IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT 'LB-1' TO STATEMENT OF LEANNE BEAGLEY

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This is attachment **'LB-1'** produced and shown to **LEANNE BEAGLEY** at the time of signing her statement on 9 October 2015.

Attachment LB-1

Turning Point
Alcohol & Drug Centre

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:

easternhealth SUMITT

SDDS Southern Dual Diagnosis Servs

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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

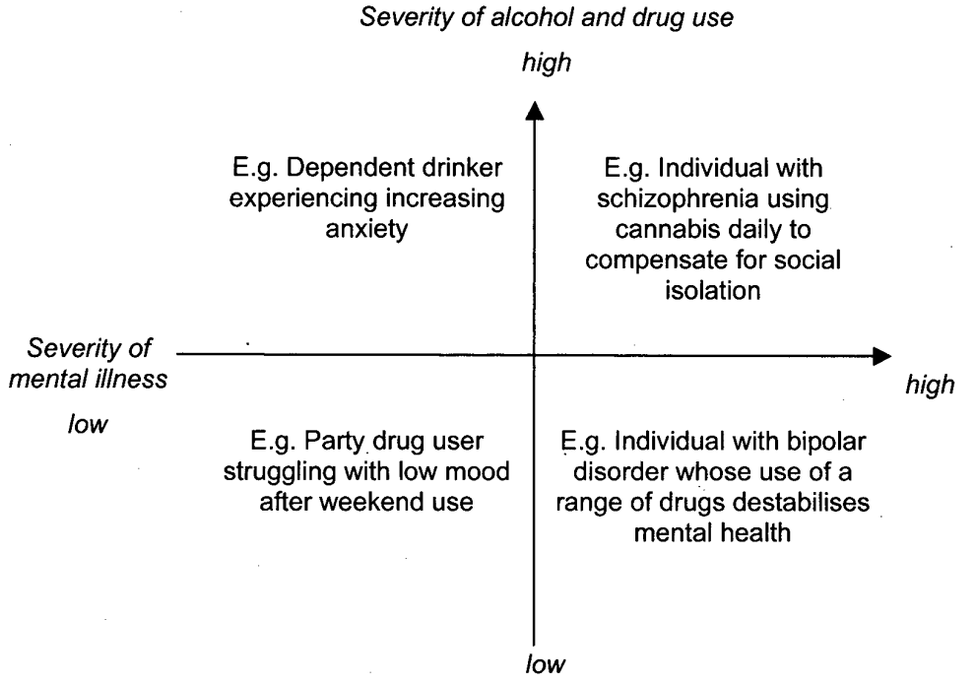
- Mental health and alcohol and drug disorders contribute 20% to the burden of disease in society
- Among people aged 15-24 these disorders form nine out of ten leading causes of the burden of disease in males and eight out of ten in females.
- Dual diagnosis is the rule rather than the exception among 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.

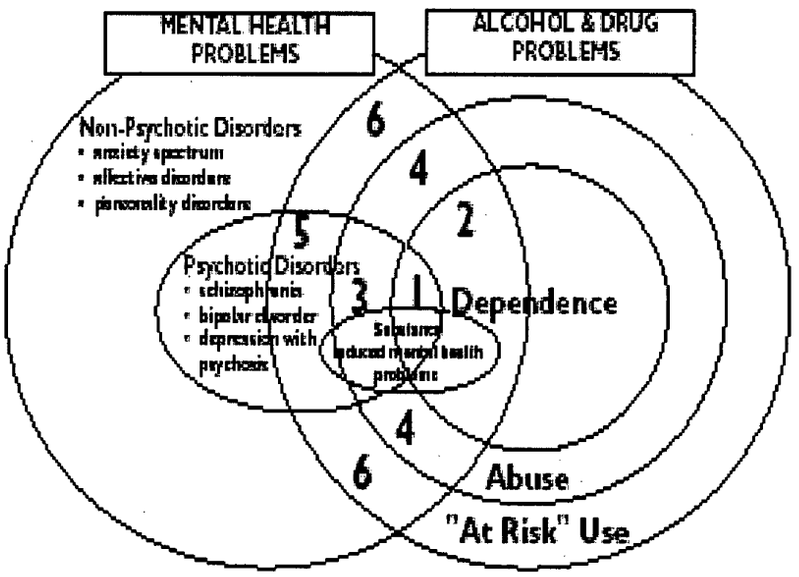
Figure 1: dual diagnosis matrix



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

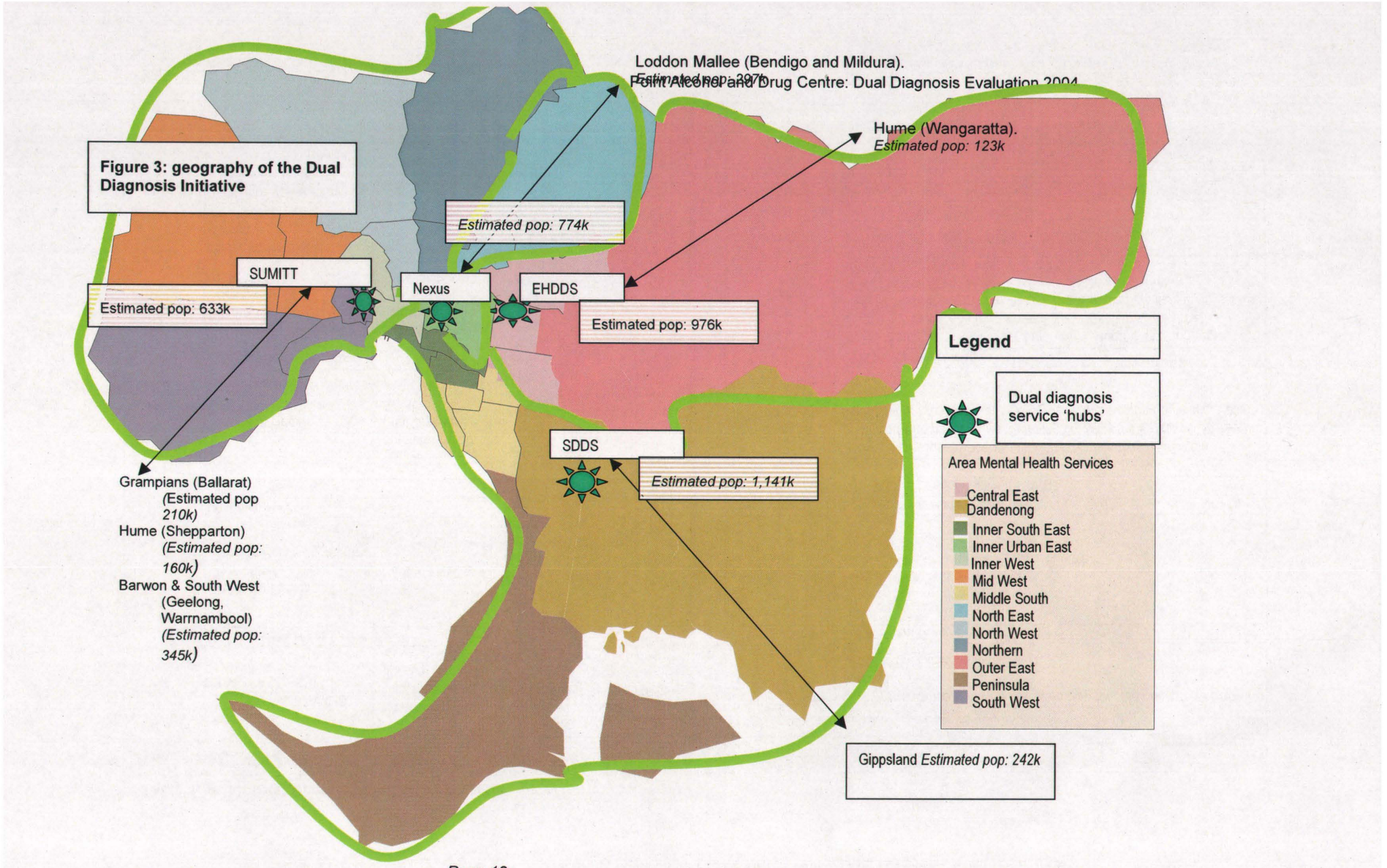


Figure 3: geography of the Dual Diagnosis Initiative
Loddon Mallee (Bendigo and Mildura).
Estimated pop: 297k
Hume (Wangaratta).
Estimated pop: 123k
Estimated pop: 774k
SUMITT
Nexus
EHDDS
Estimated pop: 633k
Estimated pop: 976k
SDDS
Estimated pop: 1,141k
Grampians (Ballarat) (Estimated pop 210k)
Hume (Shepparton) (Estimated pop: 160k)
Barwon & South West (Geelong, Warrnambool) (Estimated pop: 345k)
Gippsland Estimated pop: 242k
Legend
Dual diagnosis service 'hubs'
Area Mental Health Services
Central East
Dandenong
Inner South East
Inner Urban East
Inner West
Mid West
Middle South
North East
North West
Northern
Outer East
Peninsula
South West

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.

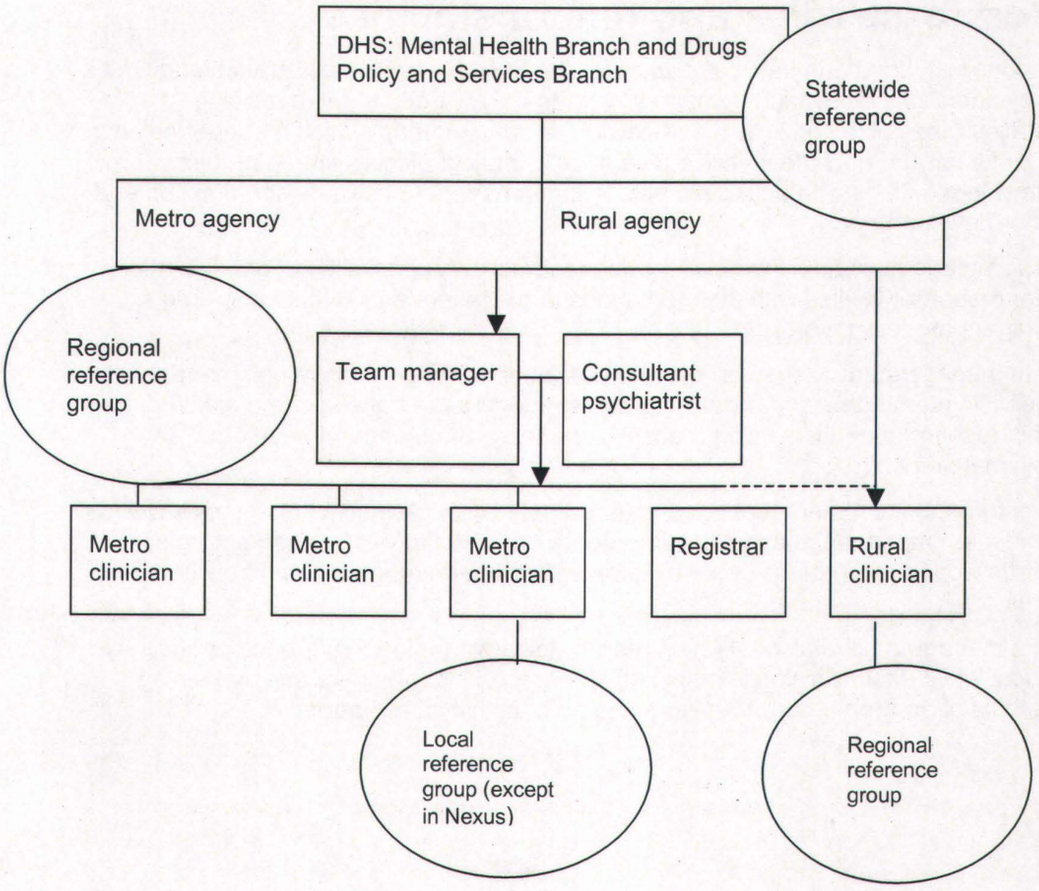
Auspicing agencies hold financial and management responsibility. In practice, the major responsibility lies with the mental health managers and alcohol and drug managers are less involved.

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

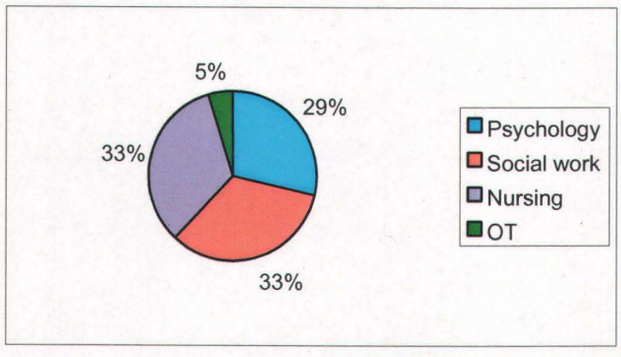


Workforce profile

Professional backgrounds

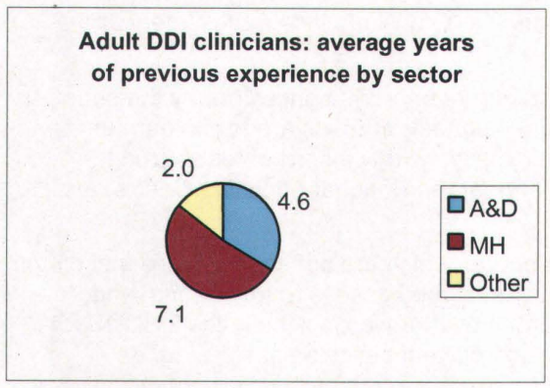
Clinicians' professional backgrounds are clinical or counselling psychology, nursing (principally psychiatric nursing), social work and (in a small minority) occupational therapy. There are three consultant psychiatrists contributing a limited number of weekly sessions.

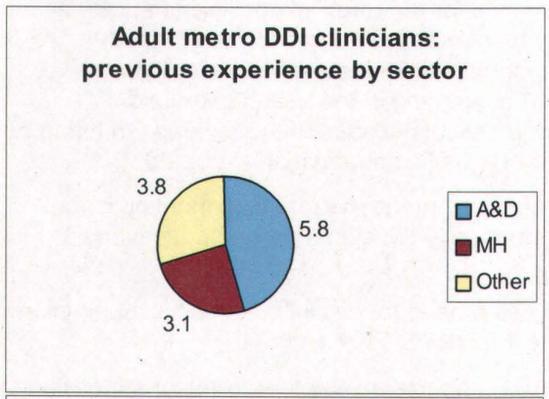
Figure 5: adult clinicians – first qualifications

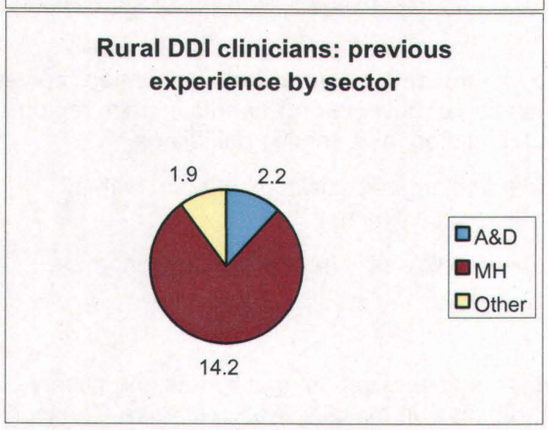


Staff were asked about their work experience.

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'.

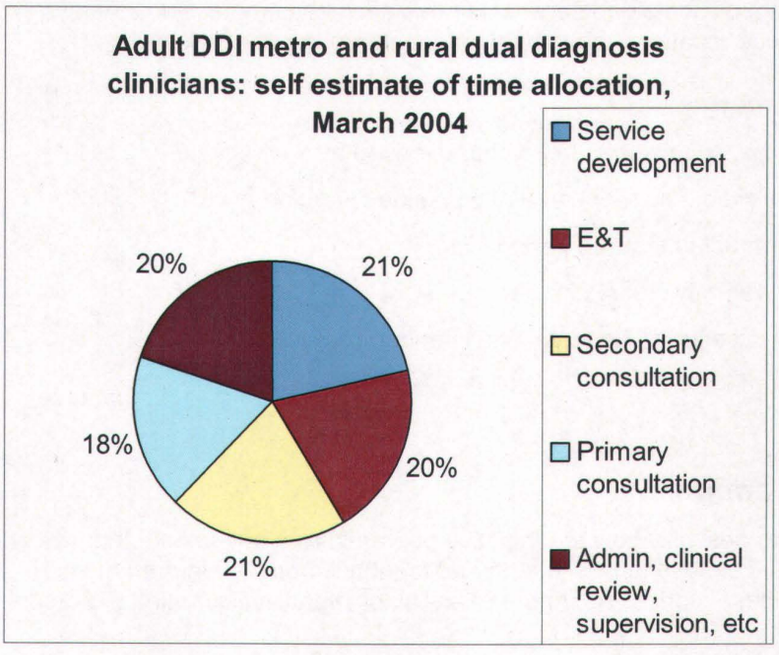
Balancing different elements

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

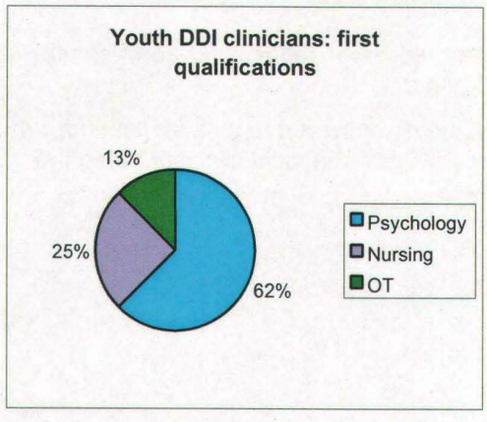
A shaded box indicates that a position has been occupied in the period indicated.

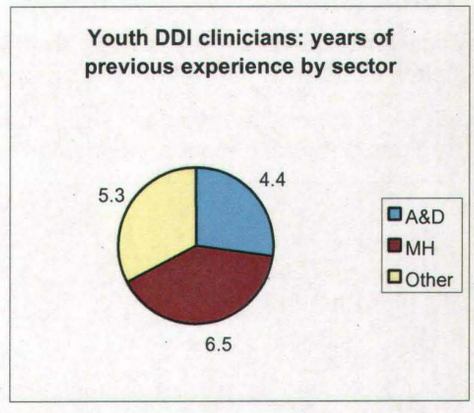
Team	EFT	Catchment	Jan-Mar 03	Apr-June 03	Jul-Sept 03	Oct-Dec 03	Jan-Mar 04	Apr-June 04
EHDDS	1	Eastern CAMHS, North East Hume						
Nexus*	2	North Eastern CAMHS Loddon Mallee			New			
							New	
SDDS	2	Inner Southern CAMHS, South East CAMHS, Gippsland					New	
SUMITT	3	North Western CAMHS Barwon and 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

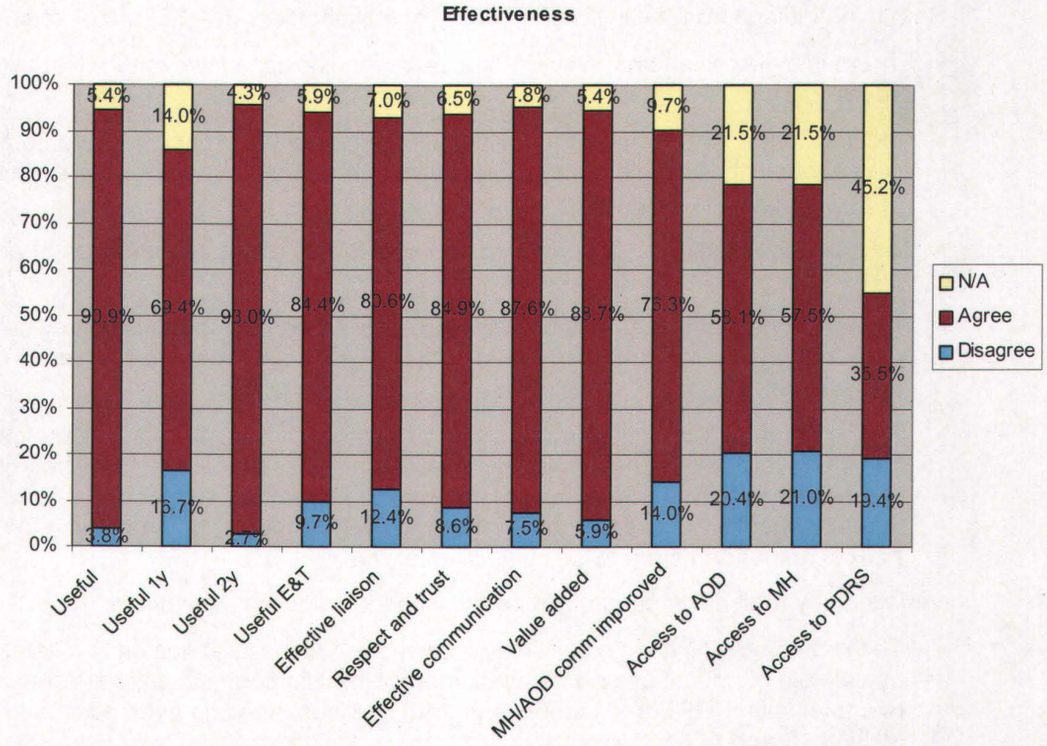
Summary findings from analysis of a survey of stakeholders (n=186) are as follows:

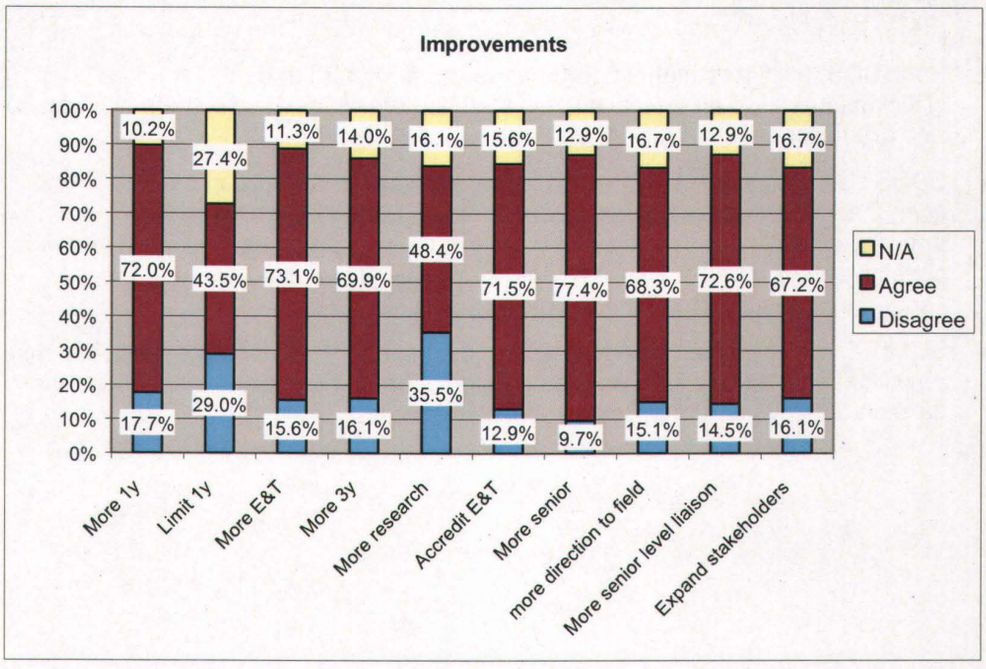
- There is a perceived improvement in dual diagnosis capacity over the last two years.
- Most stakeholders perceive the Initiative to be useful (90.9 per cent) and 88.7 per cent agree with the statement 'I have a strong belief in the value added by the dual diagnosis initiative to my service.'
- Secondary 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