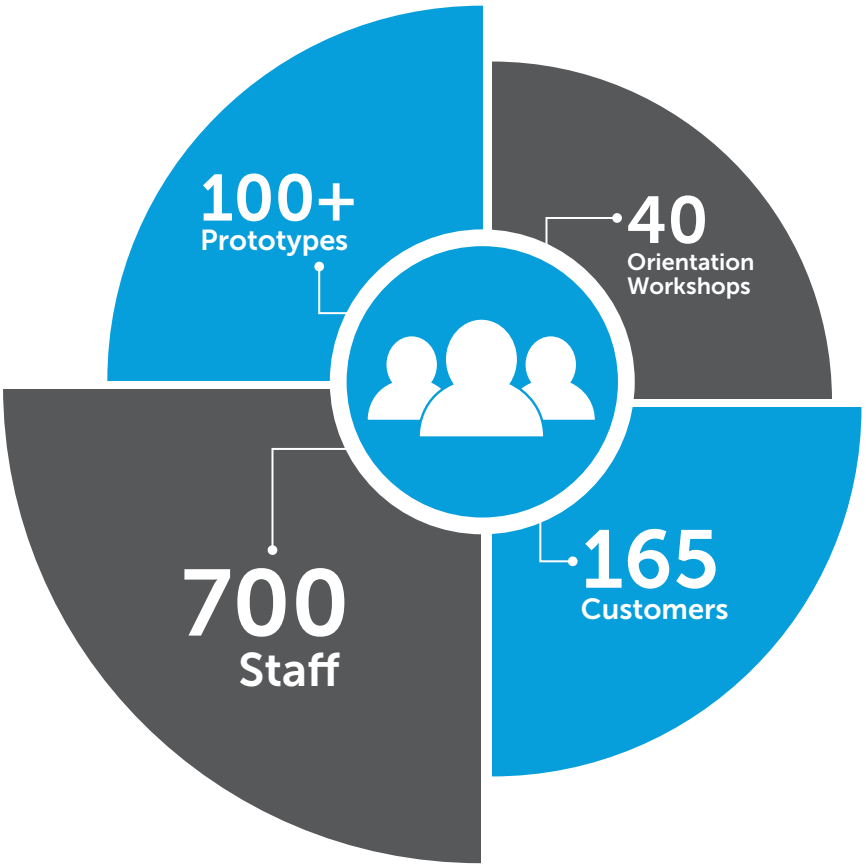
"Targets/ Funding."

The constraints of co-design (time, resources, management approval and competing demands) were consistent across sites nationally and indicate that service providers would have limitations in implementing HCD.

This report is a summary of the engagement with staff and customers (internal and external) in the orientation process and a reflection of the lessons learned.

VISUAL DISPLAY OF OUTCOMES

"This is an organisational imperative"

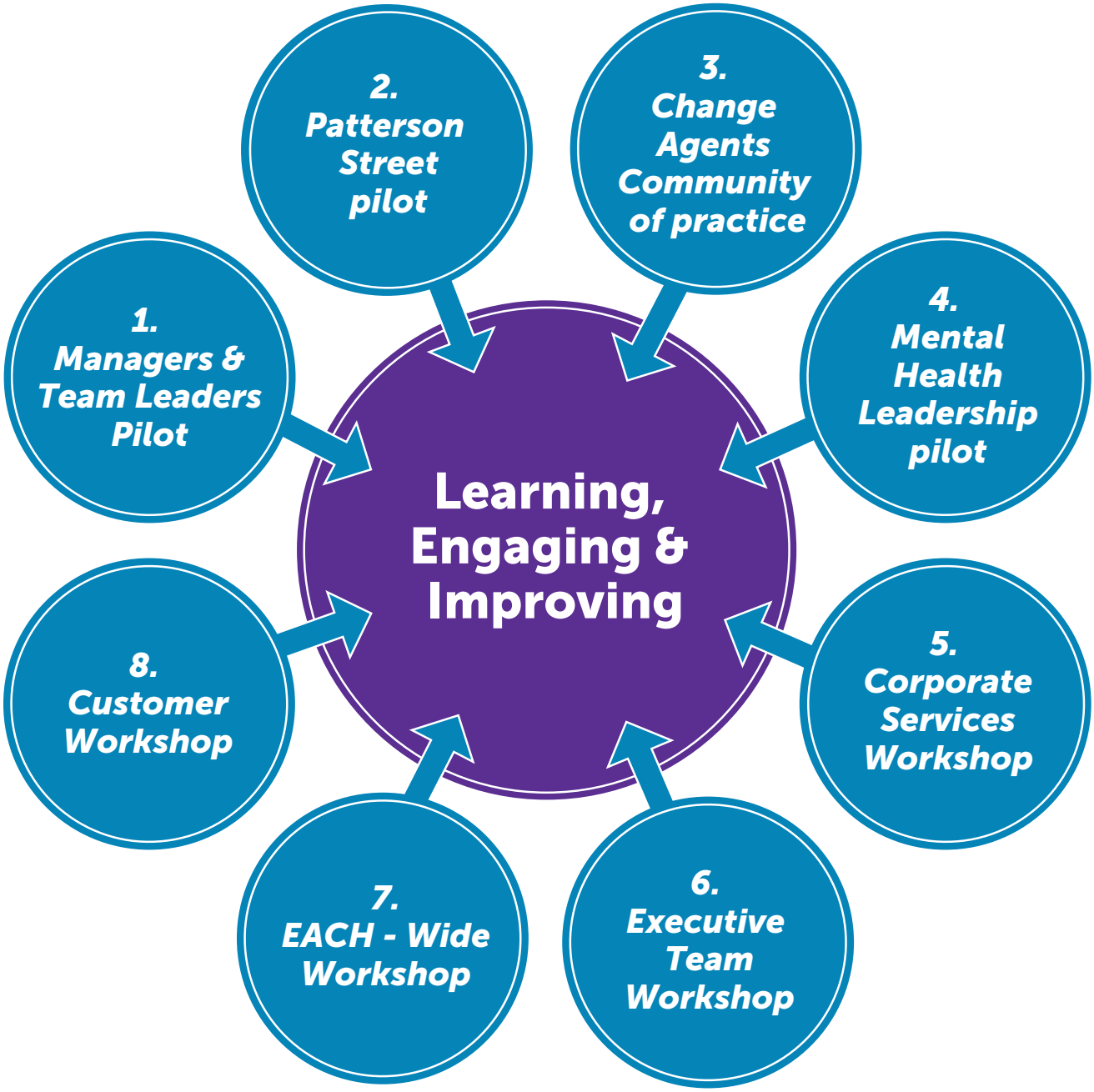


"Really positive format, an investment in our future, our workplace, people and business. I really liked HCD, I've been working with humans my whole life, it is great their worth is finally being acknowledged!"

"Hands on learning, gave me a different way to look at problems, a great way to learn, enjoyed the whole process"

"You made me think outside the box!"

ITERATE, ITERATE, ITERATE



1. MANAGER'S & TEAM LEADERS' PILOT

Service/program areas represented included Primary Health, Mental Health and Recovery

Participation and Choice, Alcohol and Other Drugs and Regional Counselling Workshops were conducted with Managers and Leaders to test the content of proposed Orientation Sessions and provide rationale, theory of Human Centred Design and desired outcomes for upcoming Orientation Workshops with staff. Thirty-five staff participated in the pilot workshops and all agreed they would be an effective way to learn about Human Centred Design and Service Principles and they would advocate for others to attend.

Feedback snapshot:

"Really enjoyed the workshop and considering the culture of consumers and how it supports or disempowers HCD. Looking forward to empowering staff and consumers to explore their creative ideas and implement them together."

"The principles reflect the work that my team are already practising. This will add to the consolidation of principles."

"I'm hoping that organisationally this entire concept will become part of our culture I want to be a part of this process support or even be a change agent. These principles will ensure EACH's success."

"Brainstorming creates a sense of hope, positivity, and starts a genuine thinking process."

"Don't change a thing! Don't change a thing."

2. PATTERSON STREET PILOT

Customers and EACH staff from a range of disciplines involved

It was decided that the diversity of Ringwood East Patterson Street site would provide the ideal place for a Pilot project to test relevance of Service Principle Orientation and Human Centred Design to diverse services.

A full workshop was delivered with staff and customers of the site. Customers of the diverse programs were invited to participate in the research activity, with staff engaging their customers to explore their experiences and to test the relevance and experiences of welcome, empathy and hope.

Feedback snapshot:

Customer Involvement

Involving customers was identified as a critical component of the workshop, with a diverse group of customers from Burmese Refugee community, Alcohol and Other Drugs Services and Mental Health services.

Staff practiced their HCD methods, empathy and curiosity to explore without judgment the customer needs and experiences and how to improve welcome, empathy and hope.

"Speaking to customers (Burmese refugees) was valuable as we could hear their own perspective on EACH services they have used and what they liked and didn't like".

"Interactive – team environment hearing feedback from clients of EACH"

Prototype Development

The activity of developing a prototype was initially viewed with some reluctance. This was a reaction that had already been anticipated, however facilitators felt for HCD principles to be genuinely applied staff would need to explore solutions from outside of their comfort zone. The responses in the evaluation suggested this was a fun and creative way to tease out ideas and staff really got into the use of the various creative tools provided. Staff were amazed at the innovation and creativity that arose out of the opportunity to engage the right brain.

'Being interactive and creative with the props in the activities. Putting things together in the prototype activity. Loved the workshop! Interesting new creative and informative Great ideas came from it.'

'The HCD process gives me hope that we can be innovative, it was highly practical designing a prototype for a real problem was empowering'.

Application of Learning

As a result of the workshop some staff immediately set about improving the Ringwood East Waiting room which had been identified by the clients as cluttered and overwhelming. While the small space could not be changed minimizing some of the items cluttering up the room was felt as a positive step to implementing a solution to the identified problem and one that did not require any added expense.

"Yes, can work soon to de-clutter the waiting room. Unable to turn outdoor area into overflow waiting room without approval"

"I now have an improved understanding of HCD and how to implement in my work"

"I plan to re-design and de-clutter podiatry clinic space"

"Yes I will look at each customer as unique and tailor solutions to individual needs"

Challenges

However, overall the responsibility for enabling implementation to occur was seen as a sitting with Management. This was identified as both a potential enabler and a potential barrier to the success of the Service Principles rollout across the organisation.

"No, (I cannot apply what I have learned) My ideas have been presented today and now it is up to management to follow through with these site needs"

"Yes, (I can apply what I have learned) if management are on board too! Needs to be advertised and promoted in the work site to be reinforced"

"Time, planning, negative people"

"Rigid guidelines that dictate less personal client processes"

"Time constraints and workload prohibitive"

3. MENTAL HEALTH LEADERSHIP PILOT

16 participants

Customers and Managers from EACH Mental Health Services participated

Consistent with the previous two pilot groups, the response to the workshop format was positive with all staff agreeing in their evaluation that this was an effective way to orient staff to Service Principles and Human Centred Design and they would recommend this workshop to colleagues.

Feedback snapshot:

Customer Involvement

The interaction was informative and fun' - 'A welcome environment'. An open, honest and safe environment for collaboration. A great model for customer engagement.

Prototype Development

Prototypes for the Mental Health Leadership team featured staff workforce development and recruitment aligned with Service Principles, creating culture of welcome, empathy and hope for staff as well as clients.

"I enjoyed the prototyping and seeing the ideas of other groups"

"Great informative, captivating, hands on ability to create a prototype from start to finish"

"Time, planning, negative people"

"Rigid guidelines that dictate less personal client processes"

"Time constraints and workload prohibitive"

"Fully support staff to explore and use HCD"

"I am looking forward to empowering staff and customers to implement ideas"

Application of Learning

"It was an open honest and safe environment, I now have a common language within the team"

"This is a great opportunity to develop positive outcomes for customers/clients"

Challenges

- The current situation of change
- Negative attitudes to change
- Staff feeling uncertain about their future
- Having the support of higher management

4. CORPORATE SERVICES WORKSHOPS

Introduction of the concept of the 'internal customer'

Workshops with Corporate Services staff emphasised the application of Service Principles and HCD methods and mind-sets to the relationship with 'internal customers'. Therefore, the customer engagement activities were predominantly with internal Service Managers and Team Leaders.

These staff were given the customer engagement design challenge to explore how as Corporate Services staff they can provide greater welcome, empathy and hope in their internal customer service provision.

Feedback snapshot:

Customer Involvement

"This will help me empathise more with the internal customer"

"Talking with customers was eye opening, a different conversation"

Content

"This gave me a new way of thinking about things"

"Just hearing a small snippet of feedback highlighted our lack of understanding of customer needs"

Culture

"There are inconsistent expectations and culture across the organisation"

"The workshop provided ways to change attitude using the Service Principles and HCD mind sets"

Capacity and application

"I am inspired and motivated to bring the Service Principles to life"

"Treating every interaction from a customer perspective will improve outcomes"

"I will be paying more attention to the customer that walks up and down the hallway"

Self-reflection

"I need to listen more to full understand what the internal customer needs, so I can service better"

"An eye opener and what I learnt I can apply to both personal and professional life I want to engage more, smile more and be more aware of hospitality when staff visit head office"

5. EXECUTIVE TEAM WORKSHOP

12 participants

Introduction of the concept of the 'internal customer'

An Orientation workshop was conducted with Executive Team and the customer engagement activity was based on Service Manager Profiles and feedback from the Corporate Services Orientation Workshops. Executive staff explored their case studies and feedback from Service Managers to design "How Might We" questions which then informed their brainstorm and prototyping exercise.

Feedback snapshot:

Customer Involvement

"I enjoyed having the time to explore "the problem" for the internal customer, rather than jumping straight into problem solving mode which is my tendency"

Content

"Hands on and practical, embedded concepts"

"I enjoyed having the time to explore 'the problem'- rather than jumping straight into problem solving mode"

"It reiterated how important it is to think in customer terms"

"Great courage displayed with a tough audience. The concrete examples and techniques translated into tangible action ideas in the bigger step"

Capacity and application

"Other people that have not done the workshop – for me, let's move forward"

Self-reflection

"Feedback from the workshops to date has given us a 'reality' check and REAL insight"

6. EACH-WIDE WORKSHOPS

Involvement of EACH staff across all state and territories

Staff expressed strong alignment with the Service Principles and felt that Human Centred Design was a creative and effective method to improve service systems and genuinely co-design with customers.

When asked what was learnt and what they would be implementing after the workshop most staff willingly provided free text responses including the list below. This highlighted the enthusiasm to embrace the Service Principles and HCD as the points of difference for EACH. It also highlights a risk to EACH if staff are enthused through training and support that they cannot implement on the ground.

Feedback snapshot:

Customer Involvement

"I enjoyed having the time to explore "the problem" for the internal customer, rather than jumping straight into solving mode which is my tendency"

"Talking with customers was eye opening, a different conversation"

Content

"I liked the pace, the reflective attitude supported by the facilitator and really felt listened to"

"Great practical workshop, value for money, really good use of many mediums, time well spent"

"Informative, inspiring, would love to know more!"

"I loved the way the day was facilitated, there was no pressure and we were allowed to step out of our comfort zone as the day progressed"

"Brainstorming and prototyping with colleagues was amazing"

"HCD would really help EACH become a more innovative organisation"

"The HCD principles help create the safety to be creative and embrace not knowing"

"I really enjoyed the content and the pace"

"great practical workshop, engaging, inspiring and thought provoking"

Culture

"This is all about attitude"

"This is incongruent with the culture of my work area"

"There is a culture of dollars before people emerging, this is incongruent with orientation session"

"This is incongruent with the culture and transactional model of the NDIS approach"

"To truly embrace co-design we need a safe to fail culture that shares solution finding with staff as well as clients, it's all about power sharing"

Capacity and application

"I will be presenting what I have learnt to my team, this is really inspiring"

"I am looking forward to putting this into practice"

"I would like to be a Change Agent!"

"I will change how I interact with clients at first meeting"

"I will be more mindful of giving my clients and families hope at the first meeting"

"There are definitely new aspects of welcome, empathy and hope I want to incorporate into my everyday practice"

"I need to ask clients for feedback more often"

7. SELF-REFLECTION

"I will be having a different attitude to my clients and colleagues – more empathy"

"I will be asking more questions and being less certain"

"I will be asking the clients more often what they think of our processes and practices and about how welcome they feel"

"I will look at the work I do through the eyes of the client"

"I will be listening more and remaining nonjudgmental in all situations, brainstorming and applying new ideas"

SUMMARY OF ORGANISATION WIDE FEEDBACK CUSTOMERS

Customers involved in the workshops reported strong alignment and validation of the Service Principle philosophy of welcome, empathy and hope and that their experiences of EACH demonstrated a more 'human interaction' than other service providers. One NDIS customer reported, 'EACH treats me like a human being, other providers treat me like a transaction'.

Customers expressed appreciation for the safe and supportive environment to share their ideas and experiences and particularly liked the opportunity to engage with the design challenge of improving service by helping us to become more welcoming, empathic and hopeful.

For most customers, the focus for improving welcome, empathy and hope was based on their experiences of waiting rooms, frontline reception staff and intake experiences. Customers on numerous occasions told us that if we get welcome, empathy and hope embedded and demonstrated in our culture, we get everything right.

Welcome, Empathy and Hope in Practice

Environmental concerns (to be done similar to quotes earlier, central theme and suggestions around):

- Waiting rooms that demonstrate hospitality – tea, coffee, water.
- Indoor plants give life and are good for mental health and provide oxygen and detox environment too.
- Display client art work and co-design waiting spaces with customers of diverse backgrounds.
- Welcome signs in many languages.
- Colour, comfortable furniture, homely environment not 'clinical', not 'stark, comfy chairs.
- Sensory modulation provision in waiting rooms and consultation spaces.
- Indigenous art work, a feel of home, comfy chairs not clinical, not medical this is an aversion for aboriginal people, we need it to feel welcoming, it is very important for psychological safety.
- Where reception areas have large volume of traffic provide a ticketing system and volunteer concierge.
- Inspirational messages on walls and consulting rooms, especially for marginalised populations eg, LGBTIQ, AOD and MH, CALD communities, men who find it hard to ask for help.
- Customer stories of hope in the waiting rooms.
- Welcome messages for diverse populations, shame sensitive communication and poster.

Staff attitudes, actions and training

- Friendly staff who smile and introduce themselves, don't under estimate the simple human connection.
- Reception staff not multi-tasking, prioritising the person who walks in the door as a VIP.
- Ensure staff have quality supervision, debriefing and support to ensure positive response to customers, care for your staff and you care for customers.
- Staff trained in hope and empathy.
- Support for people on waiting list.
- Treat us like human beings not a transaction'.
- Have staff trained by customers, customers mentor staff on how to do hospitality and customer service.
- Dental Staff with smiling faces on dental gowns.

Willingness to accept feedback, see customers as experts

- Provide as much choice and control for customers at initial appointment.
- Partner with customers, don't assume you know better than the customer.

Inclusion and access for diverse populations needs

- Ease of physical access for people with varied abilities, prams, children.
- Indigenous responsiveness – signs indicating staff are trained about indigenous issues, indigenous community members helping us co-design our waiting room spaces.
- Disability access, disability toilets that are not multipurpose baby changing areas.
- At least one trans gender toilet – 'let us know you have thought of us'.

SUMMARY OF LEARNING OUTCOMES

Implementing HCD and co-design

- The constraints of co-design (time, resources, management approval and competing demands) were consistent across sites nationally and indicate that service providers would have limitations in implementing HCD.
- Strong theme of cynicism about Management buy in and support of EACH points of difference and commitment to genuinely co-designing with customers.
- Poor understanding of co-design which led to misconceptions about when, where and how it should be used, including identifying where co-design can't/should not be used.

Management structures and culture

- The majority of staff indicated that their scope of practice and workload did not offer formal reflective space and staff felt that working in a creative Human Centred Design approach would be beneficial but not within their scope.
- A sizeable proportion of participants reported 'rigid' and 'directive authoritarian' and 'parental' styles of leadership and management that did not see staff as potential co-designers in solution finding and improvement of processes and practices.
- Staff in some areas feel that de-skilling of the workforce has impacted morale and feel less hopeful that their managers will engage them as equal solution finders and co-designers.
- Staff reported an incongruence in the way EACH spoke of applying service principles whilst they experienced a lack of support, understanding and perceived emotional intelligence absent from their managers and the styles of leadership.
- Target driven models and fee for service focus was seen to be in direct opposition to what the service principles required and yet driven by senior management as the new way of being.

Recruitment into workshops; staff and customers

- Customers expect ease of physical access for people with varied abilities, prams, children
- Indigenous responsiveness is important – signs indicating staff are trained about indigenous issues, indigenous community members helping us co-design our waiting room spaces
- Customers in the LGBTIQ community expect us to be well educated in trans gender issues – 'At least one trans gender toilet – 'let us know you have thought of us'
- As a result of an ever-growing workforce, 40-50% of EACH employees will have not completed the orientation workshops to date.

- Further, staff supporting facilitators of the workshops felt their planning and coordination was not valued and that any requests made as part of the planning could be ignored rather than being treated with respect as a colleague and supporter within EACH.

Workshop priorities and schedule

- A lack of follow through with the prototype reports following staff participation in the workshops meant that ideas generated through customer engagement interviews were not implemented.
- Staff who were enthusiastic about ideas developed felt frustrated that the work on prototypes could not be tested as no forum to discuss and progress.
- A key learning from the implementation phase was that a better approach may have been to focus all the initial training on Managers and Leaders - not just for an Introduction but for the full HCD and Service principles workshop so that Managers and Team Leaders could see the value of progressing innovative ideas and testing prototypes.
- As the workshops were orienting staff to a priority strategy that EACH was implementing to strengthen the organisation's position in the changing context it was assumed that there would be greater buy in at a leadership level. A key learning is to not assume strategic directions are well understood at all levels and orienting leadership to practical implications of our 3 points of difference may have improved follow through and implementation.
- This strategy can only be implemented fully if all staff are working together with customers to ensure service delivery is meeting customer need. This requires strong supportive leadership willing to adopt HCD and Service Principles as a strategy for future customer engagement and choice in the changing sector.

Prototype implementation

- The wealth of ideas and recommendations highlighted through the prototypes provided EACH with opportunities for further reflection and testing.
- Despite the detailed sharing of these with appropriate departments there was a perception of little interest by some management with authority to follow these through.
- Few prototypes were progressed, despite infrastructure budgeting to support changes. Challenges in time to provide business case and other requirements for prototype ideas to be implemented were highlighted as barriers to implementation.
- Staff who did attempt to pursue these found a number of barriers, one example of this was staff who proposed changes to their local waiting rooms/reception spaces in response to customer feedback were informed that if one waiting room introduces changes that the change needs to be introduced at all sites. Uniformity conflicts with HCD principles.

Facilitator Reflections

- The Orientation workshops were successful in engaging staff and clients with 98.5% of staff participants indicating this was an effective way to orient to both Service Principles and Human Centred Design.
- Every workshop generated high energy, with a highlight being engaging customers in conversation and solution finding. Staff reported the activity provided the space to have very different conversations with their clients and staff felt valued as co-designers in solution finding. Clients also reported the experience was different to their usual conversations with workers.
- Staff reported the Service Principles provide a map for human engagement in a context of transactional business models and staff appreciated putting the spotlight on culture.
- Both staff and customers reported that they were inspired as a result of attending the workshop and felt hopeful about the future of EACH, it was considered forward thinking and innovative for EACH to explore the use of Human Centred Design and to focus on welcome, empathy and hope in conversation with customers.
- Co-design offers us the ability to genuinely become a customer centric service of choice and an innovative service that is agile in response to customer feedback. Staff loved the creativity of human centred design mindsets and methods.
- Our 3 points of difference are well aligned to staff values and expectation of EACH as a service, however evidence for the 3 points of difference in every day practice are marginal. It is fair to say new staff recruited have little understanding of what the social model of health is and if we could re-write the module we would include orientation to the social model of health as part of the orientation content not just service principles and co-design.
- A governance group may have supported further testing and implementation of HCD. This was not established due to changing landscape and restructures.
- For Human Centred Design to get traction, leadership across EACH need a mindset paradigm shift. This would include a willingness to share power, decentralise decision making and to see staff as resourceful contributors to solution finding, to work together with staff and customers to co-create together. Staff would need a paradigm shift in how they view customers. Staff would need to genuinely see customers as equal partners, as having expertise that is critical to service design. Customer engagement was challenging for some staff, particularly in exploring their experience and relating to the customer as an equal collaborator. We were able to demonstrate even the most vulnerable clients were able to share their opinion and ideas as an equal co-creator of continuous improvement.
- The concept of the "internal customer" seems to be a critical one to integrate and understand in the service of improving culture and service experience for both staff and clients. Frustrations for

- Facilitating workshops across EACH provided a helicopter view of the organisation. For interstate services frustrations about technology, onboarding, corporate service and a sense of belonging and engagement to the wider EACH impacted their sense of welcome, empathy and hope. For Victoria the exponential changes through restructure, service reforms and funding model changes have resulted in a confused and fatigued workforce. There are areas of the organisation that have fully embraced the Service Principles and other areas of the organisation that wonder how the principles apply to the transactional business model approaches.
- Staff experience is directly related to customer experience. If staff morale is low then customer experience will be compromised. To have exceptional customer experience we need a workforce who feel they work in an exceptional organisation. "Customer experience is prioritised but what about the internal customer"?
- Co-design requires a spirit of collaboration and participation in solution finding together.
- It is a mindset that prioritises the sharing of power and engagement with the people most impacted by decisions, solutions, service development and design so that what is designed is designed with the end user in mind and in partnership with all stakeholders. In order to successfully implement co-design as a point of difference, we need to understand the principles, mindsets and methods of co-design and ensure that we don't say we co-design when in fact we are consulting or communicating.

CHANGE AGENT CONNECTION – A COMMUNITY OF PRACTICE

An invitation was offered at the end of each workshop for staff to consider becoming Change Agents and members of an online Community of Practice, providing the following definitions:

What is a Community of Practice? (E. Weger)

'A community of practice is a group of people who share a common interest or passion, who interact regularly to learn together and share practices that improve knowledge and innovation'.

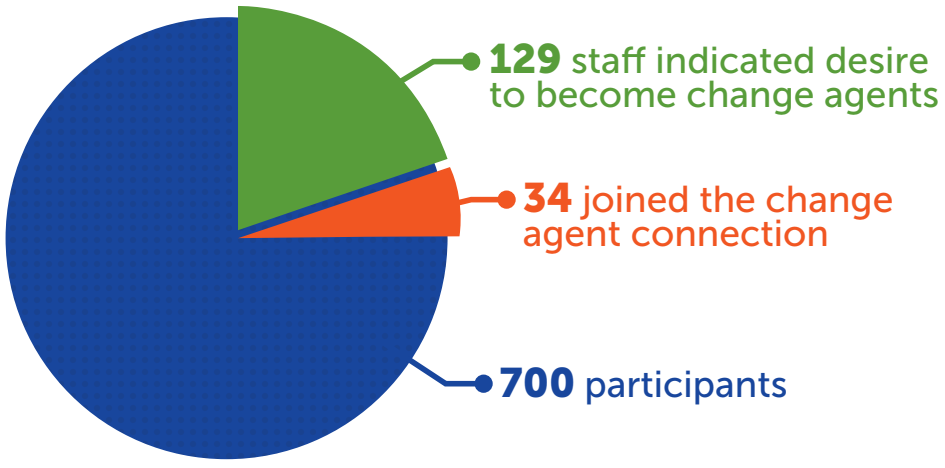
What is a Change Agent?

A person who acts as a catalyst for change. A Change Agent does not have to be a person in authority but does need to have a vision for the change to be implemented and is willing to make changes within their scope of practice.

5 Characteristics of a Change Agent (George Couros)

1. Clear vision
2. Patient yet persistent
3. Asks tough questions
4. Knowledgeable and leads by example
5. Builds relationships built on trust

The online Community of Practice platform created the opportunity for staff across EACH nationally to connect and share ideas, questions and stories about how they are implementing change at the local level. The network has provided the prospect of asking for assistance, sharing current challenges and supporting colleagues from diverse disciplines



Change Agents connect via:

- The Grid
- Skype
- Face to face meetings

Change Agents share ideas and problems and navigate any barriers they identified that were preventing a consistent implementation the principles.

The Community of Practice has focused on service principle implementation, resilience in times of change, leading without authority and problem solving specific challenges relating to morale and staff wellbeing.

Feedback snapshot

Of the 32 change agents, 18 completed the evaluation. Of that 18:

- 80% of change agents believed the Community of Practice (CoP) was an effective way to connect with staff across EACH
- 90% of change agents would be willing to identify via a Change Agent pin
- 66% of change agents had high levels of satisfaction with the CoP (high = a rating of 4+ out of 5)
- Barriers identified by the Change Agents were consistent with those identified by workshop participants more broadly including Management, Culture, Time and KPIs/rules.

I have thoroughly enjoyed supporting and challenging people on staying true to the Service Principles

I enjoy the regular updates and information sent out on the change agent forum. I enjoy embracing and demonstrating the Service Principles

Great to have a group of energetic individuals that demonstrate the Service Principles and spread the work on their value for the organisation

Inspiring articles, one on one support as needed to problem solve and stay positive

Change Agents in Action

- Tim Pitt, Jane Ludtke, Michelle Egan and Rhianna Perkin have co-facilitated Orientation Workshops with exceptional facilitation skills and enthusiasm.
- Diabetes Educator and Change Agent, Carrie Wong, led a local Primary Health Innovation Lab with customers of the Diabetes Service. Rob Walsh initiated a Transition Reflective process to support staff during change
- Other Change Agent members have engaged in the sharing of ideas and stories, to support positive morale for the Change Agent Community in times of change.

Transition Sessions

One of the by-products of the Change Agent Network was the request to support individual Change Agents in leadership positions to problem solve and support staff in times of disruption and change. This took the format of 'Transition Sessions'. The 'Transition Sessions' were voluntary and provided a safe and supportive space for staff to process the impact of change, explore some change management and self-management theory and strategies and to provide feedback to Managers regarding staff impact and staff ideas and recommendations.

CHANGE AGENT FORUMS

A survey of the Change Agent Network indicated Change Agents would appreciate a face to face forum to share ideas and inspire. Change Agents who were championing the local implementation of Service Principles in a changing context and expressed interest in strategies to support and motivate. A Change Agent Forum was held inviting Change Agents to share their experiences, show case their work and facilitate peer sessions to explore strengths and strategies. George Bej from Strativity conducted a motivational session exploring creating exceptional customer experience and the importance of exceptional employee experience and empowerment as an important contributing factor to customer satisfaction.

Where to from here?

Given the roll out of the implementation workshops has occurred concurrently with the major restructure and impacting sector reforms, providing clear evidence of impact is not available at this early stage. Follow through from orientation has been challenging, particularly in reviewing prototypes and staff ideas to improve service experience based on customer engagement.

To truly co-design as a point of difference, EACH needs to commit to ongoing collection of evidence and establishing the systems to monitor progress and ensure that all programs have the capacity to implement genuine customer engagement, co design methodology and to work from a foundation where the service principles define behaviour and culture. To do this there are additional steps that need to be taken and monitored:

- Regular surveying of staff experiences against the culture the service principles aim to embed for the internal customer. Evidence of this can be monitored through staff complaints and grievances which can be mapped against those areas of service principle experience highlighting where further input and education may be needed. Patterns of excellence and areas for improvement can be mapped against staff enagement surveys, exit interviews, and deep dives of programs where high staff absenteeism may be occurring. While this will not be the only reason for staff issues it should provide insight into whether the culture of EACH is really becoming reflective of implementation of service principles across all levels and programs.

- Mapping of customer engagement activities with a central portal on the Grid to share what form of customer engagement each program is undertaking and sharing of learnings and outcomes. For example this could be a central register of innovation labs, focus groups, co-design workshops and advisory groups.
- Human Resources division to review how the Service Principles are considered within all aspects of recruitment for employees to EACH. While some of this work has already begun the impact of its application within recruitment will still need to be gathered.
- Customer feedback and complaints can provide one option for ongoing monitoring against the service principles experience and mapping of how these can be aligned for analysis and reporting is currently underway. Evidence of the implementation of the service principles should be evident in the compliments and comments that EACH receives along with areas where improvement is still needed through complaints and concerns. Greater use of social media and invitation for comment and ideas through the EACH website.
- The EACH community engagement platform will continue to offer additional opportunities for community participants to be involved in co design activities, consultation and reviews. This is an area of ongoing development both at corporate and service design levels where staff capacity to engage internal and external customers in all levels of design and problem solving.
- Process or system developments within the new EACH structure to continually reflect the EACH 3 points of difference in practical and genuine manner whether this is through Enterprise Project Management procedures, community publications, development of new facilities or tendering for new contracts.
- Developing an online Module of our 3 points of difference so that all staff have enough understanding of our 3 points of difference to ask the question of themselves and other peers – how is what we are currently doing or planning going to reflect our points of difference?

UNDERSTANDING EACH SERVICE PRINCIPLES

The overarching philosophy of the EACH Service Principles is captured in the statement:

We welcome you with empathy and hope.

This philosophy informs the mindset and behaviors of our workforce. It reflects our beliefs and values and promotes the culture we wish to create. It also describes the experience of our customers at all points of contact with EACH. No matter who you are, no matter how complex your situation, or how multiple your issues of concern, we welcome you. Our empathy validates your concerns. We communicate hope through our belief that health and opportunity and improved quality of life is possible.

Service Principle posters are located at every site to remind both staff and customers that this is what we live and breathe and what can be expected when engaging an EACH service. The orientation process highlighted the importance of understanding empathy, what it is and what it is not and how to demonstrate empathy in a way that empowers everyone to be their best selves.

UNDERSTANDING HUMAN CENTRED DESIGN (HCD)

Human Centred Design is a method of co-design that develops solutions to problems by involving human beings most affected by the problems to be part of the solution finding process.

This approach enhances effectiveness and efficiency as well as user satisfaction. In 2015 IDEO.org, a design Organisation with a mission to improve the lives of vulnerable communities, launched the Field Guide to HCD, this provided a suite of teaching tools for the practice of 'human-centred' design in the social sector. The Orientation Workshops integrated the IDEO Field Guide with Service Principle philosophy to provide an orientation to Service Principles using the HCD mind set and methods. Staff were trained in the 7 mindsets and asked to practice the mindsets in their customer interviews.

THE 7 MINDSETS

1. Empathy

Empathy is all about stepping into the shoes of the customer to explore their problems from their perspective. With empathy we are able to explore the customer experience, their problems,

understand how their challenges and difficulties impact their service experience and using empathy to deeply learn from their perspective. Empathy is not about rescuing, fixing or saving, it requires an open, kind approach that listens with the intent of gaining an understanding, it is robust enough to welcome complaint without defensiveness.

Greenwood Avenue, Ringwood site.

2. Embrace Ambiguity

Embracing ambiguity is all about approaching the situation with a 'beginners mind' and of 'not-knowing'. By coming from this position, we allow the answer to reveal itself and shift the power into the hands of our customer rather than being the expert that assumes what our customers or the presenting problem needs. It is open and curious and is consistent with the culture of the principles of becoming a 'learning organisation'.

3. Learn from failure

This mindset is a willingness to 'experiment', to put aside perfectionism in the service of exploring and learning from what doesn't work. The emphasis is on learning, bringing our mistakes and problems out into the open with the aim of learning how to improve what we do.

This mindset requires a safe to fail approach from EACH leadership to create psychological safety to support 'safe to fail culture'. This mindset increases trust in each other to find solutions together, that we are all learning together, and we don't get it right every time. The mindset believes that if we fail early we succeed sooner. Learning from failure also helps us to welcome complaint in the service of quality improvement. EACH supported this safe to fail mindset through resourcing Innovation Labs and Service Principles Implementation. According to staff this mindset was the main work area for EACH in genuine implementation of Human Centred Design.

4. Optimism

Optimism is all about believing that a solution can be found. It is not a 'Pollyanna' view of the world that sees everything as rosy when it isn't, it is a robust belief that no matter how challenging and complex the problem, a solution is out there and can be found.

This adoption took the form of a 'How might we?' Question, where optimism was encouraged to support solution finding and exploring possibilities. Having an optimistis mindset is about staying in the realm of the aspirational in order to find innovative solutions, being willing to move outside of comfort zones and traditional views.

Canterbury Road, Bayswater site

5. Make It

Making it is about making a commitment to get ideas out of our head and into our hands in order to make our ideas tangible. This involves making a rough prototype to explore and test with customers. A 'picture paints a thousand words'.

Staff were given the time and resources to make their ideas tangible and testable. This process encouraged creativity and experiment to test ideas and improve on them based on feedback.

Over 104 prototypes were made as staff embraced the making it mindset.

6. Iterate, iterate, iterate

The mindset of iterate, iterate, iterate understands that we won't get it right the first time, we need to keep testing, learning and evolving our ideas to meet the needs of customers. If something is not working, we need to be willing to let it go and start again based on customer feedback, it is a flexible mindset that is open to continual amendments in an agile way to support changing with the changing needs of the market place.

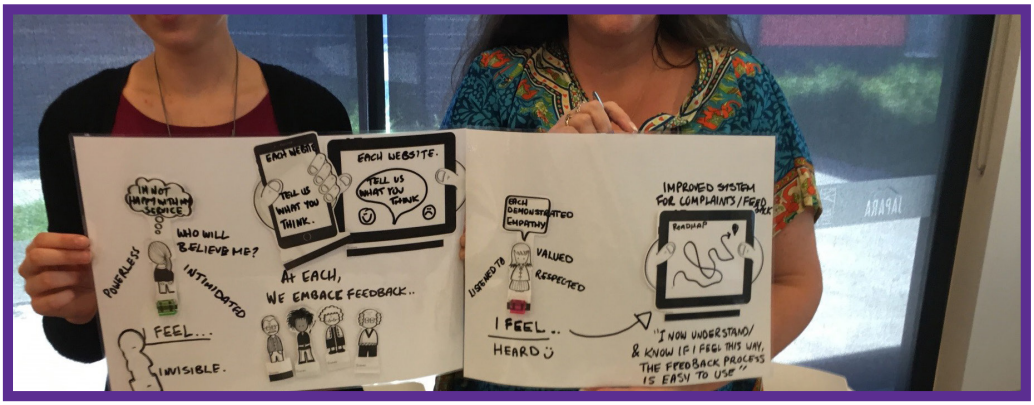
The initial feedback staff received for their prototypes during their workshop process encouraged reflection and underlined the importance of iteration. As this was limited in the workshop context, staff were encouraged to engage in further review with customers, internal and external, and apply the mindset of iterate, iterate, iterate.

7. Creative Confidence

Creative confidence is the belief that every human being has the capacity to be creative, no matter what we were told when we were growing up. Creative confidence trusts your ability to come up with creative solutions to big problems and to dive in.

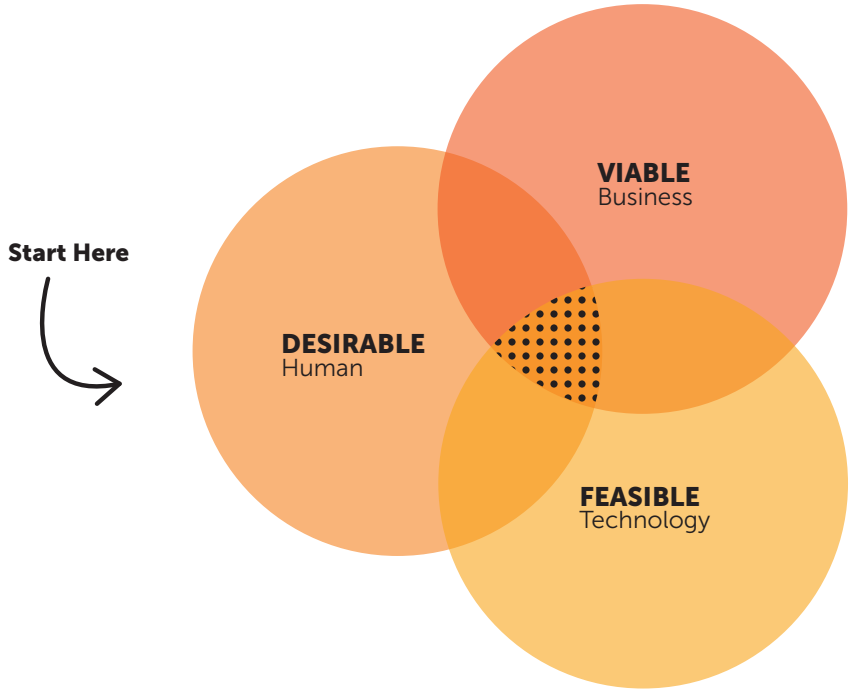
Supporting staff to gain confidence in a creative approach to problem solving was key part of the training. With EACH, and the not for profit health and community services sector living through a significant policy and funding realignment, the ability for staff to approach problem solving from a variety of perspectives is an essential skill for staff to learn and apply. Prior methods and approaches may not achieve the outcomes now required.

The 7 mindsets have the potential to support staff resilience in times of unprecedented change. Staff reported the mindsets would make a significant difference to worker wellbeing and organisational innovation if genuinely integrated into cultural mindset at every level.



Canterbury Road, Bayswater site – Group 1 External Client Prototype

THE PHASES OF HCD METHODS AT A GLANCE



Summary of HCD Methods – Source IDEO HCD Facilitators Kit

INSPIRATION

This phase involves:

- Learning from our customers, hearing their hopes, desires, frustrations and experiences.
- Framing questions and thinking about what impact is desired and what issues are to be tackled.

The EACH Orientation workshops had the design challenge; 'How might we improve our demonstration of welcome, empathy and hope'. The design challenge was the basis for the Customer Engagement Activity. Staff were encouraged to practice their welcome, empathy and hope as well as the 7 mindsets when engaging with the customer. Their objective was to welcome complaint, listen to understand, create a plan, consider questions to dig deeper with empathy and understanding and then explore this through interviews with 'experts' (customers, external or internal) who had the relevant experience. They were to have the mindset of a beginner, curious and open to learn.

Prospect Street, Box Hill site

IDEATION

This phase involves:

- Synthesizing what has been learnt and making sense of all that was heard
- Generating ideas and identify opportunities for design and testing.

Staff created specific 'How might we' questions in response to their interviews with customers. This process included brainstorming ideas, deferring judgment and encouraging wild ideas with the aim of going for quantity. The next step was prototyping to bring the ideas to life quickly. This was achieved through story boarding and rapid prototyping where the ideas were made tangible and ready to test for feedback and iteration.

Bell Street, Preston site

Implementation

This phase involves:

- Development of a prototype that can evolve with further feedback from customers
- Consideration of pilots and trials, any ideas for further evolution of the concepts, while always keeping the customers at the heart and centre of the process.
- Reflection on potential desirability, viability and feasibility. This enables identification of which ideas are too good to ignore or worth pursuing further to pilot and which ideas need to be on hold for a time or not taken any further.

The Orientation Workshops did not have the time for implementation and testing with customers. Staff were encouraged to take their prototype ideas to team meetings, clients and customers and were supported to do this through provision of their workshop Customer Engagement Summary and photos of prototypes for further testing and iteration. Staff received a full summary report of their findings in the customer interviews, their brainstorming of ideas and photos of Prototypes created. This support their ongoing conversation at a local level and potential consideration of testing prototypes worthy of implementation.

Prospect Street, Box Hill – Group 3 External client prototype

GETTING CLEAR ABOUT CO-DESIGN

The term 'co-design' is used a lot in the Service Sector and needs to be clarified as it can be misused. Understanding the truths and myths of co-design is key.

Co-Design TRUTHS	Co-design MYTHS
Is person-centred	Customers are always right
Is inclusive and draws on many perspectives	We should give people what they want
Focuses on desired outcome	If we've engaged users, that's co-design
Develops practical real life solutions	If I'm part of a co-design approach I get to determine the results
Makes ideas, experiences and possibilities visible and tangible	Co-design can be applied to anything

Co-Design for Community Inclusion - Source Huddle NDS Project

Co-design is one of our 3 Points of Difference in the EACH 2020 National Strategy. As part of being a customer centric organisation we are committed to engaging with individuals and communities as the end users of our service system to actively understand, explore and ultimately improve the service system together. We start with customer desire, exploring viability and feasibility in the pursuit of innovation and service improvements.

The workshops explored customer desire and expectation in regard to providing a service that demonstrated welcome, empathy and hope. Staff then proceeded to explore the viability, feasibility and possibility of innovative ways to improve the service based on their customer interview.

The prototypes were informed by the 'sweet spot' which was the place where desirable, viable and feasible combined to make ideas probable and possible. Whilst some desires and solutions were outside of the viable and feasible arena, we acknowledged that these could well be ideas too good to ignore and we needed to be able to map these ideas and not inhibit brainstorming solely to the viable and feasible arena as this is where innovative ideas often are, in the realm of 'not yet possible'.

Human Centred Design deliberately engages users of the system, the staff and the clients and other experts to actively understand, explore, create and ultimately change the system. Staff across EACH nationally embraced this objective and were inspired by the mindset, methods and creativity of colleagues in the process of putting HCD into practice.

The workshops provided the forum and the tools to have meaningful conversations in the spirit of shared power and a genuine attempt to understand how processes and service experiences can be improved.

Short Street, Port Macquarie site

'In the beginners mind there are many possibilities in the experts mind there are few'

- Zen Proverb

Human Centred Design calls for a paradigm shift in thinking in regards to community participation and genuinely co-designing. Thought Leaders Hiemans and Timms (2014) encourage a new participatory mindset where power is shared bringing possibility of innovation and inspiration. Staff reported that our culture and leadership styles were not supportive of this new shift in power and were more likely to demonstrate traditional styles of command and control through authoritative directions. According to Hiemens and Timms the successful organisation's of the future will be shared, open, collaborative, relational and participatory, this is the spirit of Human Centred Design.

Understanding New Power

Jeremy Heimens has provided an excellent commentary on the changing relationship with power in organisations of the 21st Century that provides pertinent advice in the context of introducing co-design.

Old power works like a currency. It is held by a few. Once gained it is jealously guarded. It is closed, inaccessible and leader driven. It downloads and it captures.

New power operates differently, like a current. It is made by many. It is open, participatory, and peer-driven. It uploads and distributes. Like water or electricity, it is most forceful when it surges. The goal with new power it not to hoard it but to channel it.

Co-design is one way of engaging crowd wisdom and a maker culture. The mindsets and methods of co-design encourage open, shared, relational collaboration and overall participation in the pursuit of exceptional customer experience and service delivery.

Old Power	New Power
Currency	Current
Held by a few	Made by many
Commanded	Shared
Closed	Open
Transaction	Relationship
Managerialism, institutionalism, representative governance	Informal, opt-in decision making; self -organisation; networked governance
Exclusivity, competition, authority, resource consolidation	Open source collaboration, crowd wis-dom, sharing
Discretion, confidentiality, separation between private and public spheres	Radical transparency
Professionalism, specialisation	Do-it-ourselves, 'maker culture'
Long term affiliation and loyalty, less overall participation	Short term, conditional affiliation; more overall participation

'What new power looks like' - Source Jeremy Heimens TED talk

APPENDIX

Service Principle Plain English Definitions

Service Principle	Definition	Perimeters
We welcome you with Empathy & Hope	We put ourselves in your shoes, we demonstrate compassion and we believe whatever your situation, you can improve your quality of life. We provide welcoming experience and environment that is non-judgemental and responds from a commitment to genuine connection.(Compassionate and strength based practice, human rights)	This does not mean we rescue, save or become a door mat with no boundaries. We empower the other person and are always in an empowered mindset ourselves
We make services safe and easy to access	Safety is our first priority, we understand the importance of physical and psychological safety. We will make it easy for you to find us, enter buildings, access information and get access to the services you need (Trauma informed and human rights informed)	We will communicate waiting times and apologise for system or other issues outside of our control that create barriers to access. We will always validate the impact and distress and acknowledge our limitations. If we are not the right service for you we will let you know at the earliest awareness and refer you to appropriate services and information
We are trained to respond to all of your needs	We will work with you and other people or services to respond to the multiple needs you may have. We have a holistic view of people presenting for service and make it our business to know how to refer or provide information that is useful for multiple needs. Our staff are co-occurring capable (Co-occurring capability)	This does not mean we are always the right service for every need or that one worker can provide every service required.

Service Principle	Definition	Perimeters
We respect diversity and learn about your culture	Our staff are culturally capable. We are trained to understand various cultural backgrounds and needs and are sensitive to cultural protocols. We recognise that culture is not just about race but encompasses culture of family, sexual orientation, spirituality, substance use, mental health and other stigmatising cultural impact (Cultural Capability & Reconciliation Action Plan)	This does not mean we will condone practices of cultures that cause harm or disrespect
We recognise and respond to the impact of trauma	We are trained to understand the prevalence and impact of trauma and know how to provide psychological safety. Our sites and protocols assume every person we meet has experienced trauma. We seek every possibility of giving you choice, voice, empowerment and collaboration. We understand some behaviours are symptoms of trauma and coping strategies. We have confidence to talk about your trauma without re-traumatisation. We negotiate risk in partnership with you (We observe the principles of Trauma Informed Care)	We do not attempt to refer people to trauma processing or assume that every person who has experienced trauma requires a trauma treatment intervention.
We include the people important to you	We will ask you who you would like to be involved or informed and updated about your care. We have consent conversations and protocols to ensure the people you decide are important to your care are involved, including external service providers. We recognise the importance of networking and strategic linkages (Collaborative and Family Inclusive Practice)	We do not include people who will put you at risk or where there is an ethical dilemma for our service that compromises the safety of others
We believe making change is possible	We hold hope that whatever your circumstances and no matter the complexity of your situation, the capacity to improve your wellbeing and quality of life is possible (this was Recovery Oriented Care)	We will be honest and transparent about any limitations of our ability to help you and will offer other services if we do not have the right service for you

Service Principle	Definition	Perimeters
We respect your lived experience and work with your strengths	We recognise your resourcefulness, strengths, courage and self-determination. We honour your lived experience of life in all its forms and what you have to teach us about your experience. We take direction from you to understand your needs and the lifestyle of your choosing.	This does not mean that we will follow instructions that will lead to harm of self or others. We will not join in the opinion of others when there is evidence of racism, sexism or other forms of disrespect
We work with you and others to respond to your needs	We work together with you and other individuals and services that will support a collaborative response towards the best outcomes. We have protocols of consent to help us share information with ease when that is important to you	We will not work with others who put your health and wellbeing at risk and will set boundaries as appropriate to ensure everyone's safety
We advocate with you and for you and your community	We actively inform you of your rights and support you to exercise your rights, where possible we work with you to remove barriers and assist you to contact appropriate advocates and consultants. Where possible we will undertake broad advocacy and community education to diminish stigma and create opportunities	This does not mean we take a "crusader approach", try to fix everything or take excessive responsibility for peoples difficulties
We are committed to getting better at all that we do	We welcome complaint in the service of improving our services and taking action on barriers and difficulties in your service experience. We practice humility and acknowledge we do not always get it right and are not exempt from making errors or having systems and protocols that cannot be improved. We will always thank individuals and families for their critical complaints and document complaints in Riskman, conduct reflective practice and seek to improve what we do based on client feedback.	We may not always be able to improve our systems and protocols in the timely manner individuals need There are some things outside of our control, we will work within the perimeters of what is possible and feedback issues with systems and protocols that other parts of our service can attend to

MINDSETS

Creative Confidence
Trust in your ability to come up with creative solutions to big problems and dive in.

Empathy
Step into someone else's shoes and start to solve problems from their perspective.

Embrace Ambiguity
Give yourself permission to explore so that the right answer can reveal itself.

Make It
Get ideas out of your head and into people's hands so you can learn from them and improve.

Learn From Failure
Experiment and prototype to learn what doesn't work, so you can learn what will.

Iterate, Iterate, Iterate
Keep testing, learning from, and evolving your ideas so you can get them just right.

Optimism
Embrace the idea that a solution is out there and that you can find it.

RESOURCES

Learn more and share your experiences on **designkit.org**.

HUMAN-CENTERED DESIGN

At a Glance

INSPIRATION

In this phase, you'll learn how to better understand people. You'll observe their lives, hear their hopes and desires, and get smart on your design challenge.

Frame Your Challenge
Start with a big question that you want to design for. Think about the impact you want to have and start with a challenge that you are excited to tackle.

Create a Plan
Think ahead about what you want to learn more about, who you can learn from, and where you can learn. Ask questions that lead to deeper understanding of and empathy for the people you're designing for.

Go Out and Research
Seek inspiration by going out into the world and learning from Interviews, Immersion, Expert Interview, and Analogous Inspiration. Talk with people who represent extreme perspectives to push your thinking and challenge your assumptions—remember that they are the experts on their own experiences.

IDEATION

Here you'll make sense of everything that you've heard, generate tons of ideas, identify opportunities for design, and test and refine your solutions.

Synthesis
Make sense out of what you learned during Inspiration to uncover opportunities to design for by Downloading Your Learnings, Finding Themes and Insights, and Creating "How Might We" Questions.

Brainstorming
Energize your team and drum up a staggering amount of innovative ideas. Keep these rules in mind: defer judgement; encourage wild ideas; build on the ideas of others; stay focused on the topic; one conversation at a time; be visual; and go for quantity.

Prototyping
Bring ideas to life quickly so you can test them, get feedback, and continue to improve your idea— getting solutions that work out in the world. Try Storyboarding, Rapid Prototyping, Testing and Getting Feedback, and Integrating Feedback and Iterating.

IMPLEMENTATION

In the Implementation phase you'll bring your solution to life, and to market. Continue to learn and evolve your idea as you Keep Iterating, Live Prototype, and Pilot your concept. Keep the very people you're looking to serve at the heart of the process.

This workshop does not go deep into Implementation, but you can learn more about this phase and related methods on designkit.org.

DESIGN KIT

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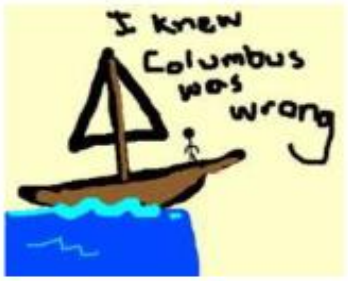
7 Toxic Beliefs for business

- Efficiency matters most
- Conformance is better
- Power trickles down
- Individuals are instruments
- Change is engineered
- Data decides
- Pragmatism beats passion



each

THE MINDSETS

Empathy

Optimism

Creative Confidence

Iterate, Iterate, Iterate

Making

Embracing Ambiguity

Learning from Failure

each

Plan Your Customer interview

Your task is to be curious to learn?

Before sitting down with your customer, capture some of the questions you want to ask.

Start off with easy, non-intrusive warmup questions. The aim is to make the customer comfortable especially given the restrictions of the training environment there will be more interviewers than interviewees! Introduce yourselves and thank the customer for sharing their experience. *We welcome complaint in the service of improvement so let them know that. We are committed to getting better at all that we do, and we value their opinion.*

Even if you are a very experienced interviewer this is your chance to try some different types of research techniques! Look for opportunities to ask open ended “Draw me”, “Show me”, “Tell me a story”, and “5 Whys?” Questions. The task is to dig deeper to understand.

Remember to assign roles. You will have 1or 2 interviewers and 1-2 observers/scribes. The observer’s role is take notes and mark down any quotes you think are really insightful, different or sum up something being said. Your scribes will help you capture the interview.

You might want each interviewer to try different question types. For example if one person is more comfortable with “Draw me” have them look for opportunities to ask the customer to draw something (rather than trying to explain it). It may be a system change or a physical change. Scribes are not exempt from asking questions if you have a burning question please enquire, this is an amazing opportunity to understand what your customer needs, likes, dislikes, finds frustrating, hopes for and expects from services.

Relax, this is a conversation between humans, listen more than you talk and capture what you learn!

Circle your theme: **Welcome** **Empathy** **Hope**

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Your Prototype

Name of Your Idea: _____

_____

A. Opportunity for Design
What theme did you focus on? (welcome, empathy, hope) What *How Might We* question did your team come up with?

Feel free to sketch your idea here

B. Your Solution
Briefly describe your solution in 1–2 sentences.

C. Your Prototype
What does your prototype include?

D. Highlights of Field Learning
what are 1-2 helpful things you need to consider when testing your idea?

E. Potential Next Iteration
If you were building out another iteration of your prototype what would you try next?

Test Your Prototype and Get Feedback

The questions below help to organise the feedback in your testing phase. If you need more room please feel free to answer these questions in your own notebook. Be sure to debrief with your teammates after each prototype testing session.

What worked?

What was exciting?

What did people value most?

What about the idea resonated with them?

What didn't work?

What would you change?

Were there suggestions for improvement?

What did you learn that will make it better?

What questions came?

What needs further investigation?

What surprised you?

What might you test next to answer those questions?

What new inspiration arose?

Did anything happen that you didn't expect?

What might you try next?

What is a Change Agent?

A person who acts as a catalyst for change. A Change Agent does not have to be the person in authority but does need to have a vision for the change to be implemented and is willing to make changes within their scope of practice. Service Principle Change Agents are members of a Community of Practice to support the implementation of the Service Principles at a local level.

5 Characteristics of a Change Agent (George Couros):

1. Clear vision
2. Patient yet persistent
3. Asks tough questions
4. Knowledgeable and leads by example
5. Builds relationships built on trust

The Service Principles Change Agent Connection will be a **Community Practice of Change Agents** who are willing to take action in their local context **to implement the Service Principles** and inspire those around them to include the customer in collaboration and co-design. Our common interest is successful implementation of our new EACH Service Principles.
This e-community will offer the space to explore ideas, share resources and stories of what is happening at your site and in your program to implement positive change for our customers and staff.
We hope this e-community will be an inspiring support to us all in the midst of disruption and change.

What is a Community of Practice?

A Community of Practice is a group of people who share a common interest or passion, who interact regularly to learn together and share practices that improve knowledge and innovation. (E. Weger)
The Community of Practice is a Change Platform that supports transformational change initiatives around service principle implementation. Change Platforms take advantage of social technologies to make large scale collaboration effective. This platform encourages Change agents to use the platform to drive deep change through conversations, shared ideas and solution finding in the community of Change Agents and beyond. (Hamel & Zanini)

“Nothing about us without us!”

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-11

This is the attachment marked '**GJC-11**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

Victorian Travelling Fellowship

Co-occurring mental health and substance use disorders:

An investigation of service system modifications and initiatives designed to provide an integrated treatment response

Gary Croton

Eastern Hume Dual Diagnosis Service

Contents

Section 1.

Project information

Fellow Name: Gary Croton

Title of project: Co-occurring mental health and substance use disorders: an investigation of service system modifications and initiatives designed to provide an integrated treatment response.

Fellowship study area: Co-occurring mental health and substance use disorders

Fellow's organisation: Eastern Hume Dual Diagnosis Service
Division of Psychiatry
Northeast Health, Wangaratta

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Date of Report: 12 /04/04

Acknowledgements: I would like to thank the Department of Human Services and the Victorian Quality Council for making the fellowship available. A number of people have contributed generously to this report with practical assistance and in discussions around the content. I would like to thank the persons who met with me during the study, Dr Tim Rolfe for his valuable comments, Dr Ruth Vine, Michael Nuck, Jennifer Ahrens, Gary Bourke, Andrew Quayle, Val Goodwin, Russell Maher, Peter Cash, Owen Connolly, Sarah Marrinan, and drug treatment and mental health colleagues in Eastern Hume.

Terminology: This report uses the terms '*dual diagnosis*' and '*co-occurring disorders*' interchangeably to refer to co-occurring mental health and substance use disorders.

Report Format: This report includes many web links. It is hoped that this may be a useful device linking the reader to further information on the work of key informants and agencies.

Section 2.

Project summary

Top three outcomes

- Formed ongoing links with overseas counterparts
- Compared Victorian and international initiatives addressing co-occurring disorders.
- Generated recommendations around further developing Victoria's approach to achieving more effective treatment for co-occurring disorders.

Main activities undertaken

- Negotiated itinerary with a range of clinicians and researchers
- Researched and wrote background literature review
- Visits to sites in the United Kingdom, USA and New Zealand.
- Digitally-recorded interviews with key informants.
- Compiled the *Co-occurring Mental Health & Substance Use Disorders Resource CD*. Presented each informant with a copy of the CD.
- Compiled report and clarified details with key informants.
- Considered learnings from the fellowship and their application to the Victorian healthcare system and used this to inform the recommendations contained in this report.

Major learnings

- Co-occurring disorders are the expectation not the exception for clients of mental health and drug treatment agencies.

- The prevalence of co-occurring disorders and the large attached personal, healthcare and societal costs suggests that more effectively addressing co-occurring disorders should be a high priority for all levels of the Victorian health care system.

- Integrated treatment of co-occurring disorders is an evidence-based best practice that, when robustly implemented, will result in better outcomes for persons with co-occurring disorders and an eventual reduction in the costs of services.

- Integrated treatment is achievable within existing Victorian mental health agencies, under their current structure, with minimal investment of additional resources.

- Integrated treatment of co-occurring disorders is not currently a realistic goal for Victorian drug treatment services; however drug treatment services have a critically important role in achieving better outcomes for persons with co-occurring disorders.

- An implication of the prevalence of co-occurring disorders in Victorian mental health and drug treatment agencies is that attempts to develop up a co-occurring disorders specific treatment system (specialist dual diagnosis inpatient and outpatient clinics) are philosophically and strategically misguided and likely to contribute to system complexity and barriers to treatment.

- Increasing a system's capacity to provide effective treatment of co-occurring disorders requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals.

Lessons for the Victorian healthcare system

The recommendations in this section arose directly from my experiences during the Fellowship and related study. The Fellowship gave me the chance to meet with and observe the work of persons with substantial experience in implementing integrated treatment. Several informants had well-developed knowledge of the improved outcomes and cost-savings that occur when integrated treatment is robustly implemented.

I have prefaced the recommendations with …

1. A brief appraisal of the Victorian dual diagnosis initiative to date – provided to give context to the recommendations

2. Draft suggestions for indicators of more effective treatment of co-occurring disorders in Victoria

In drafting the recommendations I initially attempted to sort them by whether they involved central or regional planning bodies, drug treatment or mental health agencies or clinicians but found this unworkable. In their sum the recommendations constitute a system-wide approach to achieving better outcomes for persons with co-occurring disorders and involve actions by all stakeholders towards this end.

Notable omissions from the recommendations are recommendations around the form and content of direct clinical delivery. Persons with co-occurring disorders are not a homogenous group and I judged it too ambitious to attempt such recommendations in this current report. However the fellowship did expose me to a range of valuable clinical innovations and approaches and these are described in the sections describing the study itinerary.

The Victorian Dual Diagnosis Initiative: An appraisal

The Victorian Dual Diagnosis Initiative has been operational since mid-2001. This initiative represents a substantial investment in and commitment to achieving better outcomes for persons with co-occurring disorders in a partnership of Victorian Drug Treatment Services and the Mental Health Branch. To date the Victorian initiative is the most comprehensive approach to addressing co-occurring disorders, on a state-wide basis, in Australia or New Zealand.

The stated aim of the Dual Diagnosis Initiative is to improve the responses of mental health and drug treatment services to people with mental illness and substance use problems. Drug Treatment Services have recently underlined their commitment to this aim by funding an evaluation of the initiative (March, 2004). In 2002 the Mental Health Branch also funded Mobile Support and Treatment Team Dual Diagnosis Workers, Youth Dual Diagnosis Workers and other specialist dual diagnosis workers positions.

Since the beginning of the initiative a great deal has been accomplished - the specialist workforce has contributed to the system's collective knowledge and skill around effective treatment of co-occurring disorders and Victorian barriers to effective treatment have been more clearly identified. However there is still much to be discovered about co-occurring disorders and about the nature of an effective treatment response in Victoria. There is much that needs to be done before we may be confident that we are offering system-wide, effective treatment.

By design the initiative funded four discrete metropolitan teams and linked independent rural specialist workers. Each team has developed differently with a different emphasis on the mix of clinical, training and consultation tasks assigned to them. The current evaluation should provide some indication of the relative effectiveness of these approaches. A criticism of the initiative is that the structure has lent itself to a 'silo mentality' amongst the lead agencies with limited opportunities to learn from the collective experience or to function as a 'driver' in developing a Victorian model for more effective treatment of co-occurring disorders.

In the writer's assessment three areas have emerged that need to be prioritised in order for the service system to increase its capacity to provide effective treatment of co-occurring disorders.

1. **Policy** – to date the Victorian initiative has predominantly employed a 'bottom-up' approach. Co-occurring disorders specialists have provided training and consultation to mental health and drug treatment clinicians and services but without incentives, such as 'top-down' policy mandates, for clinicians and agencies to change existing practice.

2. **Goals and indicators** - The initiative has now developed to a stage where there is a need for evidence-based, clearly-defined goals and indicators

for the specialist workforce to work towards -see *Indicators of effective treatment of co-occurring disorders in Victoria* below.

3. **‘Buy-in’** – Currently some key stakeholders, whose understanding, support and enthusiasm is crucial to changing practice, may perceive that the issues around co-occurring disorders are too complex to address successfully. They fail to appreciate the significant potential cost and worker savings in providing effective treatment for co-occurring disorders. There is a need for the implementation of strategies designed to promote ‘buy-in’ by these key stakeholders.

Indicators of effective treatment of co-occurring disorders in Victoria

The following draft indicators are an attempt to provide some of the answer to the question of how the Victorian treatment system might look if it were offering more effective treatment of co-occurring disorders. The indicators are based on goals adopted and strategies employed by service systems that I visited and associated reading. They are not offered as a definitive list of indicators of effective treatment of co-occurring disorders in the Victorian system but as a contribution to the debate around goals for the system.

Mental Health Services

- All persons assessed by mental health agencies are screened for a substance use disorder using a validated tool.

- Where there is an indication of problematic substance use clients receive a detailed substance use assessment. Such assessments incorporate the client's stage of change in regard to their substance use.

- Where a person's mental health symptoms qualify them for service from a mental health agency their co-occurring substance use disorder is routinely treated in-house (using recognised, evidence-based practices) by the same clinician who is providing treatment for their mental health symptoms.

- Substance use or abuse is never used as a criterion for refusing or limiting service.

- Co-occurring substance use disorder diagnoses are routinely recorded with mental health diagnoses

- Individual Service Plans document the strategies to be used to address co-occurring substance use disorders as well as mental health disorders.

- In-patient unit's operating policies recognise the potential for clients to experience withdrawal (from mild to severe) on admission. Staff are competent in the use of withdrawal scales

- Psychoeducation sessions for clients and carers incorporates information around substance abuse and co-occurring disorders

- The mental health agency provides consultation and advice to other agencies who provide services to persons with co-occurring disorders

- Training around co-occurring disorders and substance disorder treatment is ongoing for all staff.

- The mental health agency advocates for the group of persons with co-occurring disorders. For instance, attempts are made to address systemic difficulties around secure, appropriate housing

- Medication prescribers have had specific training around the issues of prescribing to clients with a high prevalence of co-occurring substance use disorders.

- Each program within a mental health service has a 'co-occurring disorders champion' with particular expertise in substance abuse treatment

- Competency in delivering substance abuse treatment is a core criteria in staff appraisal activities

- Levels of competence in substance abuse treatment are key criteria in various position descriptions

- No wrong door policy: In cases where a person is assessed and it is deemed that the person's mental health symptoms do not qualify them for a service from the mental health agency but that service from a drug treatment agency is indicated then that person will still be warmly welcomed and actively and meaningfully assisted in gaining a service from the drug treatment agency. Service recording tools such as RAPID are modified to reflect and 'reward' such clinician activity.

- All service descriptions and operating philosophies refect the service's recognition of the prevalence and impact of comorbidity and specify the service's approach to detecting, assessing and providing treatment for a client's co-occurring disorders

- There is substantial evidence of close, collaborative working relationships with drug treatment agencies. This includes routine staff placements with drug treatment agencies (especially during staff orientation); services routinely being offered from the opposite agencies premises; joint education and training plans; routine management service planning meetings

- Clinicians, medical staff and management have an understanding of the prevalence and impact of multiple disorders.

Drug treatment services

- All clients receive some level of screening for mental health symptoms or disorders.

- Where there is an indication of mental health symptoms or a disorder a plan is formulated for facilitating or providing further assessment and/or treatment for that disorder

- All drug treatment clinicians are familiar with pathways to assessment and treatment of mental disorders by primary care and specialist mental health treatment agencies
- Clinicians have training in and competency in providing a suicide risk assessment
- Workforce development initiatives include a substantial component on co-occurring disorders
- Treatment Plans document the strategies to be used to facilitate or provide treatment of co-occurring mental health disorders as well as substance use disorders.
- Training around co-occurring disorders and mental health disorders is ongoing for all staff.
- Each drug treatment agency has a 'co-occurring disorders champion' with particular expertise around mental health treatment
- No wrong door policy: In cases where a person is assessed and it is deemed that the person's substance use does not qualify them for a service from the drug treatment agency but that service from a mental health agency is indicated then that person will still be welcomed and actively and meaningfully assisted in gaining a service from the mental health agency. Service recording tools such as ADIS are modified to reflect and 'reward' such clinician activity.
- All service descriptions and operating philosophies refect the service's recognition of the prevalence and impact of comorbidity and specify the service's approach to detecting, assessing and either providing or facilitating treatment for their client's co-occurring mental health symptoms/disorder
- There is substantial evidence of close, collaborative working relationships with local mental health and PDRS agencies.
- All staff have an understanding of the prevalence and impact of multiple disorders.

Recommendations
1. Policy

Preamble

Changing a service delivery system requires policies that provide incentives for adopting innovative changes (ATTC, 2000). That the system is moving to offering more effective, integrated treatment of co-occurring disorders needs to be re-enforced, through a variety of mediums, at all levels of the system. A key objective should be that, once established, a change to providing integrated treatment for co-occurring disorders is an enduring change.

Recommendations

1a) System-wide policy

That Victorian Drug Treatment Services and the Mental Health Branch draft and disseminate collaborative, co-occurring disorders, systemic guidelines that …

- Defines co-occurring disorders
- Outlines a Victorian vision for an integrated treatment response.
- Describes the various cohorts of clients with co-occurring disorders
- Suggests which of these cohorts the various agencies have responsibilities for (the four-quadrant severity matrix below may be a useful tool for this purpose)
- Outlines expectations of each workforce in regard to detection, assessment and treatment of the various cohorts
- Describes the role of the Victorian specialist co-occurring disorders workforce in developing integrated treatment
- Describes minimum expectations of both workforces in regards to inter-agency referral, collaboration and consultation.
- Outlines minimum expectations for the development and content of local protocols between drug treatment and mental health agencies

I **Less severe mental disorder /** **Less severe substance use disorder**	**III** **Less severe mental disorder /** **More severe substance use disorder**
II **More severe mental disorder /** **Less severe substance use disorder**	**IV** **More severe mental disorder /** **More severe substance use disorder**

Diagram 1 - four-quadrant severity matrix (SAMHSA, 2003).

Recommendation 1 - Policy.

1b) Mental Health System policy

That the Chief Psychiatrist, Mental Health Branch release a *Co-occurring Disorders Clinical Practice Guideline* that

- Outlines guidelines and standards for mental health clinicians in regard to detection, assessment and treatment of co-occurring substance use disorders
- Makes it explicit that integrated treatment of co-occurring disorders is the goal of the Victorian mental health system, that is, the principle of…

- *Where a person's mental health symptoms are sufficient for them to receive a service from a Victorian mental health agency then any co-occurring substance use disorder should also receive treatment by the same clinician who is providing treatment for their mental health disorder.*

1c) Drug Treatment System policy

That Drug Treatment Services release workforce guidelines that define an appropriate scope of practice for drug treatment clinicians in regard to persons with co-occurring disorders.

This document should include …

- Guidelines around appropriate practices and tools for screening for co-occurring mental health disorders
- Guidelines for a range of appropriate responses where symptoms of or an actual mental health disorder is detected
- Guidelines describing worker's responsibilities around assessing suicidality and interventions when suicidality is detected

Recommendations
2. Achieving buy-in from key stakeholders

Preamble

There are a number of key stakeholders whose knowledge, support and enthusiasm, or 'buy-in', is crucial to the success of an attempt to introduce a system-wide change such as the introduction of integrated treatment for co-occurring disorders.

These stakeholders include…

- Psychiatrists employed in the public sector
- Local mental health and drug treatment administrators
- Opinion leaders in each of the agencies actually delivering the services (not necessarily management).
- Clinicians who will be delivering the services

The more that these stakeholders can be meaningfully engaged in the planning and implementation of a change, the less likely is it that resistance to the changes will be encountered and the more likely is the initiative to succeed.

Psychiatrists have oversight and responsibility for all clinical service delivery in Victorian mental health services and therefore constitute the single most important stakeholder group needing to be engaged in implementing integrated treatment. Without the explicit support of psychiatrists employed in the public sector integrated treatment of co-occurring disorders will not happen. As with other key stakeholders psychiatrists knowledge about and willingness to provide integrated treatment for co-occurring disorders varies from Precontemplation to long-standing Action and innovation. The existing Victorian dual diagnosis initiative has limited ability to address the training needs of psychiatrists.

Recommendation 2a describes a method for maximising stakeholder participation, ownership and knowledge whilst tailoring the implementation of integrated treatment to specific local conditions. It is based on processes followed in the United Kingdom and Arizona.

Recommendations

2a) Regional Integrated Treatment Implementation Planning Groups

That the Department of Human Services establish time-limited Regional Integrated Treatment Implementation Planning Groups (RITIPG) in each mental health area.
RITIPGs membership should include persons with substantial ability to shape local service delivery including management from local drug treatment, mental health and PDRSS agencies, consumer and carer representation, local

Recommendation 2 - Achieving buy-in from key stakeholders

specialist dual diagnosis workers, clinical 'dual diagnosis champions' and regional DHS.
Whilst RITIPGs bear some resemblance to the current Victorian Dual Diagnosis Initiative's *Local Advisory Groups* a key difference is that RITIPGs have more defined, goal-focused tasks to do with engaging local stakeholders in collaborative, strategic outcome-oriented actions to maximise the local treatment response to persons with co-occurring disorders.

2a -i) Regional profile of issues around co-occurring disorders.

Each ITIPG is to be initially responsible for generating a regional profile of issues around co-occurring disorders.
This should include

- Local prevalence estimates by co-occurring disorders cohort, or plans to generate such estimates
- Local service mapping
- Local perceptions of client groups that fall through the gaps (fail to receive a service or receive an inadequate or ineffective service)

- Description of local barriers to the implementation of integrated treatment
- Other local issues relevant to outcomes for persons with co-occurring disorders such as rurality, local substance use patterns, housing needs
- Local training needs

Note: An ***Agency Co-occurring Disorders Competency Assessment*** tool, developed for Victorian conditions, would have the potential to inform the regional profile.

2a – ii) Regional profile dissemination

Once completed the regional profile of issues around co-occurring disorders should be disseminated to all local stakeholders for further input and comment

2a – iii) Regional integrated treatment implementation plan

On the basis of the regional profile and associated feedback each RITIPG is to be responsible for generating a regional integrated treatment implementation plan
Plans should include …

- Evidence of consultation and collaboration in the preparation of the plan
- Strategies to address specific local barriers to integrated treatment
- Statements identifying which co-occurring disorders cohorts will be addressed by which agency
- Care pathways for each cohort
- Education and training strategy

Recommendation 2 - Achieving 'buy-in' from key stakeholders

- Interagency protocols
- Mechanisms to review the effectiveness of the strategies and formulate further strategies.

2b) Psychiatrist buy-in

That the mental health branch considers strategies to further engage psychiatrists employed in the public sector in providing integrated treatment of co-occurring disorders. One possible response may be to offer a series of psychiatrist-focused symposiums, with substantial incentives for participation.

2c) Co-occurring disorders champions

That it become routine practice that each mental health, PDRS and drug treatment agency has a 'co-occurring disorders champion' amongst the staff. The criteria for champion selection should include their ability to influence the service delivery and policies of the agency. Ideally the champion will have some expertise in the treatment offered by the opposite agency. Champions should liaise with local specialist co-occurring disorders workers and may receive support and training from specialist workers.

Recommendations
3. Education and training

Preamble

There is a need for a planned and comprehensive approach to training that systematically addresses the diversity of training needs of different groups whose knowledge and attitudes influence outcomes for persons with co-occurring disorders.

A strength of the current approach of local specialist workers developing training packages in response to identified local needs is that it 'starts where participants are' in regard to improving treatment response to persons with co-occurring disorders. This approach has primarily targeted the drug treatment and mental health workforces.
There is a need for...

- A mechanism to pool and review training packages to ensure that they are evidence-based and contain a defined minimum content
- Training packages for non-drug treatment /mental health agencies which provide services to persons with co-occurring disorders
- Training packages for carer and client groups
- Strategies to engage tertiary education institutions in providing more substantial components on substance use disorders and co-occurring disorders in a wide variety of undergraduate courses.

Training that only provides how-to-do-it, action strategies for providing more integrated treatment is likely to be ineffective. Such training fails to recognise that many participants will be precontemplative about the need to change existing practices.

Persons with co-occurring disorders have two stigmatised, often-relapsing disorders and such individuals may be further stigmatised by behaviours consequent on their multiple disorders. Training around co-occurring disorders that fails to identify and work with participant's attitudes to persons with co-occurring disorders is likely to be less effective than training that addresses participant's attitude as well as their knowledge and skill development.

Recommendations

3a) Tertiary education providers: drug treatment and co-occurring disorders content
That Drug Treatment Services and the Mental Health Branch liaise with the tertiary training sector to promote a larger component of education around substance treatment and co-occurring disorders in a wide range of undergraduate courses (Social Work; Medicine; Occupational Therapy; Nursing). One strategy could be to offer an award or bursary, for the institution or course that most substantially addresses this need.

Recommendation 3 - Education and training

3b) Training delivered by the specialist workforce: minimum curricula

That the dual diagnosis specialist workforce collaboratively defines a minimum set of curriculum elements for training offered by them to the drug treatment and mental health workforces. This recommendation sits alongside the recognition that delivery of this minimum set and further curriculum development will be modified in response to local circumstances and needs analysis. Minimum curricula should be informed by workforce co-occurring disorders guidelines (see recommendations 1a, 1b, 1c)

One means of refining the content of training could be by developing a central repository, such as a website accessible only to members of the specialist workforce, where training modules are posted, reviewed and developed.

3c) Addressing workforce attitudes towards persons with co-occurring disorders

That the dual diagnosis specialist workforce, in delivering training packages to the drug treatment and mental health workforces, incorporate activities that identify and work with participant's attitudes to persons with co-occurring disorders.

3d) Stage of change analysis

That the dual diagnosis specialist workforce, in delivering training packages to the drug treatment and mental health workforces, utilise a stage-of-change analysis around participant's readiness to provide or facilitate treatment of co-occurring disorders.

3e) Mobile Support and Treatment Team's dual diagnosis worker's training needs

That a state-wide Mobile Support and Treatment team dual diagnosis worker training initiative be rolled out with substantial collective input from the specialist co-occurring disorders workforce.

3f) Mobile Support and Treatment Team's dual diagnosis worker's support needs

That further development of guidelines on the relationship between the specialist teams and the Mobile Support and Treatment Team's dual diagnosis workers occur.

3d) Multimedia training resources

That consideration is given to funding the development of multimedia training resources around co-occurring disorders. Such resources may support and supplement the training activities of the specialist workforce.

Recommendations
4. Research

Preamble

To date the literature around co-occurring disorders to date has been largely dominated by North American contributions describing their research and clinical initiatives. While those advances have the potential to inform Australian clinical activity, service planning and research they do not necessarily translate without modification to local conditions and there is a substantial need for research around the spectrum of co-occurring disorders in Australia. A range of research priorities around co-occurring disorders in the Australian context are identified in the Commonwealth Department of Health and Ageing, (2003) Current practice in the management of clients with comorbid mental health and substance use disorders in tertiary care settings.

Recommendations

4a) Central Register
That a central register of all completed and in process Australian research around co-occurring disorders be initiated. This register should be web-based in order to offer maximum accessibility to stakeholders

4b) Prioritising research
That gaps in our knowledge around co-occurring disorders and effective treatment responses in an Australian context are identified and prioritised.

4c) Disseminating research outcomes
That mechanisms be developed to rapidly disseminate research outcomes to Victorian drug treatment and mental health clinicians

4d) Research opportunities
That all planning of initiatives to address co-occurring disorders in Victoria prioritises any research opportunities afforded by the initiative.

Recommendations
5. Victorian specialist co-occurring disorders workforce

Preamble

The Victorian specialist co-occurring disorders workforce represents a significant resource with the potential to further develop and refine goals and strategies and resources for the Victorian treatment system around co-occurring disorders. Mechanisms need to be developed to systematically harvest the collective experience of the specialist workforce and more strategically use the workforce in driving a change to treatment of co-occurring disorders.

In pockets there has been a high turnover of members of the Victorian co-occurring disorders specialist workforce – this reflects international experiences and, as this has not been a universal Victorian experience, lends itself to an analysis of those factors that sustain a specialist workforce. A workforce development aspect of staff turnover is that those workers with specialist workforce experience often move to other parts of the system.

High workforce turnover may be related to …

- Critical mass of the co-occurring disorders specialist team
- The demands and expectations upon specialist workers
- Access to and availability of high quality clinical and project supervision
- Lack of definition of the roles of a specialist worker
- Isolated instances of inadequate managerial understanding of issues around co-occurring disorders and a consequent lack of commitment to supporting and resourcing the specialist workforce.
- The majority of rural workers being solo workers - the United Kingdom's Dual Diagnosis Good Practice Guide (DOH, 2002) states that '*isolated dual diagnosis specialists will become burned out or disconnected from wider knowledge and developments'.*

Recommendations

5a) Mechanisms for communication and collaboration

That mechanisms be developed to facilitate greater communication and collaboration between specialist workforce teams and clinicians. At a minimum these should include bi-annual meetings of the workforce to communicate about their experiences and approaches, identify barriers to effective treatment and strategies to address those barriers. Another approach may be to encourage specialist workforce clinician placements with other specialist workforce teams. A central website with contributions from all teams may also contribute to collaboration and communication

Recommendation 5 - Specialist co-occurring disorders workforce

5b) Support for the specialist workforce

That the Victorian co-occurring disorders specialist workforce be supported by

- Routine quality clinical and project supervision
- Regular training opportunities targeting the specific needs of the specialist workforce
- A permanent worker whose role is to inform the further development of curriculum for use by all specialist teams and to facilitate the provision of training to specialist dual diagnosis teams across Victoria.

5c) Clinical resources development

That the Victorian co-occurring disorders specialist workforce is charged with developing resources to assist clinicians in treating persons with co-occurring disorders. One example could be found in the development of co-occurring disorders treatment or support guidelines targeting each of the mental health, drug treatment and Psychiatric Disability Rehabilitation and Support Services sectors.

Recommendations
6. Other recommendations

Preamble

A range of tools have been developed to assist agencies in increasing their capacity to provide routine integrated treatment of co-occurring disorders. Most of these tools have been developed in North America and may not be suitable for local use without modification. Among other tools, Dr Ken Minkoff has developed the '*Compass*' – a tool for an agency to self-assess its competencies in relation to co-occurring disorders (see page 54). New Hampshire's Mueser, Noordsy, Drake and Fox (2003) have developed a '*Dual Disorder Treatment Fidelity Scale*' to measure a service's fidelity to their integrated treatment model (see page 62).

There is a need for a website which can…

- Act as a central access point for clinicians and other stakeholders seeking a wide range of information and resources related to co-occurring disorders
- Profile and link the activities of the Victorian dual diagnosis initiative
- Serve to reduce the isolation of rural specialist workers

A new Victorian co-occurring disorders conference would contribute to the collective Victorian knowledge of effective treatment responses and underline Victoria's commitment to achieving better outcomes for persons with co-occurring disorders.

Many of the key informants that I met with during the study reflected positively on the input and focus provided by external consultants. There are consultants available with substantial expertise in working with whole systems to improve the treatment response to persons with co-occurring disorders (see visits 8, 9, 10, 11, 12, 16, 17, 18, 19).

If central planning bodies were to gather a range of data around the financial and social costs and cross-sector service demands by persons with co-occurring disorders this would promote a wider recognition of the prevalence and impact of co-occurring disorders and provide a powerful argument for modifying the service system to more effectively address the needs of persons with co-occurring disorders.
Such data, gathered at defined intervals, may also provide feedback about the effectiveness of strategies addressing the treatment system's response to co-occurring disorders.

The term 'dual diagnosis' has been criticised by a number of authors (Maslin, 2003; Weaver, Renton, Stimson, Tyrer, 1999; Drake and Wallach, 2000) for its lack of precision and because this client population often has a multiplicity rather than a dyad of disorders (Todd, Sellman, Robertson, 1998).

Recommendation 5 - Other recommendations

Recommendations

6a) Tools
That planners consider strategies to promote the development of a *Victorian Agency Co-occurring Disorders Competency Assessment Tool*

6b) Website
That the Victorian Mental Health Branch and Drug Treatment Services consider strategies to promote the development of a Victorian co-occurring disorders website.

6c) Data collection
That ADIS and RAPID data collection systems be modified to promote the recognition and recording of multiple diagnoses and to 'reward' clinician activity around improved interagency referral and collaboration.

6d) Conference
That central planning bodies consider strategies for funding a new conference around co-occurring disorders. That such a conference invites keynote speakers with expertise around system change towards better outcomes for persons with co-occurring disorders. That such a conference has a strong focus on practical, evidence-based clinical responses to the spectrum of co-occurring disorders

6e) External consultants
That central planning bodies consider engaging an outside consultant to help facilitate system-wide change

6f) Monitoring costs of co-occurring disorders across multiple systems
That central planning bodies develop a strategy to gather a range of data, at defined intervals, around the financial and social costs and cross-sector service demands by persons with co-occurring disorders. Such data may provide feedback about the effectiveness of strategies addressing the treatment system's response to co-occurring disorders.

6g) Terminology
That attempts be made to select and promote a more accurate, less ambiguous term than 'dual diagnosis' to describe co-occurring mental health and substance use disorders

Australia
Further Reading & Resources

ANCD (2003) Reports on the 2003 Rural & Regional Comorbidity Workshops Australian National Council on Drugs

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http://www.health.nsw.gov.au/health-public-affairs/publications/mhsubuse/index.html

NSW Health Department. (2000). The Management of People with a co-existing Mental Health and Substance Use Disorder Service Delivery Guidelines
http://www.health.nsw.gov.au/health-public-affairs/publications/mhsubuse/index.html

Robinson, S., Gomes, A., Pennebaker, D., Quigley, A., Bennetts, A. Co-occurring mental illness & substance abuse: A Service Review (2001) ISBN 1-877083-13-5. The Centre for Mental Health Services Research Inc. Perth WA
http://www.cmhsr.com.au/research_evi_bas.htm

Section 3.

Description of the study itinerary

Section 3.1:

Background notes

There are a number of structural, social and economic differences between the United Kingdom, the United States, New Zealand and Australia relevant to an inquiry about integrated treatment of co-occurring disorders.

Some of these factors include:
Healthcare system structures: The healthcare systems of the United Kingdom, New Zealand and Australia are broadly similar enough to allow comparison. However the USA's managed healthcare system has particular strengths and barriers in regards to integrated treatment that, in parts, may be less relevant to the other three countries. Nonetheless the substantial body of epidemiological research, treatment research and system change technology that has originated in the USA has the potential to inform research and treatment initiatives involving integrated treatment of co-occurring disorders in Australia.

Nature of substance use: Most UK and USA informants cited the ready availability of crack cocaine as having had significant impact on the nature and complexity of presentations to both mental health and drug treatment services. While prevalence studies often fail to show use amongst sub-groups or to distinguish between crack and cocaine, it does appear that crack cocaine use is highly prevalent amongst socially marginalised groups such as the seriously mentally ill. Cocaine is more readily available in the USA than in the UK (EPSAD, 1999).

Focus of drug treatment: Whilst generalisations have risk my impression was that the USA appears to have a more concentrated focus on abstinence goals than do Australia, New Zealand or the United Kingdom. It appears that in the USA harm reduction approaches are more controversial and may be more likely to cause clinician's internal conflict around whether they are 'enabling' substance use.

Deinstitutionalisation: In tracing the history of co-occurring disorders a number of informants from the USA described the de-institutionalisation process as having led to a large, visible, often homeless, population of seriously, mentally ill persons formerly living in institutions who now had access to substances and for whom there were only limited community supports.
Deinstitutionalisation was not identified as a key factor by any UK or NZ informants and appears to have been a less pivotal process in those countries.

Assertive Outreach Teams (AOT's): The AOT mental health team model is widespread in the UK and USA but there are few existing examples in Australia with good fidelity to the model. AOT teams are designed to provide intensive support to persons with severe mental illness who would otherwise be difficult to engage with services - many AOT clients will have multiple diagnoses.

Assertive outreach teams should have the following characteristics:

- A team approach rather than case management
- Team caseload smaller than 12 service users for each staff member
- Planned long-term work with clients from a defined client group
- Majority of the work outside a service setting
- Evening and weekend availability / 24 hour access to an on-call system for AOT service users. (University of Durham, n/d)

Section 3.2.

United Kingdom Visits

26/10/03 to 6/11/03

Visit No: 1	**Key informant:** Liz Brewin Institute of Psychiatry King's College University of London
Date: 28/10/03	

Summary of informant's co-occurring disorders-related role/activities:

i) COMO Project:

The Como Project developed after Menezes, Johnson, Thornicroft and Marshall's (1996) prevalence study examining substance use amongst persons with severe mental illness in South London. These researchers found one-year substance abuse prevalence rates amongst person with psychotic disorders of 36%. Clients with co-occurring substance abuse had spent twice as many days in hospital as clients without substance abuse.

In 1999, following the prevalence study, the Maudsley recruited Liz as a co-occurring disorders trainer and researcher for a random control trial evaluating training for mental health workers. Liz devised a 5-day training package which was delivered to Community Mental Health Teams in four London boroughs. The teams serving as a control group received no training.

The researcher's hypothesis was that there would be a change in the clients of those staff who had received training. Clients with co-occurring psychosis and substance use disorders were identified and case notes reviewed. Clients were assessed with a range of instruments pre and post-intervention. Mental health clinicians were rated around attitude, confidence, knowledge and stress and the experimental group were provided with follow-up supervision.

While no significant difference was found between the experimental and control groups of clients difference was found between the experimental and control staff groups. Results will be published in 2004.

ii) Camden / Islington Project:

In 2001 the Camden / Islington Health Trust were planning mental health worker co-occurring disorder training. They decided to evaluate different models of training - a 12-day model previously devised by Liz, with the 5-day model used in the COMO project. Liz delivered a large-scale training initiative (9 mental health teams) and provided clinical supervision for staff completing the 5-day course.

Participants were surveyed pre and post education. Data about patients at baseline was collected using case note review and post-intervention data is currently being collected.

iii) Pan-London Dissemination Project:

The pan-London Dissemination Project is a train the trainer initiative to disseminate the 5-day training package across London. 33 trainers,

Visit No: 1 cont	Key informant: Liz Brewin
Date: 28/10/03	

nominated by their local trusts, have to date trained over 200 mental health staff. Evaluation is occurring using participant's evaluation forms

iv) Other discussion themes:
Much of Liz's work has been concerned with the effectiveness and impact of training initiatives and how best to measure that. Liz described some provisional discussions that have occurred around a National train the trainer's initiative. She described a group that has been established in her local South London Trust to examine how the Trust's services articulate around the needs of persons with co-occurring disorders. Liz described potential implications for persons with co-occurring disorders of the UK's imminent decriminalisation of cannabis.

I asked Liz about how she saw co-occurring disorders developing in the future. She responded that she hopes that we will reach a point where there is no longer a need to compartmentalise around diagnosis, where each clinician is clear on their roles and responsibilities and confident to meet each client as they come

Activities undertaken during visit:
I sat in on co-occurring disorders-focused group supervision session facilitated by Elizabeth with an East London Assertive Outreach Team, followed by discussions and an interview with Elizabeth at the Maudsley Hospital

Key lessons learned:
Liz's work impresses as a model articulation of co-occurring disorders research, training and evaluation initiatives. Her work highlights the difficulties that are likely to be encountered in attempting to measure the impact of training and supervision interventions.

Suitability to own practice:
This visit drew my attention to the need to more rigorously evaluate the impact of training that I provide as well as potential difficulties in attempting to do so. Visiting the Assertive Outreach Team revealed some of the challenges in practice encountered by an agency that is increasing its capacity to provide integrated treatment of co-occurring disorders. The visit demonstrated the practice and value of offering group clinical supervision to supplement training initiatives.

Suitability to Victorian healthcare system:
Highlighted the need to evaluate Victoria's range of approaches to training around co-occurring disorders for both the mental health and substance treatment workforces

Visit No: 2	Organisation:	Haringey Dual Diagnosis Service Haringey London United Kingdom
Date: 29/10/03		

Summary of organisation's co-occurring disorders-related role/activities:
Established in 1999 Haringey Dual Diagnosis Service is a specialist co-occurring disorders service operating from a shared-case management model with referrals from both mental health and drug treatment services. Haringey Dual Diagnosis Service was highlighted as an example of good practice in the UK Dual Diagnosis Good Practice Guide (DoH, 2002). The service has a multidisciplinary staff of 15-16. Its catchment of 270,000 persons includes areas with significant deprivation, crowding, substance use and racial tension.

Haringey Dual Diagnosis Service's definition of dual diagnosis embraces all mental health diagnoses, including Personality Disorders, provided that the disorders are severe and enduring (greater than 6 months). The service's aims include:
- Supporting workers to work with clients with co-occurring disorders
- Linking difficult-to-engage clients back into existing services
- Advocating at individual, policy and systems levels for clients with co-occurring disorders

Haringey Dual Diagnosis services include:
- Comprehensive assessment including re-evaluation of mental health symptoms in the light of addictive behaviour.
- Short term interventions focused around harm minimisation
- Longer term work addressing substance misuse issues.
- Provides an ethnic minorities specific outreach service
- Inpatient and outpatient carer support
- Training for both mental health and drug treatment workers. A recent training initiative with an inpatient unit was aimed at establishing the protocol that each client admitted will have an alcohol assessment.

Haringey Dual Diagnosis Service has had input into both the stand-alone P.G. Dip /MSc Dual Diagnosis courses and the Dual Diagnosis component of nurse training Courses offered by Middlesex university

Interview with Kim Moore, Team Manager:
Kim profiled the service, its genesis, aims, strategies and the demands upon it. She described the service's particular focus on using engagement strategies to link clients with complex needs back into existing services and the team's philosophy and approach including the importance of harm minimisation, clinician flexibility and a client-centred, respectful response. Kim described the impact of crack cocaine upon the seriously mentally ill population.

Visit No: 2 cont	Organisation: Haringey Dual Diagnosis Service
Date: 29/10/03	

Kim foresees streamlining the services currently offered by HDDS and would like to develop an integrated day program in partnership with substance misuse and mental health services.

Activities undertaken during visit:
In a whole-day visit I sat in on the weekly team intake and review meeting, sat in on a client's initial assessment, met with team members and recorded interviews with Kim Moore.

Key lessons learned:
This visit underscored the importance of engagement strategies and careful ongoing assessment of persons with multiple disorders and complex needs.

Suitability to own practice:
Instructive in range of issues around working with clients with particularly complex needs in a particularly deprived environment

Suitability to Victorian healthcare system:
This service developed in the context of a much higher mental health bed ratio than exists in the Victorian mental health system and a significant part of its work has been focused on the needs of a larger inpatient population.
Where agencies utilise a shared case management model clear role definition for the specialist worker is crucial.

Visit No: 3	Key informant: Prashant Phillips University College London
Date: 31/10/03	

Summary of informant's co-occurring disorders-related role/activities:

- Current Research Fellow University College, London
- Honorary Clinical Nurse Specialist - Drug Misuse - Camden & Islington Mental Health NHS Trust.
- Advisor to the National Association for Mental Health (MIND) for dual diagnosis
- Prashant has been involved in co-occurring disorders work since 1995 and is an experienced trainer around co-occurring disorders
- Current PhD thesis: '*Understanding drug and alcohol use among the mentally ill - an investigation of the context and motivations for drug and alcohol use among an in-patient sample of individuals with psychotic illnesses'.*
- See Appendix 2 for a list of Prashant's co-occurring disorders related papers and publications.

Activities undertaken during visit:

Recorded interview with Prashant

Key lessons learned:

Prashant traced the UK's 'co-occurring disorders history', discussed possible systemic responses to co-occurring disorders and described his research activities.

Systemic responses to co-occurring disorders:

Initiatives targeting the mental health workforce's capacity to provide integrated treatment are widespread in the United Kingdom and have usually been developed by the drug treatment arm of local health trusts. Most often these initiatives are based on a training, consultation and liaison model, similar to Victoria's dual diagnosis initiative, with only limited direct service delivery. There are issues of a shortage of people with the qualifications for these roles and high turnover of workers. This may be related to a lack of clinical supervision or, in some instances, expectations that specialist workers will manage all of the clients identified as having co-occurring disorders.

Co-occurring disorders capacity building initiatives have been substantially strengthened by policy directives stipulating that addressing co-occurring substance use disorders is core business for mental health services (see Louis Appleby in the UK Dual Diagnosis Good Practice Guide - DoH, 2002). In Prashant's assessment there is still some resistance from some mental health workers to providing integrated treatment for co-occurring substance use disorders however there has been considerable movement in this regard over the past 3 to 4 years. Mental health clinicians appear more alert to and knowledgeable about the impact of client's substance use.

Visit No: 3 cont	Key informant: Prashant Phillips
Date: 31/10/03	

Prashant discussed the systemic options of …
- Developing existing mental health and substance treatment services so that they are more effective in addressing co-occurring disorders

or
- Developing dual diagnosis specific services or a dual diagnosis specific service system.

Prashant's assessment is that the first option is preferable as there are neither the funds nor the will to develop up a third treatment system and it is relatively easy to skill up mental health workers with drug treatment knowledge and skills. Prashant stated that the second option fails to adequately recognise the size of the population of persons with a mental disorder who have a co-occurring substance use disorder.

Prashant also noted that crack cocaine has had a significant impact over the last 7 years on the co-occurring disorders presentations to UK mental health services.

Prashant's co-occurring disorders research:
Epidemiology
Rates of problematic substance use amongst persons who have mental health admissions may be higher than amongst those who only receive community services. Prashant's recent study of mental health inpatients substance use (*n*=264) used staff ratings to determine substance use disorders and found that 49% of inpatients met criteria for substance abuse or dependence. In comparison London studies of persons treated in the community have found rates of substance use disorders among persons receiving mental health treatment of around 35%

Substance use during inpatient admissions may be higher than expected – the same study found that 87 % of clients had used during any admission, 81% had used during their current admission and 52% had used cannabis on the wards. 46% of the sample had bought drugs from another inpatient.

Motivations for substance use
Client's reasons for use and beliefs about their substance use are central to treatment planning. In Prashant's study, socialisation followed by hedonism was the main reasons identified by clients for their substance use. Self-medication appeared to account for only a small percentage of substance use.

Substance use amongst older persons
There are unanswered questions around substance use in older persons including prevalence, reasons for use, substances used, beliefs about substance use, health outcomes and substance use by carers.

Visit No: 3 cont	Key informant: Prashant Phillips
Date: 31/10/03	

Future directions
Prashant would like to see more evidence about effective treatment responses for particular comorbidities and more service development to improve the response to the needs of persons with high-prevalence, low-impact type co-occurring disorders. In this regard Prashant identified the need for a more flexible response from some addiction treatment services.

Prashant feels that there may be a need for some specialist dual diagnosis services for clients with particularly complex needs but there is some risk that such units may become 'dumping grounds'. Prashant sees value in the development of a central repository that compiles together and sets curricula for co-occurring disorders in particular and substance treatment in general. He would like to see the development of minimum qualifications and standards for addiction workers.

Suitability to own practice:
This contact brought home to me that I need to develop strategies to promote and incorporate research into the activities of the Eastern Hume Dual Diagnosis Service (EHDDS). Another realisation was that I need to focus more on the distinction between 'use without impairment' and a 'substance use disorder' in the training offered by EHDDS.

Suitability to Victorian healthcare system:
This visit underlined the importance of top-down policies to complement and support the bottom-up activities of a specialist co-occurring disorders workforce.
Specifically the needs for

- Central guidelines around individual mental health worker's and agencies response to co-occurring substance use disorders.
- Consideration of the service system's response to persons with non-psychotic type co-occurring disorders
- Measure of the nature of and strategies to address substance use in inpatient units
- Research around problematic substance use in older persons

Visit No: 4	Organisation: COMPASS Dual Diagnosis Programme Birmingham United Kingdom
Date: 03/11/03	

Summary of organisation's co-occurring disorders-related role/activities:

Background
In 1998 a Northern Birmingham Mental Health Trust prevalence study found that 24% of clients with severe mental illness had used alcohol and/or drugs problematically in the previous year (Graham, Maslin, Copello, Birchwood, Mueser, McGovern and Georgiou, 2001). Substances used most commonly were alcohol followed by cannabis. Key workers identified pleasure enhancement and coping as the most common reasons for use (Graham and Maslin, 2002).

COMPASS
Developing since 1998 COMPASS is a 'specialist multidisciplinary team that aims to train and support existing mental health and substance misuse services to provide treatment that covers both the mental health and substance use difficulties of service users' (Graham, 2002). COMPASS has a focus on the severely mentally ill type co-occurring disorder population and the Assertive Outreach Teams (AOT) because of the prevalence and complexity of persons with co-occurring disorders in that arm of the mental health system. Professor Kim Mueser from New Hampshire acted as an external consultant in the development of the COMPASS model.

The key principle underpinning COMPASS's integrated approach is that *'both mental health and substance use problems and the relationship between the two are addressed simultaneously by the mainstream mental health clinician'* (Graham, 2002). COMPASS states that their 'integrated shared care' model is in opposition to creating a third, specialist dual diagnosis, service.

The 6-member team comprises a service director, research psychologist, three senior community psychiatric nurses, a senior occupational therapist and sessional input from a consultant psychiatrist in addictions. Until recently COMPASS was headed by Dr Hermine Graham (see Appendix 2 for a list of Dr Graham's co-occurring disorders related publications).

The COMPASS team has developed a manualised cognitive-behavioural integrated treatment approach for co-occurring disorders (C-BIT) that serves as a basis for their training around co-occurring disorders. The comprehensive treatment manual describes cognitive-behavioural treatment approaches tailored to client's phase of treatment. Dr Graham has recently published a related text Cognitive Behavioural Integrated Treatment (C-BIT): A Treatment Manual for Substance Use in persons with Severe Mental health Problems (2003).

Visit No: 4 cont	Organisation:
Date: 03/11/03	COMPASS Dual Diagnosis Programme

COMPASS services:
The COMPASS programme offers three integrated-treatment orientated, services to substance misuse and mental health services:

(1) Training & clinical work with Assertive Outreach Teams
This training is around COMPASS's manualised cognitive-behavioural approach and is supplemented by team supervision/case discussion sessions. The intervention is being evaluated using a quasi-experimental research design in which 3 Birmingham AOT teams have received the C-BIT package while another 2 AOT teams served as a control group (see Research section below).

(2) Consultation/Liaison: Brief Intervention
COMPASS offers training in specialist assessment and brief motivational interviewing to key staff in other mental health and substance misuse teams within the trust with the aim of building client's motivation to address mental health and substance misuse problems. COMPASS will, on occasion, provide the specialist assessment and treatment brokering. A research-based evaluation is occurring.

(3) Consultation/Liaison: Group Programme
The COMPASS team conducts group-work with clients at both inpatient mental health and substance misuse units. The focus of the groups is on engagement, harm reduction, psychoeducation and the exploration of relationships between client's substance use and mental health.

Research:
A large scale evaluation of the effectiveness of an integrated, shared care approach to the treatment of co-existing severe mental health and substance use problems within the five AOT's was completed in August, 2003. AOT teams were evaluated each six months for 36 months with the purpose of establishing whether an integrated treatment approach is workable and effective within existing mainstream mental health services and, if so, whether it has a positive impact on service user outcome (*n*=58). The results are currently being analysed (late-2003) and outcomes will be published.

COMPASS hosts bi-monthly visitor information sessions on service development issues for other health trusts seeking to develop similar services for clients with co-occurring disorders. The COMPASS programme was highlighted as an example of good practice in the UK Dual Diagnosis Good Practice Guide (DoH, 2002).

Visit No: 4 cont	Organisation:
Date: 03/11/03	COMPASS Dual Diagnosis Programme

Activities undertaken during visit:
On this visit I was able to sit in on a morning's training with members of an AOT team. This session focused on a component of COMPASS's cognitive-behavioural integrated treatment manualised approach. I spent the remainder of the day with the team's manager, Mike Preece and other team members including an outreach visit to a client in a newly-built, acute inpatient unit and an evening meal with the COMPASS team.

Key lessons learned:
This visit broadened my understanding of the staged application of cognitive-behavioural interventions for persons with severe mental illness.

Regarding the evaluation of substance misuse interventions in psychosis Copello et al. (2001), based on the experience at COMPASS, argue that one should evaluate changes in the mental health team involved rather than in client/s.

Suitability to own practice:
An outcome of this visit is that my own practice, and any training that I offer, will incorporate more stage-matched use of cognitive-behavioural approaches for persons with severe mental illness and substance use.

Suitability to Victorian healthcare system:
COMPASS's development was informed by the recognition that 'integrated treatment approaches developed in the USA cannot be wholly imported because of contextual factors that guide service provision in the two countries' (Graham et al, 2003) and this also holds true for Victoria.

COMPASS's approach of incorporating research into the effectiveness of their integrated-shared care approach will contribute to the evidence base around effective responses to co-occurring disorders and may serve as a model for Victorian initiatives addressing co-occurring disorders.

COMPASS's refinement of cognitive-behavioural approaches for persons with severe mental illness and substance use should inform the training offered by the Victorian specialist co-occurring disorders workforce.

Visit No: 5	Key informant:	Jood Gibbins Dorset Dual Diagnosis Service Bournemouth United Kingdom
Date: 06/11/03		

Summary of informant's co-occurring disorders-related role/activities:
Jood Gibbins has been the solo, specialist co-occurring disorders worker with the Dorset Dual Diagnosis Service since the service's establishment in 1996. The service has a mixed metropolitan and rural catchment including the Bournemouth, Dorset and Poole regions.

Dorset Dual Diagnosis Service was one of the first co-occurring disorders initiatives established in the United Kingdom. As a pioneering service it has provided consultation to a number of similar services established since 1996. One result of this demand upon Dorset Dual Diagnosis Service was the establishment of the National Dual Diagnosis Network. The network offers members a regular, email-based magazine and membership is free by contacting Moksha Darnton.

Services:
Dorset Dual Diagnosis Service offers education and training, clinical supervision and some direct service delivery.

Education and Training
Jood has trained in motivational interviewing with William Miller in the USA and much of the training that she offers has a focus on motivational interviewing. Until recently Jood offered a 4-day motivational interviewing skills course supplemented by 3-monthly update afternoons for course completers.

Jood's 2004 training plan is to vary this format to a series of 1-day 'tasters' that focus on the spirit of motivational interviewing and encourage workers to re-evaluate their ideas about working with clients with substance use disorders. From the 'taster' sessions clinicians will be able to undertake a 2-day skills-focused module and an advanced coaching course for completers of the 2-day module.

Jood also coordinates and lectures for the co-occurring disorders component the University of Southampton's addiction courses. Jood recently organised a 1-day co-occurring disorders training specifically for psychiatrists.

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Clinical
Jood maintains a caseload of 5 clients with severe and enduring mental illness, referred from mental health and usually seen with their case coordinator. Services range from a one-off, intensive assessment with comprehensive report to longer-term work. Jood plans to streamline this service into a regular clinic.

Visit No: 5 cont	Key informant: Jood Gibbins
Date: 06/11/03	Dorset Dual Diagnosis Service

Other themes
Jood described an early initiative of the service in which she was placed 2-days per week for 6 months with a Community Mental Health Team. At the conclusion of the placement an independent evaluation, using a focus group, found that the team members felt that they had lost their focus on co-occurring disorders once Jood left the team. The clinician's strongest message was that they need to have a permanent worker on the team whose role is to facilitate their working with client's substance use.

We discussed the high co-occurring disorders specialist worker turnover and the difficulties in finding staff qualified to work in this role. Jood feels that high quality supervision is a key element in retaining staff in this field. The UK Dual Diagnosis Good Practice Guide (DoH, 2002) recommended that planners '*provide supervision for all specialist staff whether they form part of a specialist team or not'.*

Jood described a Sainsbury Centre study of six specialist co-occurring disorders teams. The study found high staff and service attrition and concluded that such services should not have workers working in isolation.

Future directions
Jood would like to see…
- The growth of early intervention services that recognise and incorporate evidence based responses to client's substance use
- At least one staff member in each mental health service with drug treatment expertise
- That mental health services have clear treatment pathways for clients with substance misuse
- An increase in the evidence base around the impact of motivational approaches to the substance use of clients with severe mental illness

Activities undertaken during visit:
Interview with Jood Gibbins and a conversation with Moksha Darnton, the projects assistant and National Dual Diagnosis Network Coordinator

Key lessons learned:
This visit highlighted
- The need to have a person with substance abuse expertise employed as a 'co-occurring disorder's driver' working on each mental health service.
- The need to engage psychiatrists in providing integrated treatment and the importance of a training initiative tailored to psychiatrist's specific needs.
- The importance of clinical supervision for members of specialist co-occurring disorders workforce
- The need for strategies to increase the drug treatment component and the co-occurring disorders component of a wide range of undergraduate courses.

Visit No: 5 cont	Key informant: Jood Gibbins
Date: 06/11/03	Dorset Dual Diagnosis Service

Suitability to own practice:
There were a number of parallels between the Dorset specialist service and the specialist service that I am employed by. Jood's reflections on identifying which elements of a specialist service are effective and on dealing with the multiple demands upon a specialist worker were particularly valuable for me.

Suitability to Victorian healthcare system:
The Dorset Dual Diagnosis Service offers broadly similar services to those of the Victorian dual diagnosis initiative but has been running for around six years longer.

United Kingdom
Further Reading & Resources

Abdulrahim, D. (2001) Substance Misuse and Mental Health Co-Morbidity (Dual Diagnosis) Standards for Mental Health Services. Health Advisory Service. ISBN 1-9028-28-02-X
http://www.nta.nhs.uk/publications/dual_diagnosis.htm

Banerjee, S. (Ed), Clancy, C. (Ed), Crome, I (Ed). (2002) Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis) An Information Manual - 2002 Royal College of Psychiatrists' Research Unit. Commissioned by the Department of Health
http://www.rcpsych.ac.uk/cru/complete/ddip.htm

Crawford, V., Crome, I. (Ed) (2001) Co-existing Problems of Mental Health and Substance Misuse ('Dual Diagnosis') A Review of Relevant Literature Royal College of Psychiatrists' Research Unit. Commissioned by the Department of Health
http://www.rcpsych.ac.uk/cru/complete/ddip.htm

Department of Health (2002) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide

McMurran, M. Expert Paper: Dual Diagnosis of Mental Disorder and Substance Misuse NHS National Programme on Forensic Mental Health Research and Development

Mears, A., Clancy, C., Banerjee, S., Crome, I., Agbo-Quaye, S. (2001) Co-existing Problems of Mental Disorder and Substance Misuse ('Dual Diagnosis') A Training Needs Analysis Royal College of Psychiatrists' Research Unit. Commissioned by the Department of Health
http://www.rcpsych.ac.uk/cru/complete/ddip.htm

Social Care Institute for Excellence (2003) Families that have alcohol and mental health problems: A template for partnership working.
http://195.195.162.67/sciesproducts/resourceguides/resourceguides.htm

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Section 3.3

USA Visits

7/11/03 to 29/11/03

Visit No: 6.	Key informant:	Dr Bert Pepper Psychiatrist New City New York State
Date: 10/11/03		

Summary of informants co-occurring disorders-related role/activities:

Dr Pepper has had a long and very distinguished career in psychiatry. In private practice for 40 years, Dr. Pepper has faculty appointments to New York University College of Medicine and Harvard Medical School. He is a former Commissioner of Mental Hygiene for the State of Maryland and for the Rockland County, NY Community Mental Health Centre (see online curriculum vitae). http://www.bertpepper.com/cv.html

Dr Pepper was an early pioneer in recognising co-occurring disorders. Over the past two decades he has made a substantial and significant contribution to flagging the issues around and achieving better outcomes for persons with co-occurring disorders. Dr Pepper was one of the first to propose many of the responses to co-occurring disorders that are now cornerstones of an evidence-based approach. His work stands out for its relevance, breadth of vision, wellsprings of scholarship and huge clinical experience, and its underpinning of considerable humanity and concern for others. Dr Pepper is an accessible expert widely recognised for his particular expertise around youth with co-occurring disorders.
http://www.drugstory.org/experts.html#mental_disorders

Dr Pepper was founder and executive director of *The Information Exchange*, a not for profit agency whose mission was to improve treatment for mentally ill and emotionally troubled persons, especially those who also have substance abuse/alcohol disorders. From 1995 to 1996 Dr Pepper was consultant to the United States, Federal, Substance Abuse and Mental Health Services Administration (SAMHSA) on co-occurring mental health and substance-related disorders.

Dr Pepper has published extensively around co-occurring disorders (see Appendix 2). Dr Pepper frequently presents on co-occurring disorders at major conferences.

Activities undertaken during visit:
Dr Pepper spent an afternoon with me including lunch, a tour of local mental health facilities, a forest walk and an interview at Dr Pepper's offices.

Key lessons learned:
Dr Pepper outlined a history of the recognition of and response to co-occurring disorders. He discussed the current structural barriers to providing effective, integrated treatment in the USA. These barriers include funding mechanisms; separation of agencies; different professional jargons between mental health and substance abuse providers; stigma of both disorders

Visit No: 6 cont	Key informant: Dr Bert Pepper
Date: 10/11/03	Psychiatrist

individually and collectively (perhaps compounded by the stigma of forensic involvement arising from inadequate treatment); systemic, agency and clinician level resistance to change

On integrated treatment
Dr Pepper has been a long-term advocate for integrated treatment (Ryglewicz and Pepper, 1996; Pepper, 1997) stating that integration is vital because the commonest cause of mental health relapse in persons with co-occurring disorders is substance abuse and the commonest cause of relapse to substance abuse is untreated mental health issues (Pepper, 2001). Dr Pepper has proposed a range of strategies to facilitate access to and evaluation of integrated treatment (Pepper, 1997)

Youth with co-occurring disorders
Dr Pepper has a focus on the confluence of trauma, emotional disorders and substance use. He notes that persons who have experienced trauma are much more likely to develop substance abuse (and more likely again if the trauma was repeated or perpetrated by someone close to the child) and to experience disruption of personality development, psychiatric problems, suicide attempts and forensic involvement.

He argues that by focusing on the abuse and neglect of children and adolescents, we can build a foundation for integrated treatment and find opportunities for the prevention of co-occurring disorders. Dr Pepper cites the National Co-Morbidity Survey which revealed that, of the ten million persons in the USA identified as having co-occurring disorders, 90% had developed the emotional disorder first, at a median age of 11 years and then gone on to develop substance abuse between the ages of 17 and 21 – suggesting an opportunity for comorbidity prevention if we can focus on troubled 11 to 13-year olds.

Transinstitutionalisation
Dr Pepper traced the impact of deinstitutionalization in the USA. In 1955 the nation had 559,000 public mental health hospital beds. By 2000 only 60,000 beds were left while, at the same time, the population had risen by 100,000,000 persons. Demand for existing beds and funding mechanisms ensure that admissions are necessarily brief – Dr Pepper concludes that the USA has moved from too many beds and over-hospitalisation to too few beds and under-hospitalisation (Pepper, 2001)

At the same time as the above changes there has been an explosion in the size of the USA's incarcerated population – moving from a total size of 200,000 persons in 1972 to 2 million persons in 2000. There is evidence that a substantial percentage of these persons may be mentally ill with only limited treatment available to them (Teplin, 1994; Teplin, Abram and McClelland, 1996). Dr Pepper has proposed a typology to classify criminal acts where they involve substance use and/or mental disorder (Pepper, n/d).

Visit No: 6 cont	Key informant:	Dr Bert Pepper
Date: 10/11/03		Psychiatrist

Cannabis and psychosis
Dr Pepper makes a case that there may be some persons whose psychotic disorder is caused primarily by their abuse of cannabis. Dr Pepper outlined a case in which a client that he worked with who had apparent, well-established psychosis went into complete, long-term, remission once he became abstinent from substances. This case is outlined online
http://www.wideopenwest.com/~ngersabeck/addition.html

Dr Pepper referred to two papers Cannabis and schizophrenia. A longitudinal study of Swedish conscripts (Andreasson, Allebeck, Engstrom, Rydberg, 1987) and Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study (Zammit, Allebeck, Andreasson, Lundberg, Lewis, 2002) which showed that 'cannabis use is associated with an increased risk of developing schizophrenia, consistent with a causal relation'
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=2892048&dopt=Abstract and
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12446534&dopt=Abstract

Co-occurring physical disorders
One of Dr Pepper's concerns is the inadequate treatment for physical disorders often received by persons with mental disorders. See on-line article which quotes Dr Pepper on this subject. (Lipton, 2000)
http://www.psych.org/pnews/00-11-17/physical.html

Other topics
Dr Pepper discussed some of the components of effective treatment, outlined a model for analysing an individual's social network and discussed the model's implications for therapeutic relationships. Dr Pepper has authored a biopsychosocial analysis of a range of mental disorders and abuse (Ryglewicz and Pepper, 1996)

Suitability to own practice:
Dr Pepper's insights about the genesis of, and interventions for, persons with co-occurring disorders have contributed substantially to my knowledge and practice.

Suitability to Victorian healthcare system:
Dr Pepper highlights a number of issues around co-occurring disorders that are relevant to a wide-range of Victorian healthcare providers. His thoughts on opportunities for prevention and early intervention for co-occurring disorders are particularly relevant to Victorian healthcare planners and researchers.

Visit No: 6 cont.	Key informant: Dr Bert Pepper
Date: 10/11/03	Psychiatrist

Some on-line reports and articles by Dr Pepper

Action for mental health and substance related disorders: Improving services for individuals at risk of, or with, co-occurring substance related and mental health disorders. Conference Report and Recommended National Strategy of the SAMHSA National Advisory Council. 1997
http://www.toad.net/~arcturus/dd/pepptoc.htm#toc

Blamed and Ashamed: The Treatment Experiences of Youth with Co-occurring Substance Abuse and Mental Health Disorders and Their Families
http://www.mentalhealth.org/publications/allpubs/KEN02-0129/pepper.asp

Developing A Cross Training Project For Substance Abuse, Mental Health And Criminal Justice Professionals Working With Offenders With Co-Existing Disorders (Substance Abuse/Mental Illness)
http://www.toad.net/~arcturus/dd/cttoc.htm

Mentally Ill Alcohol and Substance Abuser Overview http://www.healthieryou.com/j22.html

Interfaces between Criminal Behaviour, Alcohol and Other Drug Abuse, and Psychiatric Disorders http://www.treatment.org/Communique/Comm93/pepper.html

Consensus Panel Member for
Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse *Treatment Improvement Protocol (TIP) Series 9*
http://www.health.org/govpubs/bkd134/default.aspx

National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders 1998
http://www.nasadad.org/Departments/Research/ConsensusFramework/national_dialogue_on.htm

Visit No: 7	Organisation:	Connecticut Outreach-West Centre for Human Development Holyoke Connecticut
Date: 12/11/03		

Summary of organisation's co-occurring disorders-related role/activities:

The Centre for Human Development (CHD), founded in 1972, is a social service agency that serves children at risk, people with psychiatric and developmental disabilities, the elderly and the homeless. Much of CHD's early work was around supporting institutionalised persons to live in the community. Connecticut Outreach-West, as an arm of CHD, contracts with the **Connecticut Department of Mental Health and Addiction Services** (CDMHAS) to provide a variety of services to persons in need.

In 1995 Connecticut Outreach-West commenced a long term, intensive residential support program specifically for persons with co-occurring disorders of mental illness and substance abuse. This service utilises a team approach to help people to find and maintain apartments and to support them in their homes. It is not founded on an abstinence model, and has a current capacity of 26 clients. CDMHAS had specified that the contractor for this project had to be familiar with the Drake/ New Hampshire approach to integrated treatment of co-occurring disorders. Thomas and Melinda Fox from the New Hampshire Dartmouth Psychiatric Research Centre provided consultation to CHD and urged them to adapt the New Hampshire approach to local needs.

In adapting the Drake/New Hampshire approach Connecticut Outreach-West developed their own, staged, model for working with persons with co-occurring disorders - the 'Pyramid' model. Ascending stages in the Pyramid model are …

- Community Stabilisation
- Engagement
- Persuasion
- Active Treatment and
- Relapse Prevention.

In the clinically-focused document describing the Pyramid model Connecticut Outreach-West identified

- Goals for each stage,
- Client issues most likely to be present at this stage,
- Staff responsibilities and interventions appropriate to the stage,
- Indicators of client progress &
- Outcome measures

Connecticut Outreach-West is re-drafting the Pyramid model into an easily-carried clinician reference and focusing on the model in their worker training.

Visit No: 7 cont.	Organisation:	Connecticut Outreach-West
Date: 12/11/03		Centre for Human Development

Connecticut Outreach-West also run 'Pilots'- a subsidized housing program for persons with co-occurring disorders or a substance use disorder alone. To qualify participants must have 90 days verified 'clean-time' and be homeless or at risk of homelessness.

Activities undertaken during visit:
On this visit I was able to interview the Program Director, Milton Jones and Rebekah Logue-Palomba. I accompanied outreach workers on visits to 3 clients in their individual apartments and attended a management meeting and met with management staff from the various teams.

Key lessons learned:
The importance of establishing and maintaining engagement with a client regardless of how their circumstances change and of a longitudinal perspective in measuring client change.

Suitability to Victorian healthcare system:
The work of the Psychiatric Disability Rehabilitation and Support Services (PDRSS) sector of the Victorian mental health system is closest in nature to that of Connecticut Outreach-West. A PDRSS worker focused text that analyses client's stage of change and indicates possible worker's responses would be valuable.

Visit No: 8	Key informants: Dr Kenneth Minkoff & Dr Christie A. Cline
Date: 13/11/03	

Summary of informant's co-occurring disorders-related role/activities:
(abbreviated with Dr Minkoff's permission from **http://www.kenminkoff.com**)

Dr Minkoff is a psychiatrist widely recognised for his expertise around integrated treatment of individuals with co-occurring disorders and on the development of integrated systems of care for persons with co-occurring disorders. Dr Minkoff has provided training and consultation in all but two states of the USA as well as in Canada, Europe, and New Zealand.

Dr Minkoff's Comprehensive Continuous Integrated System of Care (CCISC) model is designed to improve co-occurring disorders treatment capacity at all levels of a treatment system - from an entire state system to individual agencies to programs within agencies.

Dr. Minkoff and his consulting partner, Dr Christie A. Cline, Medical Director, Behavioural Health Services Division, New Mexico Department of Health, currently provide, or have provided, consultation for CCISC implementation in over 15 states of the USA and 3 Canadian provinces. Often, they are contracted by the individual state's central health planning /funding authority to work with the whole system to improve the services offered to person with co-occurring disorders - see Visit 12.

Drs. Minkoff and Cline have developed a variety of CCISC-related tools (see www.zialogic.org). They include …
- Compass- a tool for an individual agency to self-assess its competencies in relation to co-occurring disorders
- Co-occurring Disorders Educational Assessment Tool which spells out core clinical competencies to be focused on in training and a format for supervisor or clinician self-evaluation of these competencies

A number of other tools are in development

Dr. Minkoff participated in a national task force, chaired by Dr David Mee-Lee to create the American Society of Addiction Medicine Patient Placement Criteria. These addiction triage criteria incorporated co-occurring disorders into national management guidelines for addiction treatment. They introduced the concepts of **Dual Diagnosis Capability** (DDC) and **Dual Diagnosis Enhanced** (DDE) as program standards for use in the design of a system of care for individuals with co-occurring disorders (see Appendix 1 – ASAM criteria).

See appendix 2 for a list of Dr Minkoff's co-occurring disorders-related publications.

Visit No: 8	Key informants:	Dr Kenneth Minkoff
Date: 13/11/03		Dr Christie A. Cline

Activities undertaken during visit:

I attended the Vermont Co-occurring Disorders CCISC Trainers Meeting, a day-long training facilitated by Drs Minkoff and Cline for representatives from each of Vermont's ten designated community mental health agencies. During the day I had conversations with Dr Minkoff and with Beth Tanzman, Director of Adult Community Mental Health Programs for the Vermont Department of Developmental and Mental Health Services. I also spoke with clinicians participating in the training series.

Key lessons learned:

Drs Minkoff and Cline knowledge of integrated treatment and their ability to practically and meaningfully apply the CCISC model to all levels of the service system was most impressive. Their ability to work through clinician's perceived barriers to integrated treatment and to engender enthusiasm for providing integrated treatment was extraordinary.

Comprehensive Continuous Integrated System of Care model (CCISC)

(Abbreviated, with Dr Minkoff's permission, from http://www.kenminkoff.com)

Dr Minkoff's CCISC model has been very influential and there are a number of readily available overviews of the model. (here or here or here or here)
http://www.samhsa.gov/reports/NewMexico/newmex-05.htm or
http://www.cwru.edu/med/psychiatry/changing.ppt or
http://www.kenminkoff.com/ccisc.html or
http://www.zialogic.org/CCISC.htm

In these overviews Dr Minkoff usually describes…

- The four basic characteristics of the CCISC model
- The eight principles of treatment for the CCISC model
- Twelve steps for CCISC implementation

See textboxes below

The four basic characteristics of the CCISC model

1. System level change:

- CCISC is designed for implementation throughout an entire system of care
- All programs within a system are given a specific assignment to provide services to a particular cohort of individuals with co-occurring disorders.
- The model integrates system change technology with clinical practice technology at all levels of the system to create comprehensive change.

2. Efficient use of existing resources:

- CCISC does not require additional resources beyond those for planning, technical assistance, and training.
- CCISC provides strategies to improve services without requiring blending or braiding of funding streams.

3. Incorporation of best practices:
- CCISC model recognised by SAMHSA as a best practice model
- Evidence based treatment for all types of persons with co-occurring disorders throughout a service system

4. Integrated treatment philosophy:

The eight principles of treatment for the CCISC model

1. Dual diagnosis is an expectation, not an exception*:*
- The prevalence of co-occurring disorders together with associated poor outcomes and high costs across multiple systems suggests that the entire system must be designed to use all resources around this expectation.
- An integrated system planning process is required in which each funding stream, each program, all clinical practices, and all clinician competencies are designed to address individuals with co-occurring disorders

2. The four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level.

Quadrant 1 : Less severe mental disorder / less severe substance abuse disorder	**Quadrant 3 :** Less severe mental disorder / more severe substance abuse disorder
Quadrant 2 : More severe mental disorder / less severe substance abuse disorder	**Quadrant 4 :** More severe mental disorder / more severe substance abuse disorder

Commonly Quadrant 1 individuals are seen in outpatient and primary care settings, Quadrant 2 individuals and some Quadrant 4 individuals are seen within the mental health system. Quadrant 3 individuals are engaged in both systems but served primarily in the substance system.

3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting. Provision of continuous, integrated treatment is an evidence-based, best practice for individuals with the most severe combinations of psychiatric and substance difficulties.
The system needs to prioritise ...
- The development of clear guidelines for how clinicians in any service setting can provide integrated treatment
- Access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.

5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary

diagnosis-specific treatment is recommended.

6. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery). Interventions should be both diagnosis-specific and specific to the client's phase of recovery and stage of change.

7. There is no single correct intervention for persons with co-occurring disorders. For each individual interventions must be individualised according to quadrant, diagnoses, level of functioning, external constraints or supports and phase of recovery/stage of change.

8. The measurement of clinical outcomes must also be individualised. Outcome measures that reinforce incremental treatment progress and promote the experience of treatment success may include:
- reduction in symptoms or use of substances,
- increases in level of functioning,
- increases in disease management skills,
- movement through stages of change,
- reduction in "harm" (internal or external),
- reduction in service use

Twelve steps for CCISC implementation

1. Integrated system planning process:
Implementation of CCISC requires a comprehensive, system-wide, integrated strategic planning process

2. Formal consensus on CCISC model:
The system must ...
- Develop a mechanism for articulating the CCISC model including the principles of treatment and the goals of implementation
- Develop a formal process for obtaining consensus from all stakeholders,
- Identify barriers to implementation and an implementation plan
- Disseminate this consensus to all stakeholders.

3. Formal consensus on funding the CCISC model:
CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream

4. Identification of priority populations, and locus of responsibility for each:
Using the four-quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system.

5. Development and implementation of program standards.

6. Structures for inter-system and inter-program care coordination:
Creation of routine structures and mechanisms for addiction programs and providers and mental health programs and providers to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries.

7. Development and implementation of practice guidelines:
- That address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome.
- Guidelines should be developed with clinician input.
- Practice guidelines must be supported by regulatory changes and by clinical auditing procedures.

8. Facilitation of identification, welcoming, and accessibility:
This requires several specific steps…
- Developing the system's capacity to identify report and track the treatment of persons with co-occurring disorders.
- Development of a "no wrong door" policy mandating a welcoming approach to persons with co-occurring disorders in all system programs
- Establish universal screening for co-occurring disorders at initial contact throughout the system.

9. Implementation of continuous integrated treatment:
Developing the expectation that clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis-specific and stage-specific recommendations for each disorder simultaneously.

10. Development of basic dual diagnosis capable competencies for all clinicians:
Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill.

11. Implementation of a system wide training plan:
Training must be ongoing, and tied to expected competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site.

12. Development of a plan for a comprehensive program array:
The CCISC model requires development of a plan in which each existing program is assigned a specific role or area of competency with regard to provision of …. services for people with co-occurring disorders. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps.

Visit No: 8	Key informants:	Dr Kenneth Minkoff
Date: 13/11/03		Dr Christie A. Cline

Suitability to own practice:
This visit increased my appreciation of the need to address co-occurring disorders at all levels of a treatment system. Drs Minkoff and Cline wealth of experience in working with systems, their strategies to do so and knowledge of the possibilities of integrated treatment will be of considerable benefit to my own practice.

Suitability to Victorian healthcare system:
The CCISC model has been developed largely in the North American context of managed health care however many of the principles and strategies in the model are relevant to the Victorian situation. The overall approach of whole of system service planning and addressing co-occurring disorders at all levels of a treatment system is necessary to achieve enduring, substantial improvements in the Victorian system's capacity to provide effective treatment to the range of person's with co-occurring disorders.

Principles and strategies of the CCISC model that impress as having particular relevance to the Victorian situation include …

System-wide:
- Dual diagnosis is an expectation not an exception
- Integrated treatment philosophy
- Development of a "no wrong door" policy that mandates a welcoming approach to persons with co-occurring disorders in all system programs

System planning:
- Comprehensive, system-wide, integrated strategic planning process for system level change.
- All system planning needs to be underpinned by a recognition of the prevalence of co-occurring disorders as well as associated poor outcomes and high costs across multiple systems
- Assigning responsibility for particular cohorts of persons with co-occurring disorders to particular agencies within the system. Using the four-quadrant model for categorizing co-occurring disorders as a guide for service planning the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system
- Development of integrated treatment oriented clinician guidelines
- The system must develop a mechanism for articulating the principles of treatment and the goals of implementation
- The system must develop a formal process for obtaining consensus from all stakeholders and then disseminate this consensus to all stakeholders
- The system must identify barriers to implementation and an implementation plan
- Creation of routine mechanisms for drug treatment agencies and clinicians and mental health agencies and clinicians to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries.
- Development and implementation of practice guidelines with clinician input

Visit No: 8	Key informants:	Dr Kenneth Minkoff
Date: 13/11/03		Dr Christie A. Cline

- Implementation of an organised system-wide training plan that is ongoing, tied to expected competencies and delivers on-site training and supervision to clinicians.

Clinical:

- Establish universal screening for co-occurring disorders at initial contact throughout the system.
- When psychiatric and substance disorders coexist both disorders should be considered primary and primary diagnosis-specific treatments should be provided in response
- Evidence based treatment for all types of persons with co-occurring disorders throughout a service system
- Focus on empathic, hopeful, integrated treatment relationships
- Access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.
- Case management and care balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, in each service setting.
- Stage wise approach to treatment
- Wide range of possible treatment responses to co-occurring disorders
- Use of success-oriented outcome measures
- Developing the ability to identify, reporting, and track the treatment of persons with co-occurring disorders.
- Expectation that clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis-specific and stage-specific recommendations for each disorder simultaneously.
- Development of basic dual diagnosis capable competencies for all clinicians

Visits 9 to 11
New Hampshire Dartmouth Psychiatric Research Centre
Background Information

Since 1987 the New Hampshire Dartmouth Psychiatric Research Centre (NHDPRC) has, under Dr Robert Drake, conducted the world's largest and most authoritative body of research into co-occurring disorders.

The team at NHDRC, currently has 6 large-scale projects studying dual diagnosis

- 10 year Follow-up of Dual Diagnosis Treatment 1998-2002
- Assertive Community Treatment for Dual Diagnosis: Continuation 2000 – 2005
- Public Academic Fellows Program in Substance Abuse Services Research 2001 – 2003
- Family Intervention for SMI and Substance Use Disorders 2001 – 2005
- Developing a Fidelity Scale for Dual Diagnosis Program Capability in Addiction Treatment 2003 – 2005
- D.C. Integrated Services Project 2002 – 2003

Completed Projects include

- Assertive Case Management for Dual Diagnosis 1989- 1992
- Boston Severe Mental Illness Study 1984-1994
- Treatment of Dual Diagnosis and Homelessness 1990 – 1993
- Assertive Community Treatment for Dual Diagnosis 1994- 1999
- Identifying Substance Abuse Disorders in the Mentally Ill 1993-1996
- Evaluation of Texas Dual Diagnosis Services 1996- 1998
- Riverbend Family Dual Diagnosis Program 1997 – 20000
- The Housing Continuum Model for Persons with SMD 1997 – 1999
- Vermont Mental Health and Substance Abuse Integrated Treatment Model Development Project 2000 – 2001

The NHDRC team has published over 225 papers and at least 5 texts relating to co-occurring disorders (See appendix 2). Their most recent publication Integrated Treatment for Dual Disorders: A Guide to Effective Practice (Mueser, Noordsy, Drake, Fox, 2003) is the most comprehensive currently-available clinical handbook on co-occurring disorders. It examines individual, group, and family interventions and offers guidelines for developing integrated treatment programs, performing assessments and psychopharmacology. Of particular interest is the Dual-Disorder Treatment Fidelity Scale.

The NHDRC team has developed the Dartmouth Assessment of Lifestyle Inventory (DALI) instrument for assessing alcohol and other drug substance use disorders in persons with severe mental illness (limited applicability in Australia because of different drug use and social circumstances). The team has developed a number of other instruments relevant to substance abuse and mental health assessment, treatment and research.

NHDRC team's New Hampshire-Dartmouth **Integrated Dual Disorder Treatment (IDDT) model** is an evidence-based practice aimed at improving the quality of life for persons with dual disorders by integrating substance abuse services with mental health services. The model combines

pharmacological, psychological, educational, and social interventions to address the needs of consumers and caregivers. It promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many. See here for an overview of the model. (Ohio SAMI CCOE, n/d) or here for a brief description of the model
http://www.ohiosamiccoe.cwru.edu/library/media/iddtoverview2003.pdf or
http://www.mentalhealthpractices.org/iddt_about.html

The IDDT model is claimed to reduce relapse of substance use and mental health disorders, hospitalisation, forensic involvement, service costs and duplication and utilisation of high cost services. The IDDT model is claimed to increase continuity of care, quality of life measures, housing stability, employment and independent living.

Mueser, Noordsy, Drake and Fox (2003) list core components of integrated treatment ...

- Shared decision making between all stakeholders
- Services addressing both disorders are provided at the same time by clinicians from the one agency
- There is a comprehensive array of services to address the multiple impairments and needs that can occur with severely mental illness type co-occurring disorders
- Assertive engagement and follow-up of clients
- Harm-minimisation, non-judgemental approach
- Clinicians adopt a long term perspective
- Motivational enhancement strategies including staged treatment approaches and use
- Multiple psychotherapeutic modalities such as individual, group and family therapy approaches.

Mueser, Noordsy, Drake and Fox (2003) have developed a 'Dual Disorder Treatment Fidelity Scale' that uses the latter seven components to measure a service's fidelity to their integrated treatment model.

Visit No: 9	Key informants: Melinda Fox and David Lynde New Hampshire Dartmouth Psychiatric Research Centre Concord offices
Date: 14/11/03	

Summary of informants co-occurring disorders-related role/activities:

Lindy Fox is a long-standing Research Associate with NHDPRC who has taught, researched and published extensively around co-occurring disorders. Lindy is co-author of the recent text Integrated Treatment for Dual Disorders: A Guide to Effective Practice (2003). Lindy co-leads co-occurring disorders treatment groups and provides consultation and training for professionals and families.
See Appendix 2 for a list of Lindy's co-occurring disorders related papers & publications.

David Lynde is Training Coordinator for the West Institute, a branch of the NHDPRC. David coordinates training around Evidence-Based Practices (including IDDT) for adults with severe mental illness.
See Appendix 2 for a list of David's co-occurring disorders related papers & publications.

Activities undertaken during visit:
I interviewed Lindy and David at their Concord offices.

Key lessons learned:

IDDT model
Ohio has made a system-wide commitment to the IDDT model. Preliminary results from there indicate that, after an initial increase in service demand when integrated treatment is established, there is a significant decrease in service demand and costs - as much as a 20% reduction in costs over one year and an 18% reduction in emergency services contacts. See here for an overview of Ohio's system wide approach to implementing integrated treatment. www.ohiosamiccoe.cwru.edu/about/aboutus.html

As a whole the New Hampshire mental health treatment system doesn't currently offer integrated treatment. While some individual agencies provide quality integrated treatment it appears that when the research went so did the treatment teams. This may be related to funding, supervision, a lack of clinical champions, monitoring and re-enforcement issues. A current research focus is around identifying the factors that maintain integrated treatment once established (see Visit 11- Paul Gorman). In this regard David discussed the continuation and growth improvement period subsequent to an integrated treatment model being established. He drew an analogy with Relapse Prevention and highlighted the need for careful attention to this phase.

Visit No: 9 cont.	Key informants:
Date: 14/11/03	Melinda Fox and David Lynde , NHDPRC

The process for influencing a whole system to change is different to that for an individual agency or program and it is unlikely that instituting integrated treatment in one or two agencies will have much influence on the whole system's ability or willingness to provide integrated treatment. David stressed the importance of being absolutely clear at the outset what the target of change is. Data such as the costs and multiple-services demands associated with persons with co-occurring disorders, gathered systematically, can create a strong case for moving to an integrated treatment model.

Clinician training and education.
Lindy observed that any time that you ask a clinician to learn something new you are asking them challenge their belief systems and methods of operating, to learn a new language and new value systems and it is natural that this will prompt resistance. David observed that clinicians receiving training may feel that there is an implication that their current practice is 'wrong'- he counters this by promoting the training in a context of evolving treatment approaches.

Lindy identified the stigma of the client population and the attitudes that clinicians have towards that client population as barriers to integrated treatment of co-occurring disorders. David observed that clinician attitude is central to their willingness to provide integrated treatment. David suggested that part of the process of getting ready to address our client's substance use involves addressing our own substance use and he will float this idea with clinicians in training around integrated treatment.

David employed a Stages of Change analysis around clinician's willingness to provide integrated treatment. He described the mismatch of their early efforts when they, as trainers, would be providing integrated treatment Action-oriented steps whilst the clinicians receiving training were actually in a Precontemplation stage - '*Does this have value for me?'… 'Do I need to change?'…. 'Why do I need to change?*' David reflected that more appropriate strategies to work with precontemplative clinicians would have been along the lines of …'*We need to talk about change. We need to talk about how you're feeling about working with clients. We need to talk about the outcomes you're seeing. We need to talk about what is the mission of your agency, what is your mission in that agency'*.

A lesson learnt across all the practices has been that getting people ready to change is a bigger step and takes much more time and effort than was originally envisaged. David described an exercise which attempts to tap into clinician's personal introspection by asking them to think of all of the members of their family who had a mental illness and then list the effects that this had upon the family. Part B of the exercise requires participants to think of all of the members of their family who had a substance use disorder and then list the effects that this had upon the family – commonly Part B is much more significant than Part A.

Visit No: 9 cont.	Key informants:
Date: 14/11/03	Melinda Fox and David Lynde , NHDPRC

Outcome measures
David described the USA's mental health system's reliance on process rather than outcome measures and the importance of systems gaining agreement on the outcome measures to be used. One of the NHDPRC's preferred outcome measures is the client's stage of change. In comparison to other outcome measures, stages of change presents less methodological complications. Some of the measures adopted in Ohio include stage of treatment / housing stability / employment / forensic involvement / involuntary hospitalisations.

Family Intervention for Serious Mental Illness (SMI) and Substance Use Disorders program (FID)
This study is currently comparing the outcomes of a 15-month intervention incorporating psychoeducation and problem solving with a 6-week intervention of psychoeducation alone. We discussed carer specific trauma and stigmatisation and the psychoeducation needs of carers. Lindy observed that the family appear to go through parallel stages of treatment to the client and hence their approach to behavioural family therapy in the FID program is as a stage-wise treatment.

Suitability to own practice:
David and Lindy's stage of change analysis of clinician resistance will inform future training offered by my local co-occurring disorders initiative.

Suitability to Victorian healthcare system:
Some of the issues highlighted by Lindy and David include …

Victorian healthcare planners
- Recognition that moving to integrated treatment may initially see an increase in service utilisation but has the potential of decreasing costs and presentations as people with complex co-occurring disorders receive effective treatment
- Importance of strategies to ensure any change to offering integrated treatment is an enduring change
- The importance of gathering data around costs and cross-sector service demands by persons with co-occurring disorders
- Importance of clear definition of Victorian treatment system goals around co-occurring disorders.
- Consideration of client's stage of change as a recognised outcome measure

Victorian co-occurring disorders specialist workforce:
- Importance of recognising clinician resistance and incorporating stages of change analysis / motivational strategies in addressing such resistance
- Promoting and developing carer-specific, stage-wise initiatives addressing carer's trauma and loss

Visit No: 10	Key informant: Dr Douglas L Noordsy New Hampshire Dartmouth Psychiatric Research Centre Lebanon offices
Date: 14/11/03	

Summary of informant's co-occurring disorders-related role/activities:
Dr Noordsy is Associate Professor of Psychiatry and Associate Director of Education and Training in the Department of Psychiatry, Dartmouth Medical School and Chief of Clinical Research at the Mental Health Centre of Greater Manchester. Till recently Dr Noordsy was also Medical Director of Westbridge – a private, non-profit organisation providing services to individuals with dual disorders and their families

Dr Noordsy has an extensive list of publications on co-occurring disorders and other mental health topics to his credit (see Appendix 2 for Dr Noordsy's dual disorder related publications). He is co-author of the recent 'Integrated Treatment for Dual Disorders: A Guide to Effective Practice' (2003). His research interests include evidence based practices for persons with co-occurring disorders.

Dr Noordsy is an active clinician having provided psychiatric care on model dual diagnosis teams from 1990 to 2003. In 2001 Dr Noordsy was awarded the Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill

Activities undertaken during visit:
I interviewed Dr Noordsy at NHDPRC Lebanon offices.

Key lessons learned:

Challenges in providing training around integrated treatment
Dr Noordsy noted that training is easier to do when participants come from an agency that is well-structured to treat both disorders simultaneously. He also observed that if a clinician has predominant experience in one arena or the other they will often need greater support to acquire the other skill set and also the sense of responsibility for both disorders – that, if they are most comfortable with treating mental illness, the sense that substance abuse is also an appropriate responsibility and target for them and vice versa.

Primary/secondary typology
Dr Noordsy observed that medical training tends to the view that one disorder will be primary and one secondary. An implication of this is that one should exclude, for instance, substance induced psychosis or depression. A danger of this primary /secondary typology is that it tends towards a treatment focus on only one of the disorders with the risk that the under-treated other disorder may then undermine the effectiveness of treatment for the first disorder.

Visit No: 10 cont	Key informant:	Dr Douglas L Noordsy
Date: 14/11/03		NHDPRC

The need to let go of the primary/secondary distinction was evidenced by a series of studies of patients with depression and alcohol dependence. They found that, if started on an antidepressant, client's depressive symptoms improved within a week of detoxification and those who received antidepressants were less likely to relapse into alcohol use – the emerging principle is that if you treat you get better outcomes. Dr Noordsy advocates the same pragmatic approach of treating what a person presents with in treating psychotic disorders. Most often it is virtually impossible to be confident about which disorder is primary, rather both disorders are there and both require treatment.

The best way to establish if a person has a substance-induced mental syndrome is to treat them, get them well and then, if they're sober and their mental syndrome is in remission for a time, you may taper off the psychiatric medication at that point and establish whether it's needed. This approach is more likely to get an effective response, and the ability to test that, than stating 'I'll wait until you're sober to treat your mental disorder'.

Prescribing to people who are using substances

Dr Noordsy discussed 'defensive prescribing' for fear of a dangerous interaction between psychotropics and substances. He made the point that there is not a lot in the literature about interactions between psychotropics and substances of abuse. Dr Noordsy referred to the chapter on pharmacology in 'Integrated Treatment for Dual Disorders: A Guide to Effective Practice'. Among many other points the pharmacology chapter notes that…

- 'Newer antidepressant and anti-psychotic medications (except Clozapine) are safer than older compounds'
- 'It is best to avoid prescribing medications with a high potential for abuse'
- 'It is best to avoid medications with high potential for interactions with substances of abuse such as MAOI's'
- The approach of the authors is to 'encourage careful adherence to medication regimes' and they 'actively avoid discouraging clients from taking their medications when they are using substances'

Dr Noordsy observed that it is often at the point when a clinician becomes actively engaged in treating both the mental illness and the substance disorder that it becomes much easier to say: '*well of course I need to treat this psychosis in order to stabilise the illness and to support the substance abuse work that we're trying to do. There may be some risks involved in that and I will carefully educate the patient about that so that they can make choices that are safe.* He stressed the importance of providing clients with information about medication, the effects of substances and any possible interactions and of carefully documenting in the client's notes that this has occurred – the client is then making an informed decision where they choose to use substances whilst taking medication.

Visit No: 10 cont	Key informant:	Dr Douglas L Noordsy
Date: 14/11/03		NHDPRC

Benzodiazepines
Dr Noordsy discussed their recent paper (Brunette, Noordsy, Xie, Drake, 2003) - *Benzodiazepine use and abuse among patients with severe mental illness and co-occurring substance use disorders*– in which the authors examined benzodiazepine use and outcomes in a six-year longitudinal study of patients with co-occurring disorders. Dr Noordsy stressed that the study was done in the context of their large trial in which there was very close observation of clients and close-monitoring of medication by a team who are particularly aware of the risks. Within that context the team did not see a huge amount of abuse of benzodiazepines. Nor did they see significant destabilisation of client's other addictions. 15% of those prescribed benzodiazepines developed benzodiazepine abuse as against only 6% of clients who weren't prescribed benzodiazepines. The paper concluded that '*physicians should consider other treatments for anxiety in this population'.*

Challenges in providing integrated treatment
Most clients aren't motivated for abstinence at the point where we start working with them. Therefore we need to tolerate a deal of substance use in order to get far enough into their world to get their trust to allow us to do the motivational work to help the client. This needs to be the approach of all members of the team. If a clinician has a rigid abstinence orientation, is very medical/authoritative in their thinking or doesn't have patience for the work then it will be much harder for the clinician to meet the patient where they are. The time course for seeing improvement may be in years.

The best position to be in is to have clients reporting honestly to the clinician - if client's experience a clinician as having a judgemental attitude they are likely to decide not to report honestly about substance use. Clinicians may have to work with their own comfort with client's choices, even where those choices may seem against the client's best interests.

Future directions:
Dr Noordsy would like to see more uniform availability of high quality, evidence-based, services. He would like to see further growth in our understanding of and knowledge about effective treatment. A research area of particular interest is the neurobiology of addiction, especially in regard to co-occurring disorders.

Around schizophrenia as a whole Dr Noordsy described the next step as being to bring our expectations to a similar level as our expectations for depression or anxiety disorders – that is, going beyond rehabilitation into remission, changing the goal from stabilisation to a return to full functioning.

Doing the job well requires resources. A change in expectations, among the treaters and the political world, is likely to lead to increased resources that will further contribute to providing a higher level of care than just stabilisation.

Visit No: 10 cont	Key informant:	Dr Douglas L Noordsy
Date: 14/11/03		NHDPRC

Suitability to own practice:
Dr Noordsy succinctly described a number of core issues around co-occurring disorders and, for each issue, proposed clear, clinically-focused principles to negotiate the issue. The pharmacology principles described by Dr Noordsy are especially valuable to me as they suggest clear guidelines for negotiating a controversial co-occurring disorders issue which, till now, has had only limited attention in the literature.

Suitability to Victorian healthcare system:
Dr Noordsy's synopsis of co-occurring disorders issues and suggestions to negotiate those issues comes from a psychiatrist's perspective. That perspective undoubtedly has particular interest for Victorian psychiatrists engaged in treating persons with co-occurring disorders as well as the broader drug treatment and mental health workforces. Dr Noordsy's analysis of the pitfalls of the primary/secondary typology and his guidelines about psychopharmacology for persons with co-occurring disorders represent significant landmarks for all persons engaged in the treatment of persons with co-occurring disorders.

Visit No: 11	Key informant:
Date: 14/11/03	**Dr Paul Gorman** **Director** **West Institute** **New Hampshire Dartmouth Psychiatric Research Centre**

Summary of informant's co-occurring disorders-related role/activities:
Paul has worked in management of mental health systems in both the public and private sector for thirty years. He is currently the Director of the West Institute at the New Hampshire-Dartmouth Psychiatric Research Center. The West Institute was founded in 2000 to promote the implementation of research-developed, Evidence-Based Practices in public mental health systems across the country whilst studying the process of implementation.
http://www.dartmouth.edu/~westinst/index2.htm

Currently, the six identified Evidence-Based Practices identified and promoted by the institute are …

- Assertive community treatment
- **Integrated dual disorders treatment**
  http://www.dartmouth.edu/~westinst/iddt.htm
- Supported employment
- Effective medication practices
- Family psychoeducation
- Illness management and recovery.

The West Institute's goal is to assist mental health systems and agencies to successfully implement Evidence Based Practices. To this end their services include describing the research findings, describing service models and providing skills training and education to implement the practices effectively. They have a strong focus on the sustainability of the practices once implemented.

See Appendix 2 for a list of Paul's co-occurring disorders related papers & publications.

Activities undertaken during visit:
Interview with Paul Gorman at NHDPRC's Lebanon offices.

Key lessons learned:
Paul described a current, large-scale, multi-site study investigating the sustainability of the integrated dual disorders treatment model once implemented. Each state involved in the study …

- Chose a number of sites in their state in which to implement the model
- Appointed a steering committee for the implementation of the model (all stakeholders including consumers and carers)
- Engaged a state-trainer who participated in a train the trainer process with a 'super-trainer' from NHDPRC. Each state-trainer then provided training to their Community Mental Health Facilities

Visit No: 11 cont.	Key informant:	Dr Paul Gorman
Date: 14/11/03		NHDPRC

- Appointed a monitor whose role is to observe and gather qualitative data on what occurs during implementation and after the trainers are withdrawn. Monitors are to remain in place for a further year after the training is completed and to employ the IDDT fidelity scale to assess fidelity to the IDDT model. It is hoped that this study will shed light on what are the factors are that mitigate for and against the sustainability of the IDDT model

Suitability to own practice:

The interview with Paul left me reflecting on what are the factors that tend towards any systemic change being an enduring change.

Suitability to Victorian healthcare system:

This visit highlighted the importance of service planners

- Engaging stakeholders in clearly describing the goals for the treatment system in regard to integrated treatment
- Developing and promoting a defined treatment model
- Developing or selecting a tool to measure fidelity to that model
- Considering strategies to promote the sustainability of any change to the treatment systems capacity to provide routine integrated treatment
- Ensuring that the 'dual diagnosis champions' in any service have sufficient 'clout' to influence service delivery and direction.

Visit No: 12	Key informant: Linda Kaufman Director of Organizational Development Department of Mental Health Washington DC
Date: 19/11/03	

Summary of informant's co-occurring disorders-related role/activities:
Washington DC's Department of Mental Health is responsible for providing comprehensive mental health services to more than 7,500 adults, children and adolescents annually as well as clients referred through the criminal justice system.

Over the past two years Linda, as Director of Organizational Development for the Department, has been closely involved with the planning and implementation of Washington's strategies to better address the treatment needs of persons with co-occurring disorders.

Activities undertaken during visit:
Interview with Linda at her offices

Key lessons learned:
Linda described the evolution of mental health services in the USA, including transinstitutionalisation – persons with mental disorders ending up in the forensic, custodial system. Linda described a growing recognition in Washington DC, over the past several years, that persons with co-occurring disorders were falling through the gaps between the mental health and substance abuse treatment systems. An observation was that the system was acting as though persons had either a mental health disorder or a substance abuse disorder when in reality the majority had both disorders.

When system planners began looking at models to address co-occurring disorders they kept hearing of Dr Minkoff and his ability to work with a whole system. Drs. Minkoff and Cline were asked to be consultants and have been active in that role since late 2002. Linda described Dr Minkoff's view that, rather than being an obstacle, bureaucracy can be a main agent of change if approached correctly. The Department responded to initial reluctance expressed by management of some agencies by promoting the perspective that integrated treatment had the potential to be helpful rather than an added burden.

Drs. Minkoff and Cline's activities have included ….
- An initial presentation to CEO's of all agencies
- An initial open training for anyone interested in co-occurring disorders
- Two-monthly train the trainers program with representatives from each of the mental health and some of the substance treatment agencies. Each of these sessions has comprised a full day of training followed by a day of technical assistance in which either Dr Minkoff or Dr Cline will visit individual agencies.

Visit No: 12 cont	Key informant: Linda Kaufman
Date: 19/11/03	DC Dept of Mental Health

Each individual trainer's responsibilities have included…

- Completing a self-assessment of their agencies competencies in relation to co-occurring disorders using Minkoff and Cline's 'Compass' tool http://www.zialogic.org/tool_no__5.htm
- Generating an agency Action Plan
- Hosting Dr Minkoff or Dr Cline on day-long technical assistance visits to their agency in which the consultants will work from the 'Compass' assessment with the team involved.

The cadre of trainers has recently indicated that they would like to take more of a leadership and planning role around co-occurring disorders

Linda has sat in on a number of technical assistance visits and reports that clinicians, in the course of the day, will often move from concern about the difficulties in implementing integrated treatment to enthusiasm about this making their work easier. Linda notes the consultants' breadth of knowledge about integrated treatment and their strong sense of how it has changed the systems that they have worked with.

Other recent local developments include

- The State Mental Health Planning Council devoted their annual conference to co-occurring disorders.
- Drs. Minkoff and Cline wrote a City Charter on directions in co-occurring disorders
- Washington's Mayor and the heads of the Health and Mental Health Departments signed off on the Charter as a city commitment.
- Since then the city has completed its first comprehensive substance abuse strategy including a section on co-occurring disorders.

Reflecting on the above developments Linda observed that while it sounds like a tidy, sequential process it has at times been quite a struggle for participants to find the time and funds to devote to the initiative. She notes that they are becoming more able to drive the process themselves.

Suitability to own practice:

My interview with Linda increased my understanding of the challenges faced by central planning bodies as well as their potential for instigating and facilitating system-wide change.

Suitability to Victorian healthcare system:

Washington DC's efforts in addressing co-occurring disorders provide a good example of a 'top-down, bottom-up' approach that appears to have had a significant impact on practice in a short time. Consideration should be given to engaging an outside consultant to help facilitate system-wide change.

Visit No: 13	Organisation: The Metropolitan Washington Council of Governments Co-occurring Disorders Committee Washington DC
Date: 20/11/03	

Summary of organisation's co-occurring disorders-related role/activities:

In existence since 1990, the Co-occurring Disorders Committee is composed of mental health and substance abuse management and direct service staff from the public and private sector in the Washington DC region and the adjoining states of Maryland and Virginia.

The Committee's aims include...

- To promote effective treatment services for individuals with co-occurring disorders.
- To promote interagency and collegial communication and collaboration among public and private treatment programs and their staff providing these services.
- To provide low-cost trainings for professionals providing treatment for individuals with co-occurring disorders. Since 1990, the committee has sponsored more than 20 workshops and seminars on co-occurring disorders topics.

Activities undertaken during visit:

I attended and addressed a monthly meeting of the Co-occurring Disorders Committee followed by lunch with participants

Key lessons learned:

The Committee provides substantial, regular training on co-occurring disorders related topics. On my visit the committee was planning a day-long training on *Medical Conditions: Implications for treating co-occurring disorders*. Recent trainings have included *Creating & managing residential programs for individuals with co-occurring disorders* and *How to identify and assist an individual with co-occurring disorders: Strategies to maximize success*

http://www.mwcog.org/services/health/dualdiagnosis/mc_workshop_brochure.pdf
http://www.mwcog.org/uploads/event-documents/y1xWVw20031022150238.pdf

The committee produces a bi-annual newsletter, The Forum, aimed at keeping clinicians up to date on policy, legislation, research and treatment information, local training, and policy positions taken by the committee. Back copies of the Forum can be downloaded from here
http://www.mwcog.org/publications/departmental.asp?CLASSIFICATION_ID=5&SUBCLASSIFICATION_ID=30

Visit No: 13 cont.	Organisation:
Date: 20/11/03	Co-occurring Disorders Committee

Other committee achievements include...

- Producing two local community resource guides of co-occurring disorder's treatment services,
- Producing a policy report with recommendations concerning the most effective co-occurring disorder's treatment services,
- Providing testimony at public hearings concerning the need for co-occurring disorder's treatment services
- Providing consultations to local programs concerning the implementation and improvement of their co-occurring disorder's services.

Suitability to own practice:

The committee impressed as a model of productive collaboration between representatives of various government and non-government agencies across three adjoining states of the USA. I was particularly impressed with the quality of the newsletter and the range and depth of topics covered in the training

Suitability to Victorian healthcare system:

This committee's collaborative activities would constitute a valuable resource to any healthcare system attempting to achieve better outcomes for persons with co-occurring disorders.

Visit No: 14	**Key informant:** **Gary Lupton** **Organisation:** **Fairfax County** **Day Treatment Program for Co-occurring Disorders**
Date: 20/11/03	

Summary of organisation's / informants co-occurring disorders-related role/activities:

Gary Lupton:
Gary is the Mental Health Manager, Adult Comprehensive Day Treatment and Site Director for Mount Vernon Community Mental Health in Fairfax County, Virginia. He chairs the Metropolitan Washington Council of Governments, Co-Occurring Disorders Committee and the Fairfax County Substance Abuse and Mental Health Committee. Gary has extensive experience in working with people with co-occurring disorders in outpatient, residential, and correctional settings

Fairfax County Day Treatment Program for Co-occurring Disorders
This service provides an intensive, 4-day per week day program designed for persons in crisis, at risk of hospitalisation or post-discharge. The program has a 25-year history with a 15-year focus on co-occurring disorders. A paper describing the service is available here (Marr, n/d) http://www.toad.net/~arcturus/dd/treat1.htm .The service runs on a 5-person staff complement with sessional psychiatrist input.

Activities undertaken during visit:
On this visit I conducted an interview with Gary Lupton, was taken on an inspection of the centre and engaged in an hour-long group discussion with day treatment team staff.

Key lessons learned:

Day treatment program
Most clients have serious mental illness and staff estimate that usually around two-thirds will have co-occurring substance use disorders. Clinicians pay careful attention to engaging clients and utilise a stepwise model around engagement, persuasion, active treatment and relapse prevention. Each client has an individually negotiated treatment plan and clients are required to formulate daily goals.

The program's approach incorporates recognition of parallel process between client and staff groups as an important, central therapeutic tool. Substance use treatment is well-integrated into overall treatment. A wide range of groups are offered. I was struck by the day program staff's dedication to and belief in the service that they offer.

Visit No: 14 cont.	Key informant: Gary Lupton
Date: 20/11/03	Organisation: Fairfax County Day Treatment

Other Fairfax County Co-occurring Disorders Initiatives
Fairfax County (population = c.1million) has a range of treatment options specifically for persons with co-occurring disorders

- Cornerstones Program is a co-occurring disorders specific, integrated residential and aftercare program with staff from both mental health and drug treatment (Quadrant 4 of the four-quadrant model)
- Franconia Road treatment centre is a dual diagnosis specific group home where male clients stay for 18 months to 2 years.
- REDD program – women specific group home similar to Franconia Road

The Fairfax County Substance Abuse and Mental Health Committee is a cross-agency initiative designed to serve as a resource for staff to bring difficult cases to. The committee, with management representatives from mental health and drug treatment agencies, attempts to generate creative treatment options for clients with particularly complex needs.

Suitability to own practice:
I was particularly struck by the day treatment program clinician's use of engagement strategies, the diversity and flexibility of their program and their ability to analyse and therapeutically employ the parallel process of staff and client groups.

Suitability to Victorian healthcare system:
The day treatment program appears to meet some of the needs that step-down initiatives address in the Victorian mental health treatment system. The structure and function of the Substance Abuse and Mental Health Committee could serve as a useful model for local agencies collaboratively trying to achieve better outcomes for clients with particularly complex needs.

Visit No: 15	Organisation: Avery Road Combined Care Montgomery County Maryland
Date: 21/11/03	

Key informants:	
Richard L. Kunkel	Behavioural Health Operations Manager Montgomery County Department of Health and Human Services, Maryland
Laura Burns-Heffner	Program Monitoring Unit Montgomery County
Scott McMillian	Executive Director Maryland Treatment Center
Lynn Smith	Program Director Avery Road Combined Care
Eric Morse (PDF)	Medical Director / Psychiatrist Avery Road Combined Care

Summary of organisation's co-occurring disorders-related role/activities:

The Avery Road Combined Care program provides intensive outpatient and residential treatment services to individuals with co-occurring disorders. Avery Road sits in Montgomery County's drug treatment continuum of care rather than its mental health continuum. A treatment vendor, Maryland Treatment Center, operates this program for the county in a county owned facility.

Client's mental health disorders are commonly the high frequency disorders (Depression, Anxiety, Post Traumatic Stress Disorder and Antisocial Personality Disorder) and clients with severe mental illness need to be quite stable to be admitted. Using American Society for Addiction Medicine (ASAM) criteria Avery Road views itself as Dual Diagnosis Capable but as moving towards Dual Diagnosis Enhanced (See Appendix 1: ASAM criteria). Having a co-occurring mental health disorder is not an essential criterion for admission to the program.

Activities undertaken during visit:

On this visit I recorded an interview and had lunch with key informants.

Visit No: 15 cont.	Organisation: Avery Road Combined Care
Date: 21/11/03	Montgomery County

Key lessons learned:

We discussed the structural factors that have contributed to the drug treatment system providing a co-occurring disorders initiative. Some of the factors identified included …

- Substance treatment services have always dealt with Axis 11 disorders (DSM-IV, 1994)
- Mental health deinstitutionalisation contributed to a significant, visible co-occurring population. The mental health service system has not had the infrastructure to deal with this population so many of them have fallen to addictions.
- Over the past 10 years crack cocaine has had significant impact on the complexity of the needs that clients are presenting with

Many of the admissions to Avery Road have been homeless and with a long history of relapse. Treatment may last between 6 and 12 months and uses a therapeutic community model. The main treatment modality is group work. The program targets physical and mental health problems, vocational guidance, job preparedness, social and family dysfunction, leisure and recreation skills.

Clients work through three levels of treatment…

- Entry and orientation (30 - 60 days)
- Core treatment (3 - 6 months)
- Live in and re-entry (2 - 4 months)

Clients have frequently reported that this is their first experience of having their mental health and substance use addressed concurrently and commonly report positively about this experience.

Suitability to own practice:

This visit underlined that providing integrated treatment of co-occurring disorders is more likely to be effective than treating substance use disorders in isolation.

Suitability to Victorian healthcare system:

Initiatives targeting clients with high-prevalence mental health disorders type co-occurring disorders are an important part of the continuum of care.

Visits 16 to 19
State of Arizona
Background Information

Arizona's health service planners face particular challenges related to poverty and rurality. Despite these challenges Arizona was a fellowship highlight for its cohesive, strategically-planned, system-wide commitment to providing an effective, integrated treatment response to persons with co-occurring disorders.

Arizona's approach to co-occurring disorders
In the latter half of the 1990's recognition of the prevalence of co-occurring disorders and of the limitations of sequential/parallel models of care led Arizona's service planners to conclude that a major change in the behavioural health system was necessary. It was felt that a limited number of specialised "dual diagnosis" programs would not address the needs of a majority of the clients with co-occurring disorders' (AITCP, 1999).

In January 1999 a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) was used to form the **Arizona Integrated Treatment Consensus Panel** (AITCP) with representation from Arizona's substance abuse and mental health service systems, consumers and carers.

The panel adopted an inclusive definition of co-occurring disorders and attempted to devise a model that addressed the continuum of co-occurring disorders (AITCP, 1999).
The Panel's definition of co-occurring disorders embraced…
- Substance abuse (DSM definitions) and/or dependence disorders and a general mental health disorder or a serious mental illness.
- Serious mental illness and substance abuse or substance dependence;
- Psychiatrically complicated substance abuse or substance dependence

Panel objectives included:
- Convening an advisory group of key stakeholders on a monthly basis
- Conducting knowledge exchange sessions with local and national experts in order to identify exemplary practices regarding integrated treatment
- Using group consensus process building methods to identify the local model and barriers to implementing integrated treatment
- Developing a work plan to overcome the barriers and implement the integrated treatment model
- Disseminating the results state-wide, and
- Monitoring implementation and results (AITCP, 1999).

AITCP actions :
- Identified, reviewed and discussed the literature addressing the methodology, skills and philosophy needed to effectively treat and support persons with co-occurring disorders.

- Participated in training provided by Dr. Ken Minkoff. Dr. Minkoff reviewed the Arizona principles and draft goals and objectives and provided recommendations for enhancements (see below).
- Dr. Kim Mueser, from New Hampshire Dartmouth Psychiatric Research Centre, provided training on the IDDT model http://www.dartmouth.edu/~psychrc/kimm.html).

The AITCP developed the overall vision, principles, goals, objectives, and strategies for implementation of integrated treatment services in Arizona. For each goal and strategy the AITCP developed 'hallmarks of success' to measure the system's effectiveness in achieving the particular goal /objective.

Four subcommittees were charged with developing specific implementation recommendations around ...
- Department of Health Services policy,
- The continuum of care,
- The competencies for providing integrated treatment and
- Funding mechanisms.

The University of Arizona was contracted to develop eight, co-occurring disorders, training videos. Presenters included Drs Kim Mueser and Patricia Penn. The modules are described here. http://www.hs.state.az.us/bhs/aitcpnews5.pdf
Modules included:
- Dual diagnosis101
- Integrated treatment – how do we do it?
- Integrated treatment 201: medications & integrated treatment
- 5 module series on motivational based treatment for co-occurring disorders.

In late-2000 the AITCP project was awarded the Arizona Governor's Award for Excellence, the highest commendation in Arizona state government.

Further reading:

There are a number of web-based documents that provide further information on Arizona's approach to co-occurring disorders.
These include…
Arizona Integrated Treatment Consensus Panel

Final Report [PDF 111K]	http://www.hs.state.az.us/bhs/finalreport.pdf
Appendix [PDF 92K]	http://www.hs.state.az.us/bhs/appendix.pdf
Implementation Plan [PDF 20K]	http://www.hs.state.az.us/bhs/finalplan.pdf
Newsletter Fall 2002	http://www.hs.state.az.us/bhs/aitcpnews5.pdf

Practice Improvement Protocol 6: Co-occurring Psychiatric and Substance Disorders – Arizona Dept of Health Services Division of Behavioural Health Services
http://www.hs.state.az.us/bhs/guidance/co_occur.pdf

Minkoff, K. (2000) State of Arizona service planning guidelines co-occurring psychiatric and substance disorders
http://www.treatment.org/topics/dual_documents.html)

Visit No: 16	Key informant:	Michelle Ryan Arizona Department of Health Division of Behavioural Health http://www.hs.state.az.us/bhs/index.htm
Date: 24& 25 Nov. 2003		

Summary of informant's co-occurring disorders-related role/activities:
The Division of Behavioral Health Services serves as the single state authority providing coordination, planning, administration, regulation and monitoring of all facets of Arizona's public behavioral health system. The Division contracts with each of six Regional Behavioral Health Authorities (RBHA) to administer behavioral health services in their region. RBHAs then sub-contract with a network of more than 350 service providers to deliver a full range of behavioral health care services, including prevention programs for adults and children, and a full continuum of services for adults with substance abuse and general mental health disorders, adults with serious mental illness, and children with serious emotional disturbance

The Division's comprehensive approach to addressing co-occurring disorders is described in the above panel, *State of Arizona, Background information*.

Activities undertaken during visit:
Michelle organised and hosted a packed 2-day visit. She introduced me to key informants, provided background information and an overview of Arizona's approach to co-occurring disorders.

Key lessons learned:
See text box above and visits 17 to 19.
Michelle noted that the Arizona Integrated Treatment Consensus Panel members made use of The Change Book: A Blueprint for Technology Transfer (see textbox, page 89) and endorse it strongly.

Suitability to own practice:
My experiences in Arizona, having the opportunity to see a system that has made substantial progress in increasing its capacity to offer integrated treatment and to review the strategies employed to achieve that progress, will inform my activities with Eastern Hume Dual Diagnosis Service.

Suitability to Victorian healthcare system:
As described above Arizona provides a model for a collaborative, inclusive, multi-level, carefully-planned, system-wide approach to achieving better outcomes for persons with co-occurring disorders.

Visit No: 17	**Organisation:** **ValueOptions** **Maricopa County** **Regional Behavioral Health Authority** **Arizona**
Date: 24/11/03	**Key informants:** **Eric Raider** **Manager, ValueOptions.** **Arizona Integrated Treatment** **Consensus Panel member** **David Olivarez** **Co-occurring Disorders Specialist** **ValueOptions**

Summary of organisation's / informants co-occurring disorders-related role/activities:

ValueOptions is one of the largest, for-profit, managed behavioural health care firms in the USA. In Arizona ValueOptions is contracted by the Department of Behavioural Health to serve as the Regional Behavioral Health Authority for Maricopa County. Maricopa County's population is over 3 million. ValueOptions provides services, such as drug treatment and mental health case management to children and adults unable to afford such services through insurance or other means. They provide services to over 60,000 Maricopa County residents through more than 85 behavioral healthcare providers and 21 case management sites.

Activities undertaken during visit:

On this visit I conducted an interview with Michelle Ryan, Eric Raider and David Olivarez in the offices of ValueOptions.

Key lessons learned:

System change

I asked informants if they could identify any local factors accounting for Arizona's comprehensive approach to providing integrated treatment. The informants identified three factors…

- The initial impetus provided by the State and its higher level support and action in mandating integrated treatment to its contractors was felt to have been the most significant factor
- Having a inclusive, effective state planning panel
- From the field the recognition of the prevalence of dual disorders combined with an appreciation that there are likely cost-savings in providing effective, integrated treatment.

Thus far it has not been possible to measure changes in outcomes as a result of integrated treatment (but has been possible to chart changes in services). A

Visit No: 17 cont.	Organisation: ValueOptions
Date: 24/11/03	Maricopa County, Arizona

new system-wide assessment/outcome package is currently being rolled out with which it will be possible to measure changes.

The local co-occurring disorder's panel still meets and is active in working towards the co-occurring disorders initiative enduring. All informants reflected positively on the input provided to the Arizona initiative from all outside consultants /trainers

Service planning
ValueOptions have incorporated American Society for Addiction Medicine criteria for levels of care (see Appendix 1) as a central planning tool. A focus has been to ensure their programs meet the criteria for either Dual Diagnosis Capable or Dual Diagnosis Enhanced. In 2003, for the first time, ValueOptions providers had their target populations and ASAM criteria written into their contracts. A planning focus has been around the principle of a 'no wrong door philosophy' for consumers seeking services from ValueOption's providers.

Training
Lack of training around integrated treatment was initially identified as the largest barrier to providing integrated treatment. ValueOptions approach was to enlist 100 clinicians, drawn from all agencies, aiming for them to be the 'co-occurring disorders champions' in their respective agencies. ValueOptions contracted Dr David MeeLee to provide 60-hours training (2-day brackets over 4-months) to these workers. http://www.dmlmd.com/index.html

ValueOptions hired David Olivarez as a specialist trainer and another worker to provide on-ground technical assistance to workers post-training. David developed an initial 8-hour training package that he has delivered to most clinicians providing mental health or drug treatment services. He is currently rolling out a 20-hour motivational interviewing follow-up package. Technical assistance involves the specialist worker working on-site with agencies or clinicians to work through any in-practice difficulties in delivering integrated treatment.

Suitability to own practice:
David very kindly provided an overview of his training packages and these will contribute to training offered by Eastern Hume Dual Diagnosis Service. David sees benefit in cross-training substance treatment and mental health clinicians. I thought that the strategy of having a worker dedicated to providing technical assistance was valuable.

Visit No: 17 cont.	Organisation: ValueOptions
Date: 24/11/03	Maricopa County, Arizona

Suitability to Victorian healthcare system:

This visit further underlined that top-down support, directives and incentives serve to complement bottom-up initiatives and are crucial to achieving system change.

Use of a range of outside consultants has substantially informed and expedited Arizona's efforts to provide improved treatment for co-occurring disorders.

Whilst the ASAM criteria may not translate unmodified to the Victorian context the development of similar criteria tailored to the Victorian situation has the potential to provide goals for agencies to work towards in seeking to improve their responsiveness to co-occurring disorders. Such criteria may also contribute to a common language across mental health and drug treatment service providers and agencies.

There may be value in developing and refining Victoria's ability to monitor the costs across multiple systems associated with persons with co-occurring disorders in order to provide a benchmark against which we can measure the effects of changes in the treatment system's response to co-occurring disorders.

Visit No: 18	Key informant: Melissa Smith Manager Co-occurring Disorders Treatment Programs EMPACT Suicide Prevention Centre
Date: 24/11/03	

Summary of organisation's co-occurring disorders-related role/activities:
EMPACT is a community, non-profit behavioural health agency that provides counselling, crisis intervention, prevention and aftercare services to Arizona, adolescents, adults and families. EMPACT have developed a range of programs targeting co-occurring disorders in adults and adolescents. All programs target the high frequency type co-occurring mental health disorders and EMPACT views these programs as Dual Diagnosis Capable rather than Dual Diagnosis Enhanced (see Appendix 1 - ASAM criteria)

Activities undertaken during visit:
On this visit I conducted an Interview with Melissa Smith and Michelle Ryan, was taken on a tour of EMPACT's facility and, in the evening, sat in on an adolescent's group

Key lessons learned:
EMPACT's treatment approaches include cognitive-behavioural therapy and motivational enhancement therapy from a strengths-based, solution-focused, family systems perspective.

Melissa provided an overview of EMPACT's range of co-occurring disorders programs …
Adolescent programs:
1. Teen Substance Abuse Treatment Program (TSAT)
TSAT targets adolescents with co-occurring disorders with 3-months of intensive outpatient services. Services include group, individual, and family counselling, urinalysis and transportation. Psychiatric and 24-hour crisis services are available and there is a 6-month aftercare component.
TSAT has been evaluated by the University of Arizona (Stevens, Estrada, Carter, Reinardy, Seitz, Swartz, 2003)
A manual for TSAT, co-authored by Melissa Smith, is downloadable from here
http://www.chestnut.org/LI/bookstore/Blurbs/Manuals/ATM/ATM109-EMPACT.html

2. Healthy Connections
Aims to decrease incidence of blood borne viruses amongst high-risk youth using an education and awareness approach (3 group and 4 individual sessions)

3. Families F.I.R.S.T.
Run in partnership with TERROS, Families F.I.R.S.T. is a component of a collaboration of substance abuse treatment professionals with child welfare specialists to provide services to families in the child welfare system. The

Visit No: 18 cont.	Key informant: Melissa Smith
Date: 24/11/03	EMPACT

service provides intensive outpatient services to clients with co-occurring mental health and substance related disorders as part of a continuum of community-based substance abuse treatment services.

4. The A.W.A.R.E. Program
AWARE is a 12-week program for adolescents in need of outpatient substance related and behavioural health services. AWARE offers weekly group counselling and fortnightly individual/family therapy, psychiatric evaluations and medication monitoring. The AWARE program aims to enhance resiliency and hence decrease substance use.

5. Drug Diversion Program
The diversion program is a 10-week substance abuse program for teens referred by their Probation Officers for services because of a felony offense due to substance use. Typical presenting issues include: marijuana use, truancies, fighting in school, anger management difficulties, poor family relationships, depression, and impulsivity.

Adult programs
6. Adult Substance Abuse Treatment Program
4-month intensive outpatient program for person with co-occurring disorders offering individual, group and family counselling, psychiatric assessment, medication monitoring, transportation, case management, stress management, peer mentoring, life skills training, family support services, anger management, employee assistance, coping skills/awareness of triggers, and connecting the client into the community.

7. C.O.O.L. Program
10-week program targeting high-risk offenders on parole from the Arizona Department of Corrections (ADC) with substance abuse and mental health disorders needs. Clients index-offence must have been substance related.

Suitability to own practice:
It was a learning experience for me to have an overview of and observe the work of an agency that has developed particular expertise in engaging and providing services to adolescents with complex needs.

Suitability to Victorian healthcare system:
The TSAT program model could inform the design of Victorian initiatives seeking to engage and treat adolescents with complex needs.

Visit No: 19	Key informant: Samantha Scheiss Northern Arizona Regional Behavioural Health Authority
Date: 25/11/03	

Summary of organisation's / informants co-occurring disorders-related role/activities:

The Northern Arizona Regional Behavioural Health Authority (NARBHA) is a non-profit, managed behavioral health care organization that serves as the Regional Behavioral Health Authority for northern Arizona. Its role is to plan, develop, implement and administer comprehensive mental health and substance abuse services to adults and children through a provider network in the five northern counties of Arizona. NARBHA covers a huge geographic area - over 62,000 square miles with large distances between centres.

Samantha Scheiss has overseen the implementation of Arizona Integrated Treatment process for NARBHA.

Activities undertaken during visit:

I interviewed Samantha via video conference from the offices of the Arizona Department of Health, Division of Behavioural Health. Michelle Ryan participated in the interview and we discussed NARBHA's approach to, and experiences in, facilitating integrated treatment for co-occurring disorders in a substantially rural and remote environment.

Key lessons learned:

Samantha has a strong focus on stakeholder 'buy-in' to an initiative, describing buy-in as stakeholder investment and enthusiasm for an initiative. She notes that it will not necessarily be management in an individual agency that will have the most buy-in to a new initiative and that skills in managing upwards as well as downwards may be important.

NARBHA instituted a regional integrated treatment panel within a month of the commencement of the statewide panel. The regional panel was charged with developing a regional implementation plan that fitted local needs and structures. The regional plan took a full year to develop with participation from all stakeholders. While the statewide implementation plan was a valuable resource in the development of the regional plan the local panel participants decided to set two, achievable goals to focus on initially. They broke these goals up into steps, with outcome indicators, to end up with a compact, achievable starting area.

NARBHA also employed a train the trainer model for their training rollout. Samantha hand-selected participants from individual agencies on the basis of their 'buy-in' to the philosophy of integrated treatment. Trainers then went back and trained their own and one other agency using a model of each training team comprising a substance abuse and a mental health worker.

Visit No: 19	Key informant: Samantha Scheiss
Date: 25/11/03	NARBHA

The trainers group purchased the University of Tucson co-occurring disorders training videos and edited those to versions to be used in their own training activities. A local strategy has been to incorporate some measure of co-occurring disorders training into the routine orientation process for new workers.

A local strategy was to target the clients with the most complex needs first. Samantha noted that measurable successes such as fewer admissions and enhanced compliance are influential in encouraging providers to offer routine integrated treatment.

Samantha noted that psychiatrists are an essential group to target to ensure that they have sufficient buy-in to providing integrated treatment. It may be necessary to have specific initiatives targeting their particular training needs. The Arizona conference with speakers such as Dr Minkoff and Dr MeeLee was influential in achieving psychiatrist buy-in.

Samantha also noted that Arizona's Division of Behavioural Health top-down commitment to integrated treatment had been instrumental in the success of the initiative. She framed system change as a process in which agencies will be at different stages at any one time. It is important to address agencies where they are at any one time; to celebrate successes at the same time as looking to what the next goal is and what are the achievable steps to reach that goal.

Samantha also cited The Change Book: A Blueprint for Technology Transfer as a particularly valuable resource in planning system change (see textbox page 90) Many of the local cadre of trainers and management attended training facilitated by one of the authors, Dr Dennis McCarty, at the University of Arizona. http://www.nattc.org/resPubs.html

Suitability to own practice:
I have been impressed by the clear strategies offered in The Change Book and Samantha's analysis of stakeholder buy-in as crucial to effecting systemic change.

Suitability to Victorian healthcare system:
The model of regional integrated treatment panels being charged with developing a regional implementation plan appears to be an effective manner of gaining widespread stakeholder buy-in and tailoring the adoption of integrated treatment to local conditions.

Samantha described psychiatrists as the most crucial group to have buy-in to providing integrated treatment because of their oversight and responsibility for clinical delivery and this appears to be as true for Victoria as for Arizona. Psychiatrist-specific co-occurring disorders training initiatives should be considered a priority for Victorian psychiatrists

Addiction Technology Transfer Centers

The Change Book: A Blueprint for Technology Transfer

- The Change Book is a free-to-download text from the Addiction Technology Transfer Centers. Go to http://www.nattc.org/resPubs.html

- The Change Book is designed to help implement change initiatives aimed at improving prevention and treatment outcomes. The manual is designed for administrators, staff, educators and policy makers to build their skills in implementing change within agencies.

- Whilst it has wide applicability the manual has arisen from the drug treatment field (SAMHSA grant). Some of the material uses initiatives addressing co-occurring disorders as case studies. The manual offers *Principles, Steps, Strategies* and *Activities* for achieving effective change

- The manual lists a number of elements necessary for the adoption of change. These include policies that provide incentives for adopting innovative changes.

- The manual rests on a *stages of change* analysis of each level of a system. It suggests strategies for addressing multiple levels of an organisation, addressing resistance to change and maintaining changes once they are established.

Visit No: 20.	Organisation: The Village Integrated Services Agency Los Angeles California
Date: 26/11/03	

Key informants	
Gary Barbagallo	Personal Service Coordinator The Village Integrated Services Agency
Guyton Colantuono	Director Transition Age Youth Program The Village Integrated Services Agency
John Travers	Community Integration Specialist The Village Integrated Services Agency
Paul Barry, M.Ed., CPRP	Associate Director The Village Integrated Services Agency
Rob Shapiro	Personal Service Coordinator The Village Integrated Services Agency
Sara Ford	Training Coordinator The Village Integrated Services Agency

Summary of organisation's co-occurring disorders-related role/activities:

The Village is a large, inner-city, multi-award winning, mental health, psychosocial rehabilitation and treatment agency. The Village was initially established around 1990 as a demonstration of the best mental health service possible and, since then, has been one of the USA's most innovative mental health providers. It has a focus on integrating the delivery of services to meet each member's distinct employment, housing, psychiatric, health, recreation and financial choices. The Village operates from a strengths-based, whole-person, health-focused philosophy. Its website offers a range of resources and information around its integrated service model.

The Village has 3 Intensive Case Management teams each staffed by 6 Personal Service Coordinators and each with a case load of about 17 people. Working in a collaborative, non-hierarchical style Village workers aim to create a high-risk/high-support environment that promotes hope and the recovery process (Ragins, n/d). The Village employs a comprehensive suite of outcome measures for people with severe and persistent mental illness. The Village offers training on a variety of topics including co-occurring disorders - "The Jedi Master Approach to Dual Diagnosis"

Activities undertaken during visit:

On this visit I attended a whole-of-community meeting; conducted an interview with Paul Barry; an interview and lunch with Guyton Colantuono, Rob Shapiro, and John Travers; an interview with Gary Barbagallo and conversations with Sara Ford.

Visit No: 20 cont.	Organisation:	The Village
Date: 26/11/03		Los Angeles

Key lessons learned:

I found The Village to be quite an extraordinary place to visit; the substantially upbeat, pervading culture is one of optimism, celebration, collaboration and partnership between members and service providers. Service providers work from a perspective of the members, their own and the agencies interacting journeys. Guyton, John and Rob traced for me the Village's evolution in its approach to member's co-occurring substance use disorders. They described moving from a strong abstinence focus to a more flexible, harm-reduction approach (that may ultimately result in abstinence) and reflected positively on the health-benefits, honesty and engagement with members that resulted from the latter approach. Guyton, John and Rob have used a range of strategies to promote a flexible staff approach to member's substance use disorders.

The Village has employed the four-stage (engagement, persuasion, active treatment and relapse prevention) model to address co-occurring disorders and have identified co-occurring disorders as the most important area on which to focus future staff trainings.

Suitability to own practice:

The Villages positive, collaborative approach to integrated psychosocial rehabilitation has substantially broadened my appreciation of possible approaches to psychosocial rehabilitation.

Suitability to Victorian healthcare system:

The Villages approach to psychosocial rehabilitation, incorporating a comprehensive integrated array of services, has the potential to inform and enhance Victorian psychosocial rehabilitation initiatives.

United States of America
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http://www.samhsa.gov/reports/congress2002/

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http://pathprogram.samhsa.gov/pdf/implementing_interventions.pdf

Treatment Improvement Protocol (TIP) Series Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse,

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Section 3.2.

New Zealand Visits

1/12/03 to 6/12/03

Visit No: 21.	Organisation: Odyssey Residential Dual Diagnosis Programme Auckland New Zealand
Date: 02/12/03	

Key informants	
Odyssey residents	**Dual Diagnosis Programme**
Duncan Paul	**Team Leader, Dual Diagnosis Programme**
John Challis	**General Manager, Odyssey, New Zealand**

Summary of organisation's co-occurring disorders-related role/activities:
Odyssey New Zealand provides specific therapeutic communities for adolescents, general adults and persons with co-occurring disorders in Auckland. Odyssey Residential Dual Diagnosis Programme is a modified therapeutic community designed for persons with co-occurring disorders. The programme requires a commitment to abstinence.

The Dual Diagnosis Programme has a capacity for 15 resident adults plus 3 to 4 clients in the re-entry phase who live in the community. The program incorporates groups, individual counseling, family therapy, and behaviour modification. Each resident is responsible for daily tasks, engages in vocational projects, and is involved in recreational activities. Urine tests are conducted 3 times per week.

Activities undertaken during visit:
On this visit I conducted individual interviews with 2 residents, an interview with John Challis, an interview with Duncan Paul. I sat in on a participant's meeting and on a staff client review/supervision session.

Key lessons learned:

Interview with John Challis, General Manager, Odyssey, New Zealand:
John has been closely involved with the Dual Diagnosis Programme since its inception and he outlined the history of the unit to me. Since Odyssey House began in the 1960's it has had a focus on addressing whatever mental health disorder were co-existing with client's substance use disorders. Two distinct client subsets have been those with Axis II disorders (DSM-IV, 1994) and those with serious mental illness. Tensions about the different expectations on these two client groups provided some of the impetus for the development of a specialist, modified therapeutic community for persons with serious mental illness-type co-occurring disorders. The Dual Diagnosis Programme has been operational since 1995.

Visit No: 21 cont.	Organisation:
Date: 02/12/03	Odyssey Residential Dual Diagnosis Programme

Interviews with residents
One of the residents was a senior member of the community while the other was in the late-assessment phase. One of the residents had substantial experience of New Zealand mental health facilities and the other resident had experience of previous, substance-specific, residential rehabilitation facilities.

Both residents reflected positively about their involvement with the dual diagnosis programme.
Positives identified about the program included…
- The stepped, graduated, approach – "*always feels as though you are moving and there is a clear goal to be going for"*
- The consistency of the rules – "*as against mental health places where it feels as though the rules are being made up as you go along"…."you're going to get pretty much the same response whichever staff member you approach"*
- There is a structure and a process to deal with any issues that arise. Both clients were very positive about the conflict resolution process, framing it as a skill-acquisition opportunity.
- The length of the program. One client felt that his previous 3-month, substance-treatment programs had been too brief to gain an enduring benefit from.
- Addressing both disorders together was cited by both informants as unusual and a positive experience.
- Staff commitment
- Development of an individual relapse prevention plan as a living document addressing both disorders was considered to be a valuable, practical working tool.

Interview with Duncan Paul
Duncan described the evolution of the community since 1995. He observed that, in initially modifying the structure, they moved too far away from some of the key therapeutic principle of therapeutic communities and had now moved back to becoming more linked with those key principles.
Duncan cited examples of…
- the approach of having senior community members acting as role models, fully involved in and responsible for the process of supporting people and dealing with issues within the community,
- the approach of having very clear explicit criteria for people moving through treatment, of having high expectations around resident's progress and their behaviour in the community.

Both of these approaches have been emphasised much more strongly over the last 5 to 6 years, more in line with a traditional therapeutic community. They have found that the community responds well to such expectations.

Duncan observed that the community culture has developed into a very strong prosocial culture over that period – able to deal with new people coming in, to deal suitably with any antisocial or self defeating behaviours and to get new people on board and engaged with treatment quickly.

Visit No: 21 cont.	Organisation:
Date: 02/12/03	Odyssey Residential Dual Diagnosis Programme

Duncan discussed the speciality skills needed to work with clients with serious mental illness in a therapeutic community environment and the reasons why non-speciality therapeutic communities struggle to incorporate persons with severe mental illness. Duncan noted the importance of staff having the skills to recognise the differences between behaviours, symptoms and the 'bits in between'. He observed that it is easier to do this consistently in a smaller community - in a larger community it may be difficult to do this or staff with these skills may be spread too thinly.

Duncan described the treatment pathway….

- Referrals are most commonly from Community Mental Health Teams but also from forensic facilities, private psychiatrists and self-referral
- Initial assessment phase lasts 4 to 8 weeks. Phase-specific tasks include assessment and stabilisation of mental state, working with resident's motivation and any behavioural issues. At the end of this phase clients meet a representative sample of the community and put their case for joining the community. Some level of insight into both disorders and commitment to the process is required.
- Levels 1 to 4: From that point the resident will graduate through four levels of treatment over a 13-month to 2-year period. These levels have been designed using a psychosocial development model and each level has specific developmental tasks associated with it. In Level 4 clients will move out into the community while remaining in treatment.
- Graduates group is held once a month and graduates are welcome to drop-in.

Whilst there is some flexibility the average length of stay is around 18 months. A maximum stay of 2 years is in place for both therapeutic and economic reasons.

Duncan described the importance of attending to getting the staff culture right and maintaining consistency – good outcomes are dependant upon having a well trained and experienced staff team who can sustain and develop that culture within the community. He noted that such a therapeutic community 'will never be a franchise operation' because the personalities of the persons directing the process has such a large effect on the outcomes

Duncan observed that while it is important to get consistency with the key rules and the application of those rules that too many rules will only serve to wear people out – part of the process is encouraging people to work out their own strategies for dealing with situations.

In concluding Duncan noted that the work can be very satisfying because of the opportunity to see the whole person. He reflected that while the team currently operate with a strong sense of confidence they are always seeking new ideas to enhance the process.

Visit No: 21 cont.	Organisation:
Date: 02/12/03	Odyssey Residential Dual Diagnosis Programme

Suitability to own practice:
I was particularly struck by staff observations around members responding well to high-expectations and of the approach of providing clear criteria and expectations for each phase of treatment.

Suitability to Victorian healthcare system:
There are currently few Victoria programmes run on therapeutic community principles that offer integrated treatment of co-occurring serious mental illness and substance use disorders. The establishment of such a facility in Victoria would contribute substantially to the continuum of treatment options for persons with co-occurring disorders. The success of establishing such a facility would depend on its ability to attract staff with experience and expertise in facilitating a programme with good fidelity to the therapeutic community model.

Visit No: 22.	Key informant:	Joanne Labrow Clinical Nurse Specialist Lakes District Health Board Rotorua
Date: 04/12/03		

Summary of informant's co-occurring disorders-related role/activities:
Joanne provided dual diagnosis training for MIND in the United Kingdom and co-authored the MIND guide: Understanding Dual Diagnosis (Phillips, Labrow, 1998). Joanne has recently authored a proposal to Lakes District Health Board for a specialist co-occurring disorder's project (Labrow, 2003)

Activities undertaken during visit:
On this visit I sat in on Lakes DHB training on methamphetamine and conducted an interview with Joanne

Key lessons learned:

New Zealand co-occurring disorders initiatives
Joanne described how New Zealand drug treatment and mental health services articulate. Funding comes from a single central agency to local District Health Boards who allocate funding to (usually) structurally-divided, local mental health and drug treatment agencies. Whilst there are specialist dual diagnosis workers in New Zealand these positions are usually initiatives of local District Health Boards. Most of these positions have a strong clinical focus, working from a case management rather than a co-case management model. Most also provide some amount of consultation and training services.

Joanne described the Odyssey Residential Dual Diagnosis Programme and also cited the NZ Ministry of Health guidelines for the management of patients with co-existing psychiatric and substance use disorders (available here) (MoH, 1994)
http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/abbcbd786b0d972bcc256b7f00781d04/$FILE/Guiddisor.pdf

Proposed facilitative model
Joanne described the model that she has proposed to Lakes District Health Board. The model aims to assist generic services in dealing with persons with co-occurring disorders.
The model incorporates
- consultation /liaison to primary and secondary services
- education and training
- clinical supervision
- research around the effectiveness of the training

Because of Rotorua's size the project has the potential to provide some level of training to most of the key agencies that provide services to persons with co-occurring disorders. The project has been approved and job ads will be posted soon. It is hoped that the project will highlight any service gaps.

Visit No: 22 cont.	Key informant: Joanne Labrow
Date: 04/12/03	Rotorua

Other topics
Joanne stated that in her assessment the success of any initiative attempting to promote integrated treatment is dependent on its ability to obtain 'buy-in' from medical staff and psychiatrists.

Joanne described a conflict in the philosophies of drug treatment and mental health systems that may be a tension in bringing the systems closer together – drug treatment necessarily has a focus on self-responsibility whereas mental health services can tend towards a more paternalistic approach. Drug treatment tools such as decisional matrixes are likely to be valuable to mental health treatment services.

We discussed the systemic differences between the USA's health system and the more nationalised systems of New Zealand, Australia and the United Kingdom. Joanne's perception is that these differences limit the generalisability of some of the co-occurring disorders research and treatment models that have come from the USA.

Dr Minkoff lectured in New Zealand in 1999 and this visit continues to be influential in New Zealand deliberations around co-occurring disorders. An overview of Dr Minkoff's New Zealand presentations is available on the web.
http://www.alcohol.org.nz/resources/newsletters/saywhen/may99-1.html

Joanne described her approach to providing dual diagnosis training for MIND in the UK. She would incorporate demonstrations of drug use and found that such approaches, for some audiences, took some of the mystery out of substance use and contributed to clinician's sense of self-efficacy in treating substance use disorders.

Joanne identified deficiencies in either drug treatment or co-occurring disorders components in a range of undergraduate courses.

Joanne's hope for co-occurring disorders is that it will eventually melt into a more holistic approach where service providers are able and willing to meet people where they are rather than by the diagnosis that they have been given.

Suitability to own practice:
Joanne's observations around co-occurring disorders, informed by her experiences working in a number of healthcare systems, helped clarify some of the issues faced by different countries in addressing co-occurring disorders.

Suitability to Victorian healthcare system:
As with a number of other key informants Joanne identified the issue of incorporating more drug treatment and co-occurring content in a range of undergraduate courses as crucial to improving the longer-term system response to persons with co-occurring disorders

New Zealand
Further Reading & Resources

New Zealand Ministry of Health (1994) Guidelines for the management of patients with co-existing psychiatric and substance use disorders
http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/abbcbd786b0d972bcc256b7f00781d04/$FILE/Guiddisor.pdf

Selman, D., Todd, F., Robertson, P. (1998) Assessment and management of co-existing substance use and mental health disorders
A comprehensive and informative report on a dual diagnosis project conducted by of New Zealand's National Addiction Centre. The report provides practical guidelines for clinicians and services.
http://www.chmeds.ac.nz/departments/psychmed/treatment/research.html

Taranaki District Health Board Coexisting Disorders and Dual Diagnosis Fact sheet. http://www.mentalhealthinsight.org.nz/drugs_alchohol/dual_diagnosis.html

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Section 4

Improving the Victorian healthcare system

What impact will the study have on my own practice/on my organisation?

I am employed by the Division of Psychiatry, Northeast Health, Wangaratta as part of the state-wide specialist co-occurring disorders workforce. My role is to provide consultation, education and training and some direct service delivery to drug treatment and mental health agencies and clinicians in the North East of Victoria. The overall aim of the service is to achieve better outcomes for persons with co-occurring mental health and substance use disorders.

The study has given me the opportunity to compare a range of approaches to improving the treatment responses to co-occurring disorders; to analyse their strengths and assess how they may fit in the context of the North East Victorian and Victorian treatment systems. I have a more defined vision of the possible improved outcomes and potential cost savings associated with implementing integrated treatment and of strategies to achieve integrated treatment. The learning that the study has provided will be pivotal to my future approaches to achieving better outcomes.

As a direct result of my fellowship experiences my practice will incorporate

- a range of strategies to promote the buy-in of key stakeholders in moving to more integrated treatment of co-occurring disorders
- more global use of the stages of change model in analysing systemic and clinician readiness to provide integrated treatment of co-occurring disorders
- an increased focus on strategies to address precontemplation / assist change
- a greater focus on evaluation of the effects of my practice

What steps will you undertake in the short to medium term to improve the Victorian healthcare system?

I am attempting to work relevant strategies and approaches gleaned from fellowship visits and associated study into the Eastern Hume Dual Diagnosis Initiative. I will describe and disseminate outcomes of this activity as they occur.

As a result of fellowship activities I have identified a quantity of resources that may contribute to co-occurring disorders capacity building and have distributed these resources to relevant local, Victorian and Australian stakeholders. I am maintaining links with a number of key informants and continuing our discussions around approaches to improving the response to persons with co-occurring disorders. I shall continue to disseminate resources and approaches, identified as a result of this activity, to relevant stakeholders.

See section 5: *Sharing and promoting the project*.

Section 5

Sharing and promoting the project

What are the activities that I will undertake to share and promote the outcome of the fellowship?

Since my return from fellowship travel I have discussed study outcomes with a range of Victorian and Australasian workers involved in healthcare system co-occurring disorders capacity building. I have been asked to speak to a variety of Victorian groups about study activities and findings. I shall respond to such requests where possible.

I have submitted an abstract to the Australian and New Zealand College of Mental Health Nurses International 30th Conference around integrated treatment.

I shall electronically disseminate this current report to local, Victorian, Australasian and international stakeholders and informants.

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Section 6

Appendices

Appendices

American Society of Addiction Medicine

ASAM Patient Placement Criteria

The Patient Placement Criteria of the American Society of Addiction Medicine (ASAM PPC) 2000 edition offered guidelines to programs on how to improve the assessment process, staff expertise, and service design to better meet the needs of persons with co-occurring disorders. Primarily focused on addiction services these criteria have been widely-adopted and are influential in the USA as a service planning tool.

Program capabilities are defined as being of three types:
- Addiction-Only Services (AOS),
- Dual Diagnosis Capable (DDC)
- Dual Diagnosis Enhanced (DDE)

AOS services cannot treat persons with psychiatric illnesses no matter how stable the illness.

DDC services *routinely accept individuals who have co-occurring disorders so long as their psychiatric disorders are sufficiently stabilized and the individuals are capable of independent functioning to such a degree that their mental disorders do not interfere with participation in addiction treatment* (MeeLee, n/d)

Measurable criteria defining DDC status include:
- the agencies mission and philosophy
- routine screening for comorbidity
- assessment incorporating psychiatric illness
- access to mental health treatment beyond the capabilities of the program
- diagnosis and treatment planning incorporating the psychiatric diagnoses
- documentation indicating monitoring of the psychiatric disorder
- programming including sessions addressing mental illness
- medication policies
- psychiatric emergency policies
- access to mental health consultation
- collaboration with mental health provider agencies
- competencies
- discharge planning (Minkoff, 2001)

DDE services "*can accommodate individuals with dual diagnoses who may be unstable or disabled to such an extent that specific psychiatric and mental health support. monitoring and accommodation are necessary in order for the individual to participate in addiction treatment… not so acute or impaired as to present a severe danger to self or others, nor do they require 24-hour, intensive psychiatric supervision*" (MeeLee, n/d)

To meet criteria for DDE status agencies must:
- meet all DDC criteria
- have higher staffing levels including specialist mental health staff and a

licensed prescriber with training in psychopharmacology.
- on site availability of mental health supervision
- smaller group sizes and more flexible expectations
- specific mental health symptom management
- documentation of interventions targeting client's mental health symptoms
- collaboration with mental health treaters, and involvement of those treaters in treatment planning
- program materials adapted to individuals with psychiatric impairment
- policies supporting welcoming return for individuals unable to complete treatment
- increased availability of individual counseling and case management.
(Minkoff, 2001)

Dr Kenneth Minkoff has proposed the creation of parallel categories for mental health programs: **Dual Diagnosis Capable- Mental Health** (DDC- MH) and **Dual Diagnosis Enhanced – Mental Health** (DDE-MH) together with measurable criteria for such programs (Minkoff, 2001).

Appendix 2
Key informant's co-occurring disorders-related publications

Prashant Phillips

A more complete list of Prashant Phillip's publications is available here
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Appendix 2
Key informant's co-occurring disorders-related publications

Hermine Graham

A more complete list of Hermine Graham's publications is available here

http://147.188.20.137/staff/FMPro?-db=staff.fp5&-format=wp.htm&-lay=main&-sortfield=sc2&-op=neq&sc2=xx&-max=2147483647&-recid=32915&-find

Books

Graham H., Copello, A., Birchwood, M., Mueser, K. (Eds.) (2003). Substance misuse in psychosis: Approaches to treatment and service delivery. Chichester: John Wiley & Sons Ltd.

Graham, H., Copello, A., Birchwood, M., Mueser, K., Orford, J., McGovern, D., Atkinson, E., Maslin, J., Preece, M., Tobin, D., Georgiou, G. (2004). Cognitive-behavioural integrated treatment (C-BIT): A treatment manual for substance misuse in people with severe mental health problems. Chichester: John Wiley & Sons Ltd.

Chapters in books

Graham, H. (2003). A cognitive conceptualisation of concurrent psychosis and problem drug and alcohol use. In Graham, H., Copello, A., Birchwood M., Mueser K. (Eds.) Substance misuse in psychosis: Approaches to treatment and service delivery. Chichester: John Wiley & Sons Ltd.

Graham, H., Copello, A., Birchwood, M., Maslin, J., McGovern, D., Orford, J., Georgiou, G. (2003). The combined psychosis and substance use (COMPASS) programme: An integrated shared-care approach. In Graham, H., Copello, A., Birchwood M., Mueser K. (Eds.) Substance misuse in psychosis: Approaches to treatment and service delivery. Chichester: John Wiley & Sons Ltd.

Graham, H., Copello, A., Birchwood, M., Maslin, J., McGovern, D., Orford, J., Georgiou, G. (2003). Cognitive-behavioural integrated treatment approach for psychosis and problem substance use. In Graham, H., Copello, A., Birchwood M., Mueser K. (Eds.) Substance misuse in psychosis: Approaches to treatment and service delivery. Chichester: John Wiley & Sons Ltd.

Journal articles

Graham, H. (1998). The role of dysfunctional beliefs in individuals who experience psychosis and use substances: implications for cognitive therapy and medication adherence. Behavioral and Cognitive Psychotherapy, 26, 193-208.

Graham, H., Maslin, J., Copello, A., Birchwood, M., Mueser, K., McGovern, D., Georgiou, G. (2001). Drug and alcohol problems amongst individuals with severe mental health problems in an inner city area of the UK. Social Psychiatry and Psychiatric Epidemiology, 36, 448-455.

Copello, A., Graham, H., Birchwood, M. (2001). Evaluating substance misuse interventions in psychosis: The limitations of the RCT with 'patient' as the unit of analysis. Editorial. Journal of Mental Health, 10 (6), 585-587.

Maslin, J., Graham, H., Cawley, M., Copello, A., Birchwood, M., Georgiou, G., McGovern, D., Mueser, K., Orford, J. (2001). Combined severe mental health and substance use problems: What are the training and support needs of staff working with this client group? Journal of Mental Health, 19 (2), 131-140.

Graham, H., Maslin, J. (2002). Problematic cannabis use amongst those with severe mental health problems in an inner city area of the UK. Addictive Behaviors, 26, 261-273.

Graham, H., (2002). Project update: The combined psychosis and substance use (COMPASS) programme. Acquire, Alcohol Concern, 33.

Graham, H., Copello, A., Birchwood, M., Orford, J., McGovern, D. Georgiou, G., Godfrey, E. (2003). Co-existing severe mental health and substance use problems: Developing integrated services in the U.K. Psychiatric Bulletin, 27,183-186

Appendix 2 Key informant's co-occurring disorders-related publications
Dr Bert Pepper

A more complete list of Dr Pepper's publications is available here
http://www.bertpepper.com/cv.html

Books
Ryglewicz, H., Pepper, B. (1996) Lives at risk: Understanding and treating young people with dual disorders. Free Press, New York.

Booklets
Ryglewicz, H., Pepper, B. Alcohol, Drugs, and Mental/Emotional Problems: What You Need To Know to Help Your Dual Disorder Client. The Information Exchange. New York.

Ryglewicz, H., Pepper, B. Alcohol and street drugs: What parents need to know. The Information Exchange. New York.

Ryglewicz, H., Pepper, B. Alcohol and Street Drugs: Time for a Choice. (Client version). The Information Exchange. New York.

Reports
Pepper, B. (1997) Action for mental health and substance related disorders: Improving services for individuals at risk of, or with, co-occurring substance related and mental health disorders. Conference Report and Recommended National Strategy of the SAMHSA National Advisory Council.
http://www.toad.net/~arcturus/dd/pepptoc.htm#toc

Chapters in books
Rahav, M., Pepper, B., et al. (1997) Homeless, mentally ill, chemical abusing men in different, community-based treatment programs Chapter in The effectiveness of innovative approaches in the treatment of drug abuse.

Pepper, B., Hendrickson, E. (1996). Working with seriously mentally ill substance abusers, Chapter in Responding to the mental & substance abuse health care needs of persons on community corrections.

Rahav, M., Pepper, B., et al. Bringing experimental research designs into existing treatment programs: The case of community-based treatment of the dually diagnosed. Chapter in Drug Abuse Treatment, Edited by Fletcher, et al.

Drake, R., McLaughlin, P., Pepper, B., Minkoff, K. (1991) Dual diagnosis of major mental illness and substance disorder. Chapter in Minkoff, K., Drake, R.(Eds) New Directions for Mental Health Services Series, No. 50. Josey Bass

McLaughlin, P., Pepper, B. (1991) Modifying the therapeutic community to treat the dually disordered. Chapter in Minkoff, K., Drake, R.(Eds) New Directions for Mental Health Services Series, No. 50. Josey Bass

Papers

Nutbrock, L., Pepper, B., et al. (1997). Stability of psychiatric symptoms among mentally ill chemical abusers in long-term residential treatment programs, Journal of Drug Issues.

Rahav, M., Pepper, B. (1995). Characteristics and treatment of homeless, mentally ill, chemical-abusing men. Journal of Psychoactive Drugs. Jan.-March, 1995.

Ryglewicz, H., Pepper, B. The dual-disorder client: Mental disorder and substance use. Innovations in Community Mental Health.

Pepper, B. (1991). Mentally ill alcohol & substance abusers: Overview. Lead article in special issue on that topic; The Journal of the California Alliance for the Mentally Ill. Served as issue editor.

Pepper, B. (1991). The information exchange: A resource for diagnosis and treatment of young adults with severe co-morbid disorders. Synapse, November - December

Pepper, B. (1991). The young adult chronic patient and substance abuse. Forum, journal of the Rockland County Mental Health Association, September

Appendix 2 Key informant's co-occurring disorders-related publications
Dr Kenneth Minkoff

A more complete list of Dr Minkoff's publications is available here
http://www.kenminkoff.com/pubs.html

Audiovisual

Minkoff K. (2000). Integrated model of treatment for dual diagnosis (videotape). Mental Illness Education Project, Boston, MA..

Papers

Minkoff, K. (1987) Resistance of mental health professionals to working with the chronic mentally ill. New Directions for Mental Health Services, Jossey-Bass, 33, 3-20, 1987.

Minkoff, K. (1987). Beyond deinstitutionalization: A new ideology for the post-institutional era. Hospital and Community Psychiatry, 38 (9), 945-950,

Minkoff, K. (1989) Development of an integrated model for the treatment of patients with dual diagnosis of psychosis and addiction. Hospital and Community Psychiatry, 40 (10), 1031-1036, October.

Batten, H., Bachman, S., Higgins, R., Manzik, N., Parham, C., Minkoff, K. (1989). Implementation issues in addictions day treatment. Hospital and Health Services Administration, 34 (3), 427-439. Fall

Drake, R., McLaughlin, P., Pepper, B., Minkoff, K. (1991) Dual diagnosis of major mental illness and substance disorder: An overview. New Directions for Mental Health Services, Jossey-Bass, 50, 3-13,.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. New Directions for Mental Health Services, Jossey-Bass, 50, 13-27, 1991.

Bachman, S., Batten, H., Minkoff, K., Higgins, R., Manzik, N., Mahoney, D. (1992). Predicting success in a community treatment program for substance abusers. American Journal on Addictions, 1 (2), 155-167.

Minkoff, K. (1993). Intervention strategies for people with dual diagnosis. Innovations & Research, 2 (4), 11-17.

Minkoff, K. (1994). Models for addiction treatment in psychiatric populations. Psychiatric Annals, 24 (8), 412-417, August.

Minkoff, K., Regner, J. (1999). Innovations in integrated dual diagnosis treatment in public managed care. Journal of Psychoactive Drugs, 31:3-12,

Minkoff, K. (2000). An integrated model for the management of co-occurring psychiatric and substance disorders in managed care systems. Disease Management & Health Outcomes, 8:250-257.

Drake, R., Essock, S., Shaner, A., Carey, K., Minkoff, K., et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services, 52:469-76.

Minkoff, K. (2001) Developing standards of care for individuals with co-occurring psychiatric and substance disorders. Psychiatric Services, 52:597-99.

Minkoff, K. (2001). Level of care determination for individuals with co-occurring psychiatric and substance disorders. Psychiatric Rehabilitation Skills, 5:163-196.

Minkoff, K., Zweben, J., Rosenthal, R., Ries, R. (2002). Developing service intensity criteria and program categories for individuals with co-occurring disorders Journal of Alcohol and Drug Abuse. *In press*.

Chapters in books

Minkoff, K. (1994). Treating the dually diagnosed in psychiatric settings. In N.S. Miller (ed.) Treating coexisting psychiatric and addictive disorders: A practical guide. Centercity, MN: Hazelden Educational Materials, 1994.

Minkoff, K. (1996). Dual diagnosis in seriously and persistently mentally ill individuals: An integrated approach. In Vaccaro, J., Clark, G. (eds.) Practicing psychiatry in the community. Washington, DC: American Psychiatric Press, Inc., 221-253.

Minkoff, K., Soreff, S. (1996). Dual diagnosis - serious mental illness and substance abuse: One person, two major problems, one approach in Soreff, S., (ed.) Handbook for the treatment of the seriously mentally ill, Seattle, WA: Hogrefe & Huber, 315-323.

Minkoff, K. (1996). Integration of addiction and psychiatric treatment in Miller, N. (Ed.). The principles and practice of addictions in psychiatry. Philadelphia, PA, 191-199.

Minkoff, K. (1997). Resistance of mental health professionals to working with people with serious mental illness. In Spaniol, L., Gagne, C., Koehler, M. (eds.) Psychological and social aspects of psychiatric disability. Boston, MA: Centre for Psychiatric Rehabilitation, 334-347.

Minkoff, K. (1997). Integration of addiction and psychiatric services. In Minkoff, K., Pollack, D. (Eds.). Managed mental health care in the public sector: A survival manual. Amsterdam. The Netherlands: Harwood Academic Publishers, 223-246.

Books and Monographs

Minkoff, K., Drake, R. (eds.) Dual diagnosis of serious mental illness and substance disorder. San Francisco, CA: Jossey-Bass, 1991.

Panel on co-occurring psychiatric and substance disorders, Centre for mental health services managed care initiative (K. Minkoff, Chair). Annotated Bibliography, July 1997.

Panel on co-occurring psychiatric and substance disorders, Centre for mental health services managed care initiative (K. Minkoff, Chair). Co-occurring psychiatric and substance disorders in managed care: Standards of care, practice guidelines, workforce competencies and training curricula, January 1998.

Appendix 2
Key informant's co-occurring disorders-related publications

New Hampshire Dartmouth Psychiatric Research Centre

This is an abbreviated, co-occurring disorders-focused, list of NHDPRC publications. A more complete list of NHDPRC publications is available here

http://www.dartmouth.edu/~psychrc/pubs.html

Papers and chapters in books:

Drake, R., Osher, F., Wallach, M. (1989). Alcohol use and abuse in schizophrenia: A prospective community study. Journal of Nervous and Mental Disease, 177, 408-414.

Drake, R., Wallach, M. (1989). Substance abuse among the chronic mentally ill. Hospital and Community Psychiatry, 40, 1041-1046.

Osher, F., Kofoed, L. (1989). Treatment of patients with psychiatric and psychoactive substance use disorders. Hospital and Community Psychiatry, 40, 1025-1030.

Teague, G., Mercer-McFadden, C., Drake, R. (1989). Dual diagnosis and continuity of care: New Hampshire's integrated initiatives for dual diagnosis patients. Tie Lines, VI, 1-3.

Bartels, S., Drake, R. (1990) Depression, hopelessness, and suicidality in schizophrenia: The neglected impact of substance abuse. In C.N. Stephanis, A.D. Rabavials, & C.R. Soldatos (Eds.), Proceedings: VIII World Congress of Psychiatry. Amsterdam: Exerpta Medica, Elsevier Publishers.

Bartels, S., Drake, R. (1990). Tarasoff and the dual diagnosis patient. In J.C. Beck (Ed.), Confidentiality vs. the Duty to Protect: Risk of Foreseeable Harm in the Practice of Psychiatry. Washington, D.C.: American Psychiatric Press.

Drake, R. (1990) Psychiatric patients have high rate of concurrent addictive disorders. Psychiatric Times, 7, 18-19.

Drake, R., Osher, F., Noordsy, D., Hurlbut, S., Teague, G., Beaudett, M. (1990). Diagnosis of alcohol use disorders in schizophrenia. Schizophrenia Bulletin, 16, 57-67.

Drake, R., Teague, G., Warren, R. (1990). Dual Diagnosis: The New Hampshire Program. Addiction and Recovery, 10, 35-39.

Mueser, K., Yarnold, P., Levinson, D., Singh, H., Bellack, A., Kee, K., Morrison, R., Yadalam, K. (1990). Prevalence of substance abuse in

schizophrenia: Demographic and clinical correlates. Schizophrenia Bulletin, 16, 31-56.

Teague, G., Schwab, B., Drake, R. (1990). Evaluating services for young adults with severe mental illness and substance use disorders. Proceedings of the National Association of State Mental Health Program Directors, Arlington, VA.

Bartels, S., Drake, R. (1991) Dual diagnosis: New challenges and directions. California Journal of the Alliance for the Mentally Ill, 2, 6-8.

Bartels, S., Thomas, W. (1991). Lessons from a residential program for people with dual diagnoses of severe mental illness and substance use disorder. Psychosocial Rehabilitation Journal, 15(2), 19-30.

Drake, R. (1991) Management of schizophrenic patients with substance abuse disorders. Relapse, 1, 3-4.

Drake, R., Antosca, L., Noordsy, D., Bartels, S., Osher, F. (1991). New Hampshire's specialized services for the dually diagnosed. In K. Minkoff & R. Drake (Eds.), Dual Diagnosis of Major Mental Illness and Substance Disorders. ((pp. 57-67). San Francisco: Jossey-Bass.

Drake, R., McLaughlin, P., Pepper, B., Minkoff, K. Dual diagnosis of major mental illness and substance use disorder: An overview. In K. Minkoff & R. Drake (Eds.), Page 3 Dual Diagnosis of Major Mental Illness and Substance Disorders. (pp. 3-12). San Francisco.

Drake, R., Osher, F., Wallach, M. (1991). Homelessness and dual diagnosis. American Psychologist, 46, 1149-1158.

Drake, R. Vaillant, G. (1991) Predicting alcoholism and personality disorder in a 33-year longitudinal study of children of alcoholics. Annual Review of Addictions Research and Treatment, 15-23.

Kline, J., Harris, M., Bebout, R., Drake, R. (1991). Contrasting integrated and linkage models of treatment for homeless, dually diagnosed adults. In K. Minkoff & R.E. Drake (Eds.), Dual Diagnosis of Major Mental Illness and Substance Disorder. (95- 106). San Francisco: Jossey-Bass, Inc.

Minkoff, K., Drake, R. (1991). Dual Diagnosis of Major Mental Illness and Substance Disorder. San Francisco: Jossey-Bass.

Noordsy, D., Fox, L. (1991). Group intervention techniques for people with dual disorders. Psychosocial Rehabilitation Journal, 15(2), 67-78.

Noordsy, D., Drake, R., Teague, G., Osher, F., Hurlbut, S., Beaudett, M., Paskus, T. (1991). Subjective experiences related to alcohol use among schizophrenics. Journal of Nervous and Mental Disease, 179, 410-414.

Bartels, S., Drake, R., McHugo, G. (1992). Alcohol abuse, depression, and suicidal behaviour in schizophrenia. American Journal of Psychiatry, 149(3), 394-395.

Clark, R., Drake, R. (1992). Substance abuse and mental illness: What families need to know. Innovations and Research, 1(4), 3-8.

Fox, T., Fox, L., Drake, R. (1992). Developing a state-wide service system for people with co-occurring severe mental illness and substance use disorders. Innovations and Research, 1(4), 9-13.

Mercer-McFadden, C., Drake, R. A review of outcome measures for assessing homeless populations with co-occurring substance abuse and severe mental illness. Report to the NIMH Office for Programs for the Homeless Mentally Ill. Rockville, MD: U.S. Department of Health and Human Services, 1992.

Minkoff, K., Drake, R. (1992) Homelessness and dual diagnosis. In R. Lamb, L. Bachrach, F. Kass (Eds.), Treating the homeless mentally ill (pp. 221-247). Washington, DC: American Psychiatric Association.

Mueser, K., Bellack, A., Blanchard, J. (1992). Comorbidity of schizophrenia and substance abuse. Journal of Consulting and Clinical Psychology, 60, 845-856, 1992.

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Bartels, S., Teague, G., Drake, R., Clark, R., Bush, P., Noordsy, D. (1993). Substance abuse in schizophrenia: Service utilization and costs. Journal of Nervous and Mental Disease, 181, 227-232.

Drake, R., Alterman, A., Rosenberg, S. (1993). Detection of substance abuse in severe mental illness. Community Mental Health Journal, 29, 175-192.

Drake, R., Bartels, S., McHugo, G. (1993)A Seven-year Follow-up Study of Substance Abuse and Homelessness in Patients with Severe Mental Disorders. National Institute on Alcohol Abuse and Alcoholism. Rockville, MD: U.S. Department of Health and Human Services.

Drake, R., Bartels, S., Teague, G., Noordsy, D., Clark, R. (1993) Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disease, 181, 606-611

Drake, R., Bebout, R., Roach, J. (1993) A research evaluation of social network case management for homeless persons with dual disorders. In M. Harris & H.C. Bergman (Eds.), Case management: Theory and practice (pp. 83-98). New York: Harwood Academic Publishers.

Drake, R., Bebout, R., Roach, J., Quimby, E., Harris, M., Teague, G. (1993) Process evaluation in the Washington, D.C., dual diagnosis project. Alcoholism Treatment Quarterly, 10, 113-124, 1993.

Drake, R., McHugo, G., Noordsy, D. (1993) Treatment of alcoholism among schizophrenic outpatients: Four-year outcomes. American Journal of Psychiatry, 150, 328-329.

Drake, R., Wallach, M. (1993). Moderate drinking among people with severe mental illness. Hospital & Community Psychiatry, 44, 780-782.

Kushner, M., Mueser, K. (1993) Psychiatric co-morbidity with alcohol use disorders, Eighth Special Report to the U.S. Congress on Alcohol and Health (Vol. NIH Pub. No. 94-3699, pp. 37-59). Rockville, MD: U.S. Department of Health and Human Services.

McHugo, G., Paskus, T., Drake, R. (1993) Detection of alcoholism in schizophrenia using the MAST. Alcoholism: Clinical and Experimental Research, 17, 187-191.

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Clark, R., Drake, R. (1994). Expenditures of time and money by families of people with severe mental illness and substance use disorders. Community Mental Health Journal, 30, 145-163.

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Nishith, P., Mueser, K., Gupta, P. (1994). Personality and hallucinogen abuse in a college population from India. Personality and Individual Differences, 17, 561-563.

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Osher, F., Drake, R., Noordsy, D., Teague, G., Hurlbut, S., Paskus, T. (1994). Correlates and outcomes of alcohol use disorder among rural schizophrenic outpatients. Journal of Clinical Psychiatry, 55, 109-113.

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Drake, R., Mercer-McFadden, C. (1995). Assessment of substance use among persons with severe mental disorders. In A.F. Lehman & L. Dixon (Eds.), Double Jeopardy: Chronic Mental Illness and Substance Abuse (pp. 47-62). New York: Harwood Academic Publishers.

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Drake, R., Noordsy, D., Ackerson, T. (1995). Integrating mental health and substance abuse treatments for persons with severe mental disorders. In A.F. Lehman & L. Dixon (Eds.), Double Jeopardy: Chronic Mental Illness and Substance Abuse (pp. 251- 264). New York: Harwood Academic Publishers.

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Mueser, K., Bennett, M., Kushner, M. (1995). Epidemiology of substance abuse among persons with chronic mental disorders. In A.F. Lehman & L. Dixon (Eds.), Double Jeopardy: Chronic Mental Illness and Substance Abuse (pp. 9-25). New York: Harwood Academic Publishers.

Mueser, K., Nishith, P., Tracy, J., DeGirolamo, J., Molinaro, M. (1995). Expectations and motives for substance use in schizophrenia. Schizophrenia Bulletin, 21, 367-378.

Quimby, E. (1995). Homeless clients' perspectives on recovery in the Washington, D.C. Dual Diagnosis Project. Contemporary Drug Problems, Summer, 265-289.

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Bartels, S., Drake, R. (1996). A pilot study of residential treatment for dual diagnoses. Journal of Nervous and Mental Disease, 184, 379-381.

Clark, R. (1996). Family support for persons with dual disorders. In R. Drake, K. Mueser (Eds.), Dual Diagnosis of Major Mental Illness and Substance Abuse Disorder II: Recent Research and Clinical Implications (pp. 65-77). San Francisco: Jossey-Bass.

Drake, R. (1996).Substance use reduction among patients with severe mental illness. Community Mental Health Journal, 32, 311-314.

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Drake, R., Noordsy, D. Treatment of comorbid disorders with a case manager approach. In N. Miller (Ed.), The Principles and Practice of Addictions in Psychiatry (pp. 221-228). Philadelphia: W.B. Saunders Company.

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Mueser, K., Noordsy, D., Fox, L., Wolfe, R. Disulfiram treatment for alcoholism in severe mental illness. The American Journal of Addictions, *In press.*

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Mueser, K., Noordsy, D., Drake, R., Fox, M. (2003). Integrated Treatment for Dual Disorders: A Guide to Effective Practice. New York: The Guilford Press

Appendix 2 Key informant's co-occurring disorders-related publications
Melinda Fox

The following is an abbreviated list of Melinda Fox's co-occurring disorders related publications.

Papers and chapters in books:

Noordsy, D., Fox, L. (1991). Group intervention techniques for people with dual disorders. Psychosocial Rehabilitation Journal. Vol 15(2) Oct 67-78.

Fox, T., Fox, L., Drake, R. (1992). Developing a state-wide service system for people with co-occurring severe mental illness and substance use disorders. Innovations and Research, 1(4), 9-13.

Noordsy, D., Schwab, B., Fox, L., Drake, R. (1994). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. (Chapter in) Powell, T. (Ed).. Understanding the self-help organization: Frameworks and findings. (pp. 314-330). viii, 345pp.

Noordsy, D., Schwab, B., Fox, L., Drake, R. (1996). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. Community Mental Health Journal. Vol 32(1) Feb

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Mueser, K., Noordsy, D., Fox, L., Wolfe, R. (2003). Disulfiram Treatment for Alcoholism in Severe Mental Illness. American Journal on Addictions. Vol 12(3) May-Jun, 242-252.

Books:

Mueser, K., Fox, L. (1997) Stagewise Family Treatment for Dual Disorders: Treatment Manual. Concord, NH: NH-Dartmouth Psychiatric Research Centre, 1997, reprinted 1998.

Mueser, K., Noordsy, D., Drake, R., Fox, M. (2003). Integrated Treatment for Dual Disorders: A Guide to Effective Practice. New York: The Guilford Press

Appendix 2 **Key informant's co-occurring disorders-related publications**
David Lynde

Drake, R., Essock, S., Shaner, A., Carey, K., Minkoff, K., Kola, L., Lynde, D., Osher, F., Clark, R., Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services. Vol 52(4) Apr. 469-476.

Torrey, W., Drake, R., Cohen, M., Fox, L., Lynde, D., Gorman, P., Wyzik, P. (2002). The challenge of implementing and sustaining integrated dual disorders treatment programs. Community Mental Health Journal. Vol 38(6) Dec. 507-521.

Mueser, K., Torrey, W., Lynde, D., Singer, P., Drake, R. (2003). Implementing evidence-based practices for people with severe mental illness. Behavior Modification. Vol 27(3) Jul. 387-411.

Appendix 2
Key informant's co-occurring disorders-related publications

Dr Doug Noordsy

A more complete list of Dr Noordsy's publications is available here
http://www.dartmouth.edu/~psychrc/dougn.html

Books and Monographs:

Minkoff, K., Noordsy, D., et al. (1998). Co-Occurring psychiatric and substance disorders in managed care systems: Standards of care, practice guidelines, workforce competencies and training curricula. Philadelphia: The Centre for Mental Health Services

Mercer-McFadden C, Drake, R., Clark, R., Vervon, N., Noordsy, D., Fox, T. (1998) Substance abuse treatment for people with severe mental disorders: A program manager's guide. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Centre.

Mueser, K., Noordsy, D., Drake, R., Fox, M. (2003). Integrated Treatment for Dual Disorders: A Guide to Effective Practice. New York: The Guilford Press

Book Chapters:

Noordsy, D., Drake, R., Teague, G., Osher, F., Hurlbut, S., Beaudette, M., Paskus, T. (1992).Subjektive erfahrungen schizophrener mit alkoholkonsum. In: Psychose und Sucht, edited by D.R. Schwoon & M. Krausz. Freiberg im Breisgau: Lambertus Verlag

Noordsy, D., Drake, R. (1994). Case management. In: Dual Disorders: A Practical Guide to Treatment, edited by N. Miller. Centre City, Minnesota: Hazeldon, 1994

Drake, R., Noordsy, D., Ackerson, T. (1995). Integrating mental health and substance abuse treatments for persons with severe mental disorders. In: Double Jeopardy: Chronic Mental Illness and Substance Abuse, edited by Lehman A.F. & Dixon L. New York: Harwood Academic Publishers, 1995

Noordsy, D., Schwab, B, Fox, L., Drake, R. (1996). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. In: Understanding the Self-Help Organization: Frameworks and Findings, edited by T.J. Powell. Newberry Park, CA: Sage Publishing, 1996

Drake, R., Noordsy, D. (1996). Case management for people with coexisting severe mental disorder and substance use disorder. In: Addiction Psychiatry, edited by N.S. Miller. Philadelphia: W.B. Saunders

Noordsy, D., Drake, R., Biesanz, J., McHugo, G. (1997). Family history of alcoholism in schizophrenia. Readings in Dual Diagnosis, edited by R. Drake, et al. Columbia, MD: IAPSRS Publications

Noordsy, D., Schwab, B, Fox, L., Drake, R. (1997). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. Readings in Dual Diagnosis, edited by R. Drake, et al. Columbia, MD: IAPSRS Publications

Noordsy, D., Mercer, C., Drake, R. (2002). Involuntary interventions in dual disorders programs. In: Ethics in Community Mental Health Care: Commonplace Concerns, edited by D.L. Cutler & P. Backlar. New York: Klewer

Noordsy, D., McQuade, D., Mueser, K. (2002). Assessment considerations. In: Substance Misuse in Psychosis: Approaches to Treatment and Service Delivery, edited by H. Graham, K. Mueser, M. Birchwood, A. Copello. West Sussex: John Wiley & Sons.

Mueser, K., Noordsy, D. (2002). Group treatment for dually diagnosed clients. In A Comprehensive Guide for Integrated Treatment, edited by D.D. Pita & L. Spaniol. Boston, MA: Centre for Psychiatric Rehabilitation.

Noordsy, D., Schwab, B., Fox, L., Drake R. (2002). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. In A Comprehensive Guide for Integrated Treatment, edited by D.D. Pita & L. Spaniol. Boston, MA: Centre for Psychiatric Rehabilitation.

Journal Articles:

Drake, R, Osher, F., Noordsy, D., Hurlbut, S., Teague, G., Beaudett M. (1990). Diagnosis of alcohol use disorders in schizophrenia. Schizophrenia Bulletin, 16:57-67=

Noordsy, D., Drake, R., Teague, G., Osher, F., Hurlbut, S., Beaudett, M., Paskus, T. (1991). Subjective experiences related to alcohol use among schizophrenics. Journal of Nervous and Mental Disease, 179:410-414

Noordsy, D., Fox, L. (1991). Group intervention techniques for people with dual disorders. Psychosocial Rehabilitation Journal, 15:67-78

Drake, R., Antosca, L., Noordsy, D., Bartels, S., Osher F. (1991). New Hampshire's specialized services for the dually diagnosed. New Directions for Mental Health Services, 50:57-67

Drake, R., Noordsy, D., McHugo, G. (1993). A pilot study of outpatient treatment of alcoholism in schizophrenia: Four-year outcomes. American Journal of Psychiatry, 150:328-329

Bartels, S., Teague, G., Drake, R., Clark, R., Bush, P., Noordsy, D. (1993). Service utilization and costs associated with substance abuse among rural schizophrenic patients. Journal of Nervous and Mental Disease, 181:227-232

Drake, R., Bartels, S., Teague, G., Noordsy, D., Clark, R. (1993). Treatment of substance use disorders in severely mentally ill patients. Journal of Nervous and Mental Disease, 181:606-611

Osher, F., Drake, R., Noordsy, D., Teague, G., Hurlbut, S., Paskus, S. (1994). Correlates and outcomes of alcohol use disorder among rural outpatients with schizophrenia. The Journal of Clinical Psychiatry, 55:109-113.

Noordsy, D., Drake, R., Biesanz, J., McHugo G. (1994). Family history of alcoholism in schizophrenia. Journal of Nervous and Mental Disease, 182:651-655.

Drake, R., Noordsy D. (1994). Case management for people with coexisting severe mental disorder and substance use disorder. Psychiatric Annals, 24:427-431.

Drake, R., Noordsy D. (1995). The role of inpatient care for patients with co-occurring severe mental disorder and substance use disorder. Community Mental Health Journal, 31:279-282.

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Mueser, K., Noordsy, D. (1996). Group treatment for dually diagnosed clients. New Directions for Mental Health Services, 55:33-51.

Mueser, K., Drake, R., Ackerson, T., Alterman, A., Miles, K., Noordsy, D. (1997). Antisocial personality disorder, conduct disorder and substance abuse in schizophrenia. Journal of Abnormal Psychology, 106:473-477.

Mueser, K., Drake, R., Noordsy, D. (1998). Integrated mental health and substance abuse treatment for severe psychiatric disorders. Journal of Practical Psychiatry and Behavioural Health, 4:129-139.

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Mueser, K., Noordsy, D., Drake, R., Fox, L. (2001). Troubles mentaux graves et abus de substances: composantes efficaces de programmes de traitements integres a l'intention des personnes presentant une comorbidite (Integrated treatment for severe mental illness and substance abuse: Effective components of programs for persons with co-occurring disorders). Sante Mentale au Quebec, 26:22-46

Brunette, M., Noordsy, D., Drake, R. (2003). Benzodiazepine use and abuse by clients with severe mental illness and substance use disorders, Psychiatric Services , 54:1395-1401.

Mueser, K., Noordsy, D., Fox, L., Wolfe, R. (2003) Disulfiram treatment for alcoholism in severe mental illness. The American Journal on Addictions, in press

Noordsy, D., Mueser, K., Xie, H., O'Keefe, C. Combining olanzapine, case management and vocational rehabilitation in community mental health care: Symptom, psychosocial and service utilization outcomes.

Appendix 2 **Key informant's co-occurring disorders-related publications**
Dr. Paul Gorman

Essock, S., Goldman, H., Van Tosh, L., Anthony, W., Appell, C., Bond, G., Dixon, L., Dunakin, L., Ganju, V., Gorman, P., Ralph, R., Rapp, C., Teague, G., Drake, R. (2003) Evidence-based practices: Setting the context and responding to concerns. Psychiatric Clinics of North America. Vol 26(4) Dec. 919-938.

Torrey, W., Drake, R., Cohen, M., Fox, L., Lynde, D., Gorman, P., Wyzik, P. (2002) The challenge of implementing and sustaining integrated dual disorders treatment programs. Community Mental Health Journal. Vol 38(6) Dec., 507-521.

Goldman, H., Ganju, V., Drake, R., Gorman, P., Hogan, M., Hyde, P., Morgan, O. (2001). Policy implications for implementing evidence-based practices. Psychiatric Services. Vol 52(12) Dec. 1591-1597.

Rosenberg, S., Mueser, K., Friedman, M., Gorman, P., Drake, R., Vidaver, R., Torrey, W., Jankowski, M. (2001). Developing effective treatments for posttraumatic disorders among people with severe mental illness. Psychiatric Services. Vol 52(11) Nov. 1453-1461.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GJC-12

This is the attachment marked '**GJC-12**' referred to in the witness statement of Gary James Croton dated 21 May 2020.

Dual Diagnosis:
The Journey, Not the destination
2019

This program was a systematic professional development program for Mildura service sector; supporting an integrated care system approach supporting people with a dual diagnosis and complex care needs.

JILL GLEESON
DUAL DIAGNOSIS CONSULTANT
KEL ROBERTSON
PSYCHIATRIC NURSE CONSULTANT

The Journey: Not the Destination.

Location: Mildura Victoria

May-June 2019

Abstract: The Journey: Not the destination is a Mildura, interagency workforce development strategy focused on a systematic approach towards an integrated care system for people with dual diagnosis and complex care needs. The project provided mental health and alcohol & drug education, interagency case planning and inter-service awareness to support workers progress towards a more inter-sectoral service delivery system. The project was developed within a recovery-oriented framework supporting best practice and the National framework for recovery oriented mental health services (2013) identified principles of uniqueness, choices, attitudes rights, dignity respect, partnerships and communication.

This approach supports the Kenneth Minkoff comprehensive, continuous, integrated system (CCISC) model. Minkoff's model focus is 'to be more about the needs of the individuals and families needing services and the values that reflect welcoming, empowered helpful partnerships throughout the system'. Minkoff & Cline 2004)

AIM:

The workforce development strategy aimed to enhance the collaborative interagency response to service users with a dual diagnosis and complex needs, by providing improved knowledge supporting positive inter-service relationships, positive culture and cooperation utilising a collaborative practice model.

OBJECTIVES:

Increase Inter-agency dual diagnosis knowledge, through Mental Health and Alcohol and Other drugs education within the Mildura area.

Encourage inter-service collaboration and information sharing

Enhance inter-service relationships

Improve Inter-service referrals and coordination

Support positive cultural changes

Support recovery focus approach across the sector.

Improve interagency information sharing.

Introduction: The Mildura interagency education and case plan workforce development project was developed to support stake holder agencies across the Mildura area, already involved in the dual diagnosis service. The project initially provided regular Mental Health and Alcohol and Drug education sessions and culminated in the presentation of a complex case study identifying current and future service improvement strategies utilising a recovery focus approach.

Background

This workforce development strategy has been driven by the Mildura Base Hospital: Mental Health Dual Diagnosis consultant and Psychiatric Nurse Consultant, on the back of already existing community development processes of the Dual Diagnosis Service.

The Mildura district Dual Diagnosis service has regularly maintained networking between stake holder agencies through the Interagency working party and the Interagency Orientation Program.

The participating stakeholder agencies consisted of Mildura Base Hospital Mental Health Services, Mallee Family Care Community Managed Mental Health, Headspace Mildura, Sunraysia Community Health Drug Treatment Services, Mallee District Aboriginal Services Emotional Health & Wellbeing, Mallee Accommodation and Support Program.

The Dual Diagnosis working party meets intermittently to support interagency relationships, programs and integrated processes.

The Interagency orientation program supported by the Dual Diagnosis working party, is a tour of agencies scheduled every 3 months. This provides an opportunity for new and existing workers from all the stake holder agencies to join a tour which assists participants to identify where the agencies are located, what the agencies provide, meet staff and hear about what services provide, and identify referral processes.

The Dual Diagnosis interagency education and case plan workforce development project stemmed from the already existing programs and the perceived need that we could work better together with increased knowledge, confidence, relationships and everyone working towards a common goal of recovery focused practice.

What we did

We developed a Mental Health, Alcohol & Drugs and Complex Needs education, local Services development program, followed by a case planning exercise. Each of the five sessions were 1.5 hours duration.

The topics included Dual Diagnosis, and the local Alcohol & Drug landscape, Substance Induced Psychosis & Anti-psychotics, Bipolar and mood stabilizers, Depression & Antidepressants, Anxiety & Ani-anxiolytics, personality disorders and Trauma.

Each session included a dual diagnosis case plan and service information session provided by stakeholder services.

The final session was a complex case plan that included a scenario that included ten agencies representing the relevant stakeholder services participating.

A certificate of attendance was provided to all participants that attended 4 or more sessions.

Session number and topic.

Session	Date (Time: 11.15am-12.45pm	Topic	Presenters	Agency Information session
1	28/05/19	Dual Diagnosis Introduction (stage of change) AOD the current Landscape DD case scenario	Mental Health Sunraysia Community Health Services (SCHS)	Mental Health SCHS
2	4/06/19	Psychosis (substance induced) Bipolar DD Case Scenario	Mental Health	Mallee Accommodation Support Program
3	11/06/19	Depression Anxiety DD case scenario	Mental Health SCHS	Mallee Family Care
4	18/06/19	Personality Disorders Trauma DD case scenario	Mental Health SCHS	Mildura District Aboriginal Services
5	25/06//19	Larger complex case study	Mental Health, Orange Door & all stakeholder services	Nil

Participating Agencies Attendance: Education Session & Case Plan

Session	Date	MHS	MASP	MFC	SCHS	MDAS	Christie Centre	Orange Door	Total
1		6	3	9	1	6	1	0	**26**
2		5	3	3	0	8	3	0	**22**
3		6	2	10	1	6	2	0	**27**
4		5	1	8	1	5	1	0	**21**
5		7	3	10	3	9	1	1	**34**
Total		**29**	**12**	**40**	**6**	**34**	**8**	**1**	**130**

How we evaluated it:

1: A pre and post evaluation of Dual Diagnosis form was completed at the first and last sessions. (Appendix 1)

2: Mildura Base Hospital Education Evaluation form was completed following each education session by attendees. (Appendix 2)

3: A feedback session was held at the next Dual Diagnosis Interagency working party.

Pre and post evaluation findings:

The average differential knowledge Improvement 87.5%

The Average program met expectations Improvement 84.2%

The Average change of practice 70.6%

Post evaluation comments:

Great presentation enjoyable

Very helpful perhaps more opportunity for networking would be helpful

This was an excellent program

Gives you a good insight into different illnesses and treatments

A great opportunity to meet with other local services and learn more about those services.

Fantastic presentations on DD and services locally would love to see this style of education drive more collaborative relationships with local services

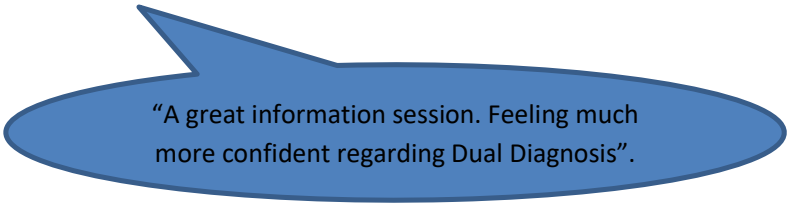
Education like this should be mandatory.

Responses from the sessional feedback forms:

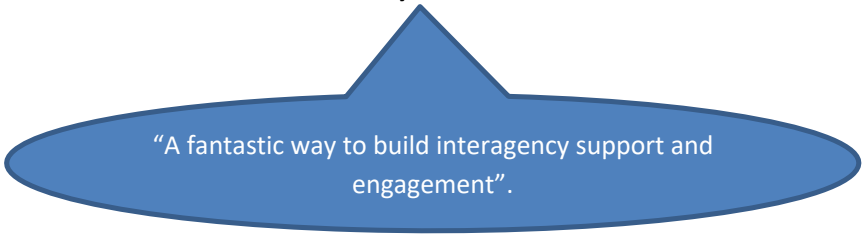
There was an overwhelmingly positive response from all 5 individual education sessions. (evaluation form Appendix 1)

Some comments from the feedback sheets

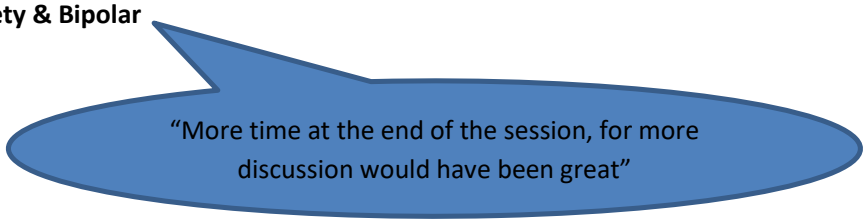
Session 1: Dual Diagnosis Introduction and the AOD Current Local Landscape.



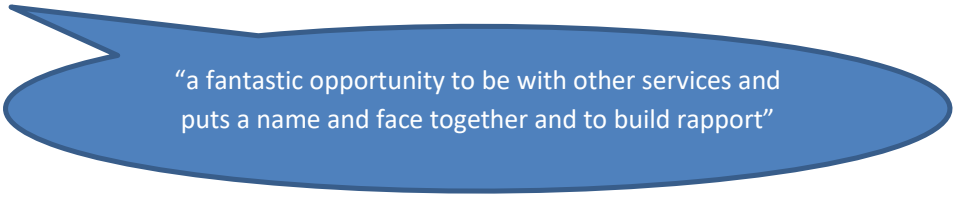
Session 2: Substance Induced Psychosis



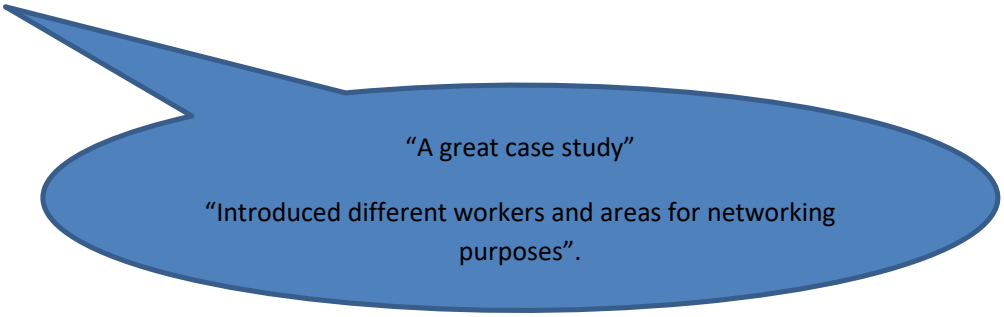
Session 3: Depression Anxiety & Bipolar



Session 4: Personality Disorders and Trauma



Session 5: A larger complex Case Study



Feedback from Dual Diagnosis Interagency Working Party (Managers and Team leaders):

MASP: Very good for new staff, Reports that staff have put some of the training into practice. The staff appreciated the service collaboration approach and opportunity to work with other services and improved confidence in working with clients with a DD and other services.

MASP workers would like future education re MH treatment and medication. Suggestion: prior to case plans that all services be briefed on the case plan so there are no surprises.

MDAS: Staff that attended reported the program was very good. The networking and finding out about other services were good, it broadened knowledge and increased confidence. Particularly around working in coordinated practice and increased awareness of other services.

MFC: Great re assisting with referrals to other services, good MH information and service information. Great case plan. Suggestions that next session each service run a session and provide a case study with a panel of reps from relevant services.

MBH: to provide future session re Mental Health what to ask re risks, Info re when to refer to who, GP MH plan, MH practice tips.

Where to from now:

- Report to Interagency DD working Party to further plan integrated service opportunities and to monitor changes in practice.
- The Dual Diagnosis Interagency working party has committed to participate in further Dual Diagnosis education, case planning to ensure a focus of putting Dual diagnosis theory into best collaborative practice continues.
- To conduct and support annual dual diagnosis training sessions, particularly for new staff from participating agencies.
- Support Mental Health First Aid for stakeholder agencies in a response to expand the following Mental Health knowledge base.
- Submit to Mildura Base Hospital Quality improvement awards.

> The challenge for a holistic health care approach to comorbidity is in the active engagement of multiple services and service providers, with a mixture of professional and non-professional support. (NDARC Guideline Co-occurring alcohol & mental health conditions in AOD treatment settings. 2016)

Facilitators Reflection & Recommendations

This innovative Workforce development strategy supporting a recovery focus practice was an effective method to enhance cross sectoral collaboration in the local area.

There was a commitment from the Dual Diagnosis Interagency working party which in turn supported the program to proceed. The number of participating agencies demonstrated the commitment to, effective knowledge sharing, integrated service delivery and the importance of a recovery focused practice across the service sector. The evaluation process demonstrated the participants appreciation of the program education and case plan process.

This program enhanced inter-service relationships with significant numbers attending and actively participating in the case plan process. There have been several requests for ongoing interagency education, case plan and other activities.

The process has seemed to spark an interest from mental health staff wanting to learn more about other agencies. Given that this is a dedicated program to support integrated practice it clearly qualifies as a Quality improvement program.

The program fits within the mental health workforce strategy Vic Gov. as a workforce innovation program.

Cross Sector Collaboration- to support the identification and implementation of new and innovative ways for workers to collaborate across sectors to improve service integration.

Mental Health workforce strategy Gov. Vic DOHHS July 2016

Conclusion:

The Journey not the Destination continues to be an evolving workforce development strategy amongst the key local agencies supporting people with a dual diagnosis and complex needs.

The project has strived to inform, educate and support improved integrated practice with the collaboration of supporting services.

The back bone of this project has been the support and nurturing of good trusting relationships amongst services and their workers, supporting the need for a multi-faceted approach to provide a streamlined best practice delivery of service.

A recovery oriented approach across the sector puts service workers in the same boat with their clients, families and carers providing an integrated united focus on the needs of individuals, families and carers.

We need to strive towards improved organisation of service systems. The quality of care will rely on service delivery systems addressing integrated approach within policy, program, procedures and practice levels. Inter-service relationships will require ongoing support to further enhance the quality of care utilising an integrated recovery focused philosophy.

References:

A National Framework for recovery-oriented mental health services. Commonwealth of Australia 2013

The Comprehensive, Continuous, Integrated System of Care (CCISC) process (Minkoff & Cline, 2004, 2005)

NDARC: Guidelines on the management of Co-occurring alcohol & mental health conditions in AOD treatment settings. 2016 Australian Government Department of Health.

Appendix:

1: Pre and Post Self Evaluation of dual Diagnosis

2: Mildura Base Hospital Education Evaluation form.

Appendix 1: Pre and Post Self Evaluation of Dual Diagnosis

Please complete this self-assessment form before the education program and after the completion of the program

Pre-Program Assessment

1=low- 5=high

1. What do you rate your current knowledge of dual diagnosis (DD)? 1 2 3 4 5 (please circle)
2. What do you rate your knowledge of local Mental Health and AODT services? 1 2 3 4 5 (please circle)
3. What would you rate your confidence in working with DD clients? 1 2 3 4 5 (please circle)
4. What would you rate your confidence in working collaboratively with other agencies?

   1 2 3 4 5 (please circle)
5. How do you rate your practice of referral to other Mental Health and AODT services?

   1 2 3 4 5 (please circle)
6. Please describe Briefly what you expect to get from this education program?

Post Program Evaluation

1. How many sessions have you attended? 1 2 3 4 5
2. What do you rate your current knowledge now of dual diagnosis (DD)? 1 2 3 4 5 (please circle)
3. What do you rate your knowledge now of local Mental Health and ADOT services? 1 2 3 4 5 (please circle)
4. What would you rate your confidence now in working with DD clients? 1 2 3 4 5 (please circle)
5. What would you rate your confidence now in working collaboratively with other agencies?

   1 2 3 4 5 (please circle)
6. How do you rate your practice now of referral to other Mental Health and AODT services? 1 2 3 4 5 (please circle) 7. Did the program meet your expectations?

   1 2 3 4 5 (please circle)
8. Has this program changed your practice?

   1 2 3 4 5 (please circle)
9. Please make any comments regarding the Dual Diagnosis Education Program?

Appendix 2:

MILDURA BASE HOSPITAL | RAMSAY HEALTH CARE

Education Evaluation Form

Mildura Base Hospital seeks to evaluate and improve education services. We value your response to this short survey.

Topic: Dual Diagnosis Training_____ Date:25/6/19

Speaker/Facilitator: Kel/Jill_____ Location: Headspace_____

Please rate the level to which you agree with the following statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. The session was held at a suitable date and time	1	2	3	4	5	N/A
2. There was enough time allocated for the session	1	2	3	4	5	N/A
3. The venue was suitable for this session	1	2	3	4	5	N/A
4. I Was assisted by organisers when required	1	2	3	4	5	N/A
5. The session had a good facilitator	1	2	3	4	5	N/A
6. The session content was relevant	1	2	3	4	5	N/A
7. The presentation was well conducted	1	2	3	4	5	N/A

Please circle Yes or No for the following questions

8. Yes No

There were gaps in the information provided at this program:

IIf Yes, please list:

9. There are additional education topics that I would like presented Yes No

If Yes, please list: _____

_____

10. Further Comments: _____

_____

Thank You Please return completed surveys to Kell or Jill