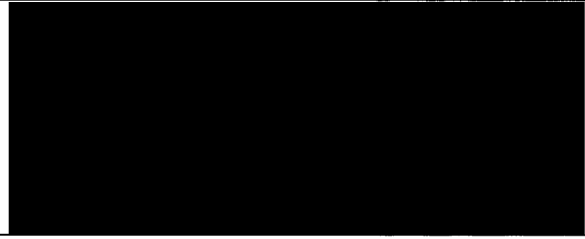


**IN THE MATTER OF THE ROYAL COMMISSION
INTO FAMILY VIOLENCE**

ATTACHMENT 'LB-2' TO STATEMENT OF LEANNE BEAGLEY

Date of Document: 9 October 2015
Filed on behalf of: State of Victoria
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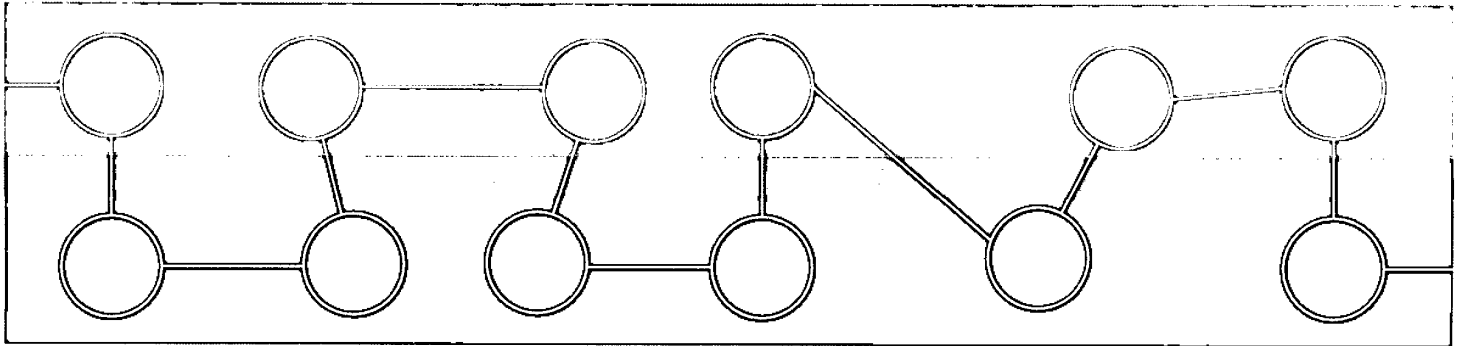


This is attachment '**LB-2**' produced and shown to **LEANNE BEAGLEY** at the time of signing her statement on 9 October 2015.

Attachment LB-2

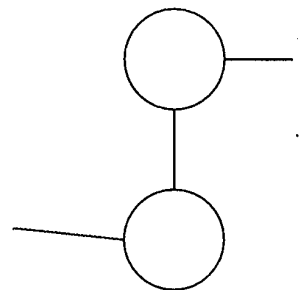
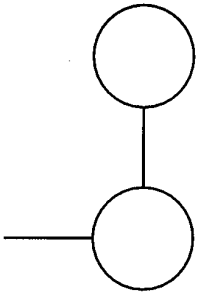
Dual diagnosis

Key directions and priorities for service development



Dual diagnosis

Key directions and priorities for service development



Acknowledgements

This document has been developed in consultation with the Dual Diagnosis Subcommittee of the Ministerial Advisory Committee on Mental Health (2005).

Particular thanks goes also to those who have given of their time and shared their experiences in providing information about the consumer and carer experience.

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Foreword

A Fairer Victoria: progress and next steps (2006) highlights the Bracks Government's commitment to improving outcomes for people with both mental health, and alcohol and drug problems.

People experiencing these dual problems are at increased risk of a range of poor outcomes including serious physical illness, social isolation, self-harm and suicide. In recent years research has demonstrated important links between substance use and mental illness. Our service providers have also noted an increase in the frequency of co-morbidity and the adverse impact this has on response to treatment and speed of recovery.

Use of illicit substances in the context of mental illness also increases the likelihood of other difficulties such as unstable housing, disrupted family relationships and unemployment. A dual diagnosis approach aims to treat mental health and drug and alcohol problems without sending the patient from one facility to another. This 'no wrong door' approach is essential to make it easier for people of all ages to access quality treatment and care. This approach will assist people to get their lives back on track, by giving them the treatment they need when they need it.

Leaders from both mental health and alcohol and other drug sectors have worked closely with consumer, carer and Indigenous representatives and others to prepare these key directions and priorities for service development. This document, *Dual diagnosis: Key directions and priorities for service development*, takes into account their work, describing the next steps to be taken in improving the provision of treatment and care. It helps specialist mental health and alcohol and other drug services to work together towards the goals and outcomes that have been agreed with consumers and carers detailed in the action plan at the end of this document.

The Bracks Government's aim is to give people the best possible access to the best care, as early as possible. To achieve this the government has recognised the need for, and invested in, service infrastructure to address dual diagnosis. More than \$30 million has been provided in the last five years for dual diagnosis service enhancements. This funding has established dual diagnosis teams as integral supports within both mental health and alcohol and other drug services across the State. While expanding direct care capacity, these teams also assist staff in each sector to respond to the often complex needs of dual diagnosis clients through consultation and education and training.

Dual diagnosis positions established within mental health mobile support and treatment teams and within youth residential rehabilitation services have bolstered the capacity of staff in these programs to provide quality care. More recently, funding has been provided to expand psychiatrist input and the education and training capacity of the dual diagnosis teams through a statewide education and training unit. More than 150 staff from mental health and alcohol and other drug services are also being offered job placements in the other sector as part of a joint professional development and leadership program.

Now it is time to further demonstrate Victoria's leadership in dual diagnosis treatment and care in Australia. I look forward to working with all of you in this important endeavour.



Hon Lisa Neville MP
Minister for Mental Health

A family's experience

At about age 15, my nephew seemed to change almost overnight. He was a handsome, intelligent, capable, sociable young man who quickly became aggressive, rude, withdrawn and uncooperative. Initially I thought it was a 'phase' or perhaps 'his friends'. I convinced my sister to approach the local doctor with her son and ask for a drug test to be done. The doctor did not support the concern about drug use. He suggested relationship counselling. The relationship counsellor suggested my sister 'let go' of her son, inferring that my sister was the only problem.

My nephew had his first psychotic episode at about 18 years of age as a result of a large dose of speed (amphetamine) taken recklessly. He was advised not to use illicit drugs and was given some medication, which he used for a while but stopped because of unpleasant side-effects (drowsiness, nausea and weight gain). Over the years his drug use continued and so did the psychotic episodes. He had numerous admissions to six different hospitals. He saw a very large number of doctors and large numbers and amounts of medication were prescribed. Over the years my sister and I begged and pleaded with doctors, nurses and social workers to recognise the connection between his drug use and his hospital admissions. Each psychotic episode was associated with the use of illicit drugs. After each hospital admission he was discharged with more medication, a new case manager and no attempt to address the problems associated with drug addiction.

My sister tried on a number of occasions to get help from alcohol and other drug services; however, apparently my nephew was not at 'rock bottom'. Unfortunately he was uncooperative with rehabilitation programs and other services offered. Unfortunately for a person with a mental illness 'rock bottom' may be too late. The person is in grave danger long before they have any ability to ask for help. My sister's despair and fear were ignored as were my concerns.

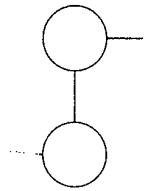
My sister was not trying to be difficult. She wrote to psychiatrists arguing that it seemed irrational for a person to be 'certifiable' for five days but then expect the same person on the sixth day to make a responsible choice regarding their wellbeing, particularly when evidence and past experience proved that the person would exit the hospital with a medical certificate, a large amount of prescribed medication, return to drug addicted friends and end up back in hospital in a matter of weeks or months. My sister also spoke to case managers often, warning of an impending psychosis and they usually dismissed her concerns and assured her that my nephew had told them he was not feeling unwell and not experiencing any early warning signs.

During this painful time my sister did not lose faith in her son. She did however lose faith in the system that was her only source of potential help.

Things changed when my nephew finally was appointed a case manager who had been trained in dual diagnosis. This person had recent training and was able to provide the strength to address the addiction issues and the sensitivity to establish a relationship with my nephew. This relationship was his life-line and over the next two years he gained sufficient insight to make some of the necessary changes in his life. He completed a drug rehabilitation program and with the support and encouragement of his case manager has been able to be drug free and psychosis free for more than five years. My sister and I are eternally grateful for the help and support that was eventually forthcoming; however, I believe that there are some serious issues regarding 'dual diagnosis'. These issues must be addressed by both alcohol and other drug services and by mental health services, working cooperatively together under the supervision of those people who have knowledge and experience with 'dual diagnosis'.

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Introduction

In Victoria, as in other parts of the world, mental health and alcohol and other drug services are working with increasing numbers of people who are experiencing both mental health and drug and alcohol problems and disorders. The co-occurrence of these problems and disorders (dual diagnosis) adds complexity to assessment, diagnosis, treatment and recovery, and is known to increase the risk of relapse.

The prevalence and complexity of dual diagnosis requires an integrated approach to assessment and treatment delivered as 'core business' within specialist mental health and alcohol and other drug services.

Delivering responses to dual diagnosis clients as part of core business in each sector ensures that people of any age are not excluded from a service because of their dual problems. It also requires that their needs are addressed within the most appropriate service setting, by suitably trained staff and that the treatment and care that they receive is best practice.

Area mental health services (AMHS), Psychiatric Disability Rehabilitation and Support Services (PDRSS) and Alcohol and Other Drugs Services (AODS) supported by Dual Diagnosis Teams have already taken some important steps in this direction.

While this early work has raised awareness about the importance of dual diagnosis and examples of good practice are emerging, a more systematic implementation of integrated approaches across both service sectors is essential if outcomes for these clients and their families and carers are to be significantly improved.

Scope of this paper

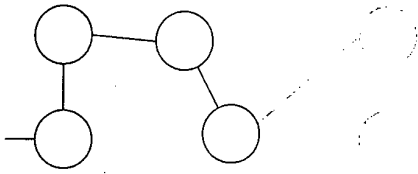
This document has been written to clarify priorities and directions for dual diagnosis service development in Victoria. It highlights current service delivery issues and provides guidance for service leaders and managers responsible for ensuring that dual diagnosis becomes core business within their services. For some this will mean continuing on with work already begun. For others, it will require refocusing effort onto dual diagnosis as a priority quality improvement activity within their services.

While not undervaluing the importance of prevention, the focus of this document is on improving services for those with existing problems. However, timely and effective treatment of either mental health disorders or drug and alcohol problems and disorders can, in themselves, be preventative in light of the increased risk of dual diagnosis for people with either disorder.

The merits of individual treatment approaches are also not discussed. Service leaders and experts in each sector have responsibility for ensuring that interventions are in accord with national practice standards and guidelines and reflect best practice. Consumer and carer involvement in the planning and evaluation of services is an essential element within these standards.

Actions required to implement the directions articulated in this document have been developed and agreed in consultation with the sectors and are provided in the Dual diagnosis action plan 2007-2010 at the end of the document. The plan highlights the key priorities that will be the focus of work over the next three years.

2 Dual diagnosis



What do we want to achieve?

This document promotes the development of a systematic approach to service provision through integrated assessment, treatment and care in both mental health and alcohol and other drug services, so that a person of any age experiencing dual diagnosis has timely access to quality treatment and support.

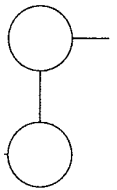
Integrated assessment, treatment and care may be provided by a clinician or treating team within the one service addressing both a person's substance use and mental health problems. It can also be provided by staff of separate agencies working together to agree and implement an individual treatment plan. This integration needs to continue beyond acute intervention and through recovery by way of formal interaction and co-operation between agencies in reassessing and treating the client.

The goals:

- The Mental Health Branch and Drugs Policy and Services Branch work with service leaders, advised by consumers and carers, to provide clear policy, funding and contractual arrangements that enable services to deliver quality dual diagnosis responses.
- Service leaders and managers within specialist mental health services (both clinical and PDRSS) and alcohol and other drug services work together with a common set of expectations and undertake local service developments that improve service access and quality for dual diagnosis clients.
- People experiencing dual diagnosis have improved outcomes, and their families and carers are better supported, through timely access to evidence-based treatment, recovery, rehabilitation and support provided by staff with the appropriate knowledge and skills.

Five service development outcomes underpin the achievement of these goals:

1. Dual diagnosis is systematically identified and responded to in a timely evidence-based manner as core business in both mental health and alcohol and other drug services.
2. Staff in mental health and alcohol and other drug services are 'dual diagnosis capable', that is, have the knowledge and skills necessary to identify and respond appropriately to dual diagnosis clients and advanced practitioners are able to provide integrated assessment, treatment and care.
3. Specialist mental health and alcohol and other drug services establish effective partnerships and agreed mechanisms that support integrated assessment, treatment and care.
4. Outcomes and service quality for dual diagnosis clients are monitored and regularly reviewed.
5. Consumers and carers are involved in the planning and evaluation of service responses.



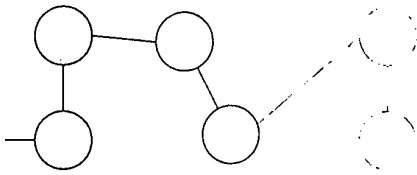
Why are we doing this?

In the last five years, a number of dual diagnosis service innovations have emerged, some of which have been supported by the Dual Diagnosis Teams. A strengthened focus and effort is required to ensure that those shown to be effective and sustainable become usual, rather than the exception, across the State and that innovative solutions to service barriers continue to be explored.

Integration of treatment and care, collaboration and innovation are required for the following reasons:

- Increasing numbers of people with dual diagnosis need and use services in each sector. Emergence of dual diagnosis difficulties is occurring at an increasingly younger age.
- Dual diagnosis is associated with poorer outcomes and increased risks to health and development over time if not treated early and effectively.
- Long-term benefits for individuals, their families and/or carers and communities can be achieved through the early recognition and timely treatment of serious health problems such as dual diagnosis.
- Services in each sector record significantly lower rates of dual diagnosis among those using their services than would be expected from census and population surveys. This raises a number of concerns about recognition and response to dual problems in services as well as the routine collection of data to inform service planning.
- Despite examples of good practice, mental health and alcohol and other drug services typically continue to provide segregated services, rather than integrated approaches to treatment and care, for dual diagnosis clients.
- System barriers that impede integration of treatment, care and recovery centrally at policy levels, and locally at service levels, need to be systematically addressed if outcomes for dual diagnosis clients are to be improved.

4 Dual diagnosis



Background information

Dual diagnosis

'Dual diagnosis' or comorbidity is a generic term referring to the co-occurrence of disorders suffered by an individual. Comorbidity of mental disorders and substance use disorders is widespread, particularly among young people.

People with mental health problems and disorders may use alcohol and/or other drugs intermittently or continuously and for reasons that are similar to people in the broader community, that is, to socialise, for enjoyment or to alter their mood. They also sometimes use substances to reduce symptoms of their illness or the unwanted effects of their medication. Self-medication, however, is usually not reported as the main reason.

Many people with drug and alcohol problems have a range of mental health problems at higher rates than in the general community, most commonly depression and anxiety. Alcohol and drug use is also increasingly common among those experiencing psychosis and other serious mental disorders.

The type, intent and frequency of drug use, the nature and severity of illness, the age of the user, and the physical and social impact of either or both disorders, all contribute to and expand the scope of problems and complexity of diagnosis.

Illicit drug and alcohol use typically worsens mental health problems even where the frequency and intensity of use do not meet the criteria for a substance use disorder. Dual diagnosis is, therefore, generally understood as one or more diagnosed mental health problems occurring at the same time as problematic drug and alcohol use or vice versa.

A useful summary of the relationship of mutual influence that occurs between mental illness and alcohol and drug use is:

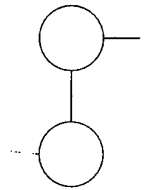
- a mental health problem or disorder leading to or associated with problematic alcohol and other drug use;
- a substance use disorder leading to or associated with a mental health problem or disorder; and
- alcohol and/or other drug use worsening or altering the course of a person's mental illness.

Dual diagnosis is still very much an evolving field, both in terms of understanding causal relationships and effective strategies for prevention, treatment and recovery.

Prevalence

As highlighted, co-occurring substance use is common rather than exceptional among people with serious mental health problems and disorders. The low prevalence study of the *National Survey of Mental Health and Well-Being* (1999) found that nicotine was the most commonly used drug (67 per cent over the last 12 months) among those experiencing psychotic disorders. This was followed by alcohol use disorder (30 per cent lifetime prevalence) and cannabis use disorder (25 per cent).

In a census of registered clients in Victoria's specialist mental health services conducted in 2002, staff reported up to 45 per cent of clients with dual diagnosis. This figure is consistent with national and international surveys of similar population groups.



The prevalence of dual diagnosis is, however, hard to assess in the broader population because of its highly variable presentation across age groups and definitional difficulties related to the criteria for a 'disorder'. Nevertheless population health research shows even higher rates (up to 50 per cent) of alcohol and drug use among people with severe mental health problems. Depression and anxiety are the most prevalent disorders co-occurring with drug and alcohol misuse although rates of drug use among people with psychosis are also high.

Impacts

Dual diagnosis is typically associated with poorer outcomes across a number of key life domains. Both the signs and symptoms of the disorders themselves, as well as associated disabilities, can have far-reaching and enduring consequences.

Research suggests¹ that when compared with those experiencing a single disorder (a mental illness or a substance use disorder), people experiencing dual diagnosis have higher rates of:

- severe illness course and relapse
- violence, suicidal behaviour and suicide
- infections and physical health problems
- social isolation and family/carer distress
- service utilisation
- antisocial behaviour and incarceration
- homelessness.

Young people with dual diagnosis are particularly at risk of poor outcomes because their age and stage of physical, neurological, psychological and social development makes them vulnerable.

Problematic drug and alcohol use is a major contributor to the poor health of Indigenous people, who are also particularly at risk with high rates of substance misuse.

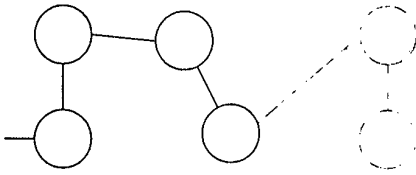
Patterns of drug use in older people are generally not well understood but can have accentuated and profound impacts because of an ageing physiology and reduced social interaction.

As well as differences across ages, the type and pattern of drug and alcohol use varies more broadly with culture, gender, peer group and social settings. These factors need to be taken into account in screening, treatment and management.

¹ Teeson, M and Proudfoot, H. Eds, (2003), *National Drug and Alcohol Research Centre, Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment, prepared for National Drug Strategy, Published by Commonwealth Department of Health and Ageing.*

Drake, R.E., Wallach, M.A., Alvenson, H.S., & Mueser, K.T. (2002) "Psychosocial aspects of substance abuse by clients with severe mental illness". *Journal of Nervous and Mental Disease*, 190, 100-106.

6 Dual diagnosis



Service recognition and response

Recognition and reporting of dual diagnosis by staff in mental health and alcohol and other drug services is variable and currently appears to be more related to individual worker knowledge and interest rather than systematic identification as part of core service assessment practices. Analysis of the reporting of dual diagnosis in RAPID (Victoria's central clinical mental health service database) shows that there is notable variance across services. Rates of dual diagnosis reported are significantly less than those expected from population prevalence data, service census data, research findings and clinical observation by staff.

Staff report rates of dual diagnosis among those using adult specialist mental health services between 20 and 50 per cent (and even higher for young people). This is not however reflected in formal reporting mechanisms where data shows rates well below 10 per cent.

The highest reporting rates in RAPID are by the four services that auspice the Dual Diagnosis Teams. Data for 2004–05 shows the highest proportion of dual diagnosis clients were of involuntary status (between 35–44 per cent) who had been admitted to acute inpatient facilities.

Clients experiencing schizophrenia and mood disorders are more likely to be reported with a substance use problem. Although young people aged 16–24 years is the group for which substance use is reported most often, the data interestingly also shows a significant prevalence in older clients.

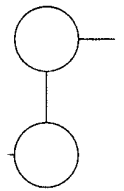
Some diagnostic information is collected regarding the use of PDRSS by clients with mental health and drug and alcohol problems but reporting compliance is also poor. Although only 30 per cent complete, the PDRSS data set indicates a high prevalence of drug and alcohol use among clients of 43.1 per cent.

Only small numbers of culturally and linguistically diverse and Indigenous clients were recorded as having a substance use disorder. This is most likely due to under-recognition and under-reporting and warrants further investigation.

It is likely that a range of factors contribute to this overall under-reporting within services, including poor identification of dual diagnosis, a narrow service focus on either mental health problems or drug and alcohol problems, poor data compliance, and different 'rules' for the recording of substance 'use' and 'disorder'.

Similar problems with under-reporting are evident in ADIS, the database used by drug treatment services.

Under-recognition can result in problems going unaddressed, a person being referred immediately to another agency or, even worse, falling into the gap between agencies and receiving no service at all.



Issues in treatment and recovery

Drug use and symptoms of withdrawal can mimic or conceal some psychiatric symptoms and symptoms of mental health problems can result from drug and alcohol use. Both disorders involve alteration of mental state so that management strategies should be tailored to someone who is cognitively impaired, possibly with poor reality testing, and who may not adequately recognise the seriousness of their condition.

Symptoms of mental illness can sometimes have their origins in alcohol and other drugs use, as substance use and processes that occur in withdrawal can resemble or hide symptoms of mental illness. Change in brain functioning can result in cognitive impairment. The change in mental state in both disorders requires the consideration of a treatment regime that one may consider for a person who is cognitively impaired, and with little insight into the nature and severity of their illness.

Effective management of dual diagnosis can be challenging in light of the increased complexity and risk. Dual diagnosis can bring with it exacerbation in challenging behaviours, including self-harm and aggression, avoidance of services, and resistance to and non-compliance with treatment and recovery programs. Those experiencing dual diagnosis can have long-lasting difficulties experiencing stigma, relapse and ongoing disability requiring services to invest in long-term care.

Importantly, innovations in treatment and recovery and new service models are demonstrating positive outcomes for dual diagnosis clients if problems are identified and responded to early and systematically².

Approaches to treatment and recovery

Just as complexity surrounds definition and diagnosis, so too are there difficulties in defining dual diagnosis best practice which continues to evolve. Models of care that are built on abstinence or harm minimisation can both be useful in different settings.

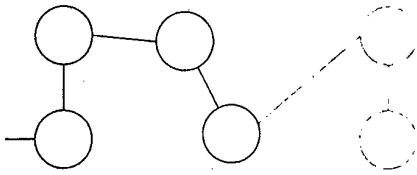
Community-based treatment services, for example, may promote a harm minimisation approach that focuses on minimising risk taking associated with substance use, whereas a residential detoxification unit or acute mental health inpatient unit will require abstinence. PDRSS will emphasise the psychosocial aspects of recovery and draw upon interventions more strongly aligned with this orientation.

Alcohol and other drug treatment services and mental health services sometimes have different perspectives on how best to respond to the needs of dual diagnosis clients and vice versa. Both sectors typically draw upon a broad bio-psychosocial framework which takes into account the influence of a range of factors known to be associated with mental health and drug and alcohol problems. Often differences between sectors relate to the emphasis on the factors that are seen as having the greatest influence on the development and persistence of problems and hence the model of intervention. Social and environmental determinants of health and wellbeing take a higher priority in the provision of alcohol and other drug services.

Such 'cultural' differences between services, while offering greater consumer choice, can hinder understanding and collaborative work across sectors. However, where evidence-based, different approaches add diversity and flexibility to service responses which can promote help seeking and engagement in treatment.

² Minkoff, K. (2001). 'Developing standards of care for individuals with co-occurring psychiatric and substance use disorders'. *Psychiatric Services*, 52(5), 597-599

8 Dual diagnosis



Consumer involvement in service planning and evaluation is a characteristic of good practice in each sector. Client-centred services which are built upon a sound therapeutic alliance (in which the merits and effectiveness of different treatment approaches are discussed) and in which the consumer is actively involved, significantly improves outcomes.

The policy and service development context

Improving the quality of both mental health and alcohol and other drug services is central to the Government's commitment to address inequality and disadvantage, and to improve overall health and wellbeing. The inclusion of dual diagnosis as one of three major areas for consideration by the Ministerial Advisory Committee on Mental Health in 2005 was recognition by Government of the importance given to work in this area.

The Victorian Government's priorities for the development of mental health services for consumers and their carers over the last four years have been outlined in *New directions for Victoria's mental health services 2002-2007*.

Six key directions were identified:

1. Expanding service capacity
2. Creating new service options
3. Extending prevention and early intervention
4. Building a strong and skilled workforce
5. Strengthening consumer participation
6. Improving carer participation and support.

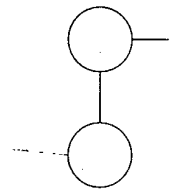
Work undertaken in strengthening dual diagnosis responses relates to all areas.

In relation to drug treatment services, over the last decade the Victorian Government has committed new funds towards expanding the range of services available in the alcohol and other drug sector. The current whole of government drug strategy *Improving health, reducing harm: Victorian drug strategy 2006-2009* was publicly released in February 2006. It aims to both strengthen existing services and to deliver a flexible and innovative range of service responses to drug and alcohol use in the Victorian community.

In Victoria, the Mental Health Branch and the Drugs Policy and Services Branch have been working together to better align policy and service development to promote integrated and innovative service models and to address administrative requirements and funding approaches that may impede service collaboration.

In November 2006, the Premier announced the creation of a new ministerial portfolio for mental health to further strengthen this collaboration. The new Minister for Mental Health oversees policy and service developments in both mental health and alcohol and drug treatment service sectors. The creation of this new portfolio reflects the high priority that Government accords to mental health and drug and alcohol matters, as well as the important relationship between these two policy and service areas.

This new ministerial portfolio has been complemented by the development of a new Mental Health and Drug Division within the Department of Human Services.



The initial SUMITT (Substance Use and Mental Illness Treatment Team) trial in the late 1990s, the subsequent development of the dual diagnosis teams and other funded dual diagnosis activities (MST and PDRSS Koori programs) have all been aimed at promoting the recognition of dual diagnosis as a part of core business in mental health and alcohol and other drug services.

In the May 2005 State Budget, the Government committed additional funding to further expand mental health and alcohol and other drug services. This included dual diagnosis specific service enhancements.

At the national level, the National Mental Health Plan, National Suicide Prevention Strategy, National Co-morbidity Project, and the National Drug Strategy all recognise dual diagnosis as an important area for further work.

The National Co-morbidity Project (a joint collaboration within the National Drug Strategy and the National Mental Health Strategy), reported on in 2001, aimed to identify appropriate strategies and policy responses nationally through workshops and the publication of related documents.

The Council of Australian Governments (COAG) has identified mental health as an important area for joint Commonwealth/State endeavour, specifically noting the importance of reducing substance use disorders.

The report *Improving Mental Health Outcomes in Victoria: The Next Wave of Reform* (July 2006) was commissioned by the Victorian Government to contribute to national discussions on mental health through the Council of Australian Governments in 2006. The Report identifies opportunities for systematically improving mental health care, including the importance of increased investment in mental health services, a stronger focus on youth mental health and the importance of early intervention.

Work will continue at the central policy and program level to identify and address obstacles to service collaboration. This will include consideration as to how new Commonwealth funded COAG dual diagnosis initiatives can be better integrated with state funded mental health and alcohol and other drug services.

Services

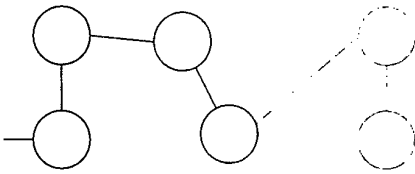
Victoria is fortunate in having a range of quality mental health and alcohol and other drug services in which to build an integrated dual diagnosis response. Specialist mental health services provide treatment and care to those with the most severe and complex mental health problems and disorders and drug treatment services provide for those who are viewed primarily as having a drug and alcohol problem.

A number of these services have engaged in developments aimed at more systematic recognition and response to dual diagnosis clients, which provide valuable learning for others about to embark on this task.

The complex characteristics of dual diagnosis across age groups demands models of service that respond to varying needs and presentations, promote engagement and deliver treatment and care in ways that are 'culturally' acceptable to people of differing ages and backgrounds.

For example, responding to the needs of young people experiencing dual diagnosis is particularly important in light of the opportunities presented by early intervention in this age group. Problems often become entwined with homelessness, ill health, income support problems, legal problems and relationship/family issues, merging into a complex and sometimes poorly differentiated picture.

10 Dual diagnosis



National consultations regarding this group have found that access to traditional service types was largely dependent upon 'reasonable and good behaviour' (*Barriers to service provision, 2004*)³ and that the complex nature of these young people is frequently not taken into account by those working with them. It is a priority to raise dual diagnosis sensitivity and capability within workers across a broad range of service types. These include accommodation, education, generalist youth services, youth counselling, and crisis and refuge services.

In addition to service issues, mental health and alcohol and other drug services operate under two different legislative frameworks, the *Mental Health Act 1986* and *Alcoholics and Drug-Dependent Persons Act 1968* which is currently under review.

These differences can, to some extent, be addressed through a better understanding of the work of each sector and the strength of evidence for delivering services in different ways.

Primary mental health services

The desire of governments to expand mental health responses to those people with the most common mental health problems, means that the central role of general practitioners (GPs), counselling services and community health services (in the delivery of mental health assessment and treatment) is increasingly recognised.

The significant prevalence of dual diagnosis involving high prevalence (the most commonly occurring) mental health problems and disorders requires a more effective response from the primary care system. The recent inclusion of psychological and allied health services as rebateable services under Medicare which will in time extend to mental health nurses offers opportunities to strengthen primary care work in this area.

The three level schema (refer to page 14) seeks to promote partnerships, not only between those with the most severe mental health and substance use disorders, but with primary care services. These services are ideally placed to identify and respond to problems early and manage problems of lesser severity.

Specialist mental health services

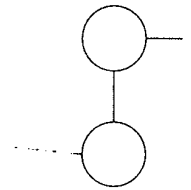
Public specialist mental health services include clinical and PDRSS as well as some statewide services.

Clinical services

Victorians access mental health services through 21 catchment areas, each of which are serviced by child and adolescent, adult and aged programs. The purpose of a catchment area is to promote access to a comprehensive and accessible range of services enabling people to receive treatment in their own community from local or regional services. This approach is somewhat different from the organisation of general medical services, to which people can present at a hospital or service of their choice.

Victoria has 13 child and adolescent service areas, 21 adult area mental health services and 17 aged person mental health services, each delivering services to a specific geographic area. The vast majority of mental health services are provided in the community rather than in hospital settings. These services include community clinics, crisis services, mobile support and treatment services, community residential placements, and sub-acute care. Less than 10 per cent of ongoing clients receive inpatient care at any time.

³ Szrirom, T. King, D. & Desmond, K (2004) *Barrier to service provision for young people with presenting substance misuse and mental health problems. A Report for the National Youth Affairs Research Scheme, National Capital Printing, Canberra.*



Orygen Youth Health is a regional youth service serving the western and north western suburbs of Melbourne. Jigsaw is an innovative youth service in Geelong

Forensic services are provided in correctional facilities and by the Victorian Institute of Forensic Mental Health (Forensicare).

Psychiatric Disability Rehabilitation and Support Services

PDRSS form the other important part of the specialist mental health service sector. Victoria has the largest non-government mental health sector in Australia, and this sector plays a vital role in meeting the needs of people with mental illness. These services are sometimes referred to as non-clinical mental health services and support consumers and carers throughout the recovery process, focusing on the needs of people with serious mental illness. Specific investments have been made in PDRSS to improve the responsiveness of services to dual diagnosis clients.

A greater understanding of mental illness, new developments in clinical treatment and care, and recognition that better outcomes can be achieved when social, education and/or employment needs are also met, are contributing to a groundswell of optimism about, and focus on, recovery from mental illness.

The name and location of health services can be found at: www.health.vic.gov.au/mentalhealth

This website identifies the catchment areas for child and adolescent services and aged person services as well as adult services. Most services also have a printed list of the suburbs in their catchment area.

Alcohol and Other Drug treatment services

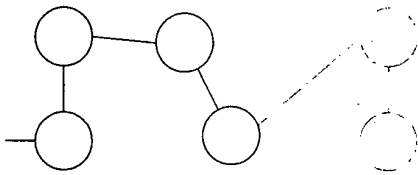
The Victorian Department of Human Services Drug Policy and Services Branch manages activities that aim to promote and protect the health and wellbeing of all Victorians by reducing death, disease and social harm caused by the use and misuse of licit and illicit drugs. The Drugs Policy and Services Branch is responsible for strategic leadership in policy and service development, funding and implementing program initiatives and regulating and monitoring safety standards.

The Department of Human Services, through the Drugs Policy and Services Branch, funds 102 alcohol and drug service agencies that provide more than 360 services across Victoria. These services are provided by a variety of agencies, including:

- 25 community health centres
- 22 hospitals
- 5 local government services
- 50 non-government organisations.

Services delivered include alcohol and drug prevention and education programs, voluntary treatment and rehabilitation services, forensic drug treatment services, and needle and syringe programs. Some services are targeted towards specific client groups, such as youth, families and Aboriginal and Torres Strait Islanders.

www.health.vic.gov.au/drugservices



Dual diagnosis initiatives

Over the last five years a number of initiatives have been funded by government aimed at improving the quality of dual diagnosis treatment and care.

The Dual Diagnosis Teams

Four Dual Diagnosis Teams have been established to assist clinical and PDRSS mental health services and alcohol and other drug services across the State to achieve better outcomes for clients with dual diagnosis.

The *2003 Turning Point Dual Diagnosis Initiative Evaluation*⁴ recognised the work undertaken by the four teams. However a range of factors including the broad geographic spread of services, competing priorities within treatment services already experiencing high demand and limited commitment by some to the dual diagnosis agenda have impacted on their capacity to be effective. There was clearly need for a restated and commonly agreed role for the teams as an integral part of mainstream treatment services and an increased ownership of this particular initiative by stakeholders.

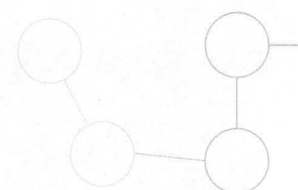
As part of ongoing service development in this area, the responsibility for the treatment and care of dual diagnosis clients as core business now sits more squarely with the managers and clinical leaders in each sector, of which the teams are an integral part. The priority in this next stage of development is for all dual diagnosis related initiatives to focus more clearly on supporting leaders in mental health and drug services to implement sustainable service developments. These developments will provide integrated approaches to treatment and care delivered as part of their suite of services.

Priority activities for the Dual Diagnosis Teams will include:

- working to provide direct care across each sector and to assist with complex dual diagnosis presentations in collaboration with senior clinical staff or case managers.
- assisting individual services to plan how they will establish quality dual diagnosis practices within their services and meet the requirements of the statewide Dual Diagnosis Action Plan 2007-2010.
- working with the Enhanced Statewide Education and Training Project (auspiced by St Vincent's Health) in the design and delivery of dual diagnosis education and training across both mental health and drug and alcohol workforces.
- managing projects that will promote service improvement, for example, the reciprocal rotations project (see page 13).

The teams play an important role in assisting area mental health services, PDRSS and alcohol and other drug services through this change process and to increase the dual diagnosis capability of their staff. The co-consultation model currently in use by the teams will need to continue as a way of expanding direct care and as a means of effecting skills transfer.

⁴ Roberts, B., Berends, L., Ritter, A. *Statewide (2004) Dual Diagnosis Initiative Evaluation Final Report Unpublished.*



Other dual diagnosis initiatives

In 2003, eight new youth dual diagnosis positions focusing on 12–18 year olds were funded within the Dual Diagnosis Teams to develop innovative dual diagnosis programs responding to the particular needs of adolescents. An additional 21 positions were also funded in Mobile Support and Treatment Teams to enhance the responsiveness of services to dual diagnosis clients.

In 2004–05, dual diagnosis workers were established within youth residential rehabilitation services to increase the proportion of young people who leave treatment services with successful outcomes, including reduced substance abuse. Six dual diagnosis positions were established in the homeless sector to better support this client group.

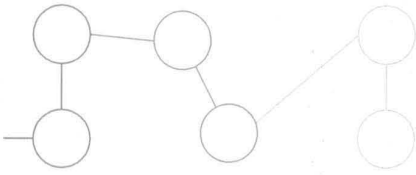
Funding has also been provided to the Victorian Aboriginal Health Service for a dual diagnosis worker since 2004–05.

In 2005–06, additional funding was provided to expand direct care services and for three workforce development projects aimed at improving the quality of services.

The projects are:

- staff rotations between mental health and alcohol and drug services
- increased psychiatrist support
- enhanced statewide education and training.

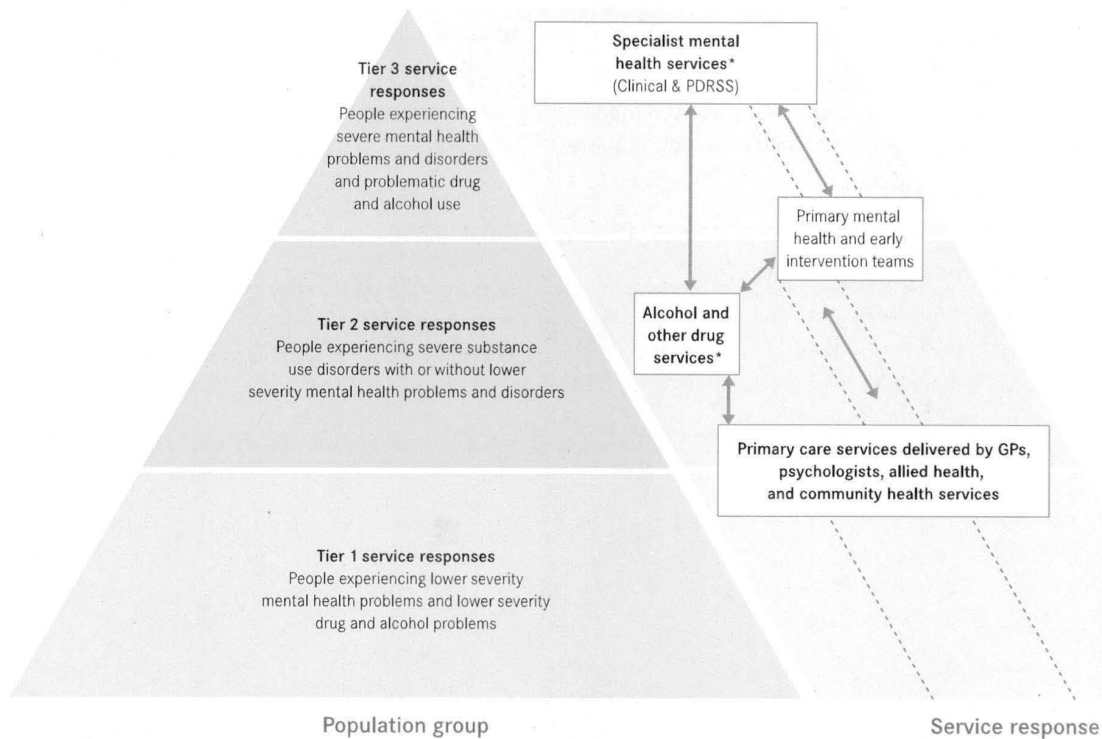
Further information about these projects is provided in the section 'Dual Diagnosis workforce development initiatives' (see page 19).



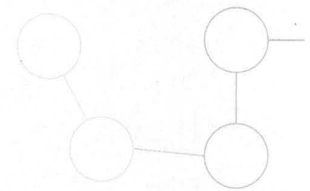
A three level schema for responding to dual diagnosis

In order to assist with the development of a more systematic approach to dual diagnosis treatment and care, a three tiered 'schema' has been developed. Figure 1 provides a graphical representation of this schema, reflecting current services and a hierarchy of responses. The schema is intended to assist in understanding how service responses may best be organised.

Figure 1: A systematic response to dual diagnosis



*The Dual Diagnosis Initiatives support specialist mental health services and alcohol and other drug services across the state.



Tier 3 services for people experiencing severe mental health problems and disorders and problematic drug and alcohol use

People with a serious and complex substance use disorder and a serious mental illness require an integrated response to their problems that takes account of all aspects of their illness.

Specialist mental health staff and PDRSS staff require the knowledge and skills to provide this integrated assessment, treatment and care to people of all ages experiencing dual diagnosis. Services must bring together best practice models of psychiatry, rehabilitation and addiction medicine. Integrated treatment may be provided by a clinician who treats both the client's substance use and mental health problems. Integrated treatment can also occur when clinicians from separate agencies agree on an individual treatment plan addressing both disorders and then provide treatment. This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client.

For example, a person admitted to an acute inpatient unit experiencing a psychotic episode and currently using drugs would have treatment for psychosis and drug use provided in the one setting. This may include appropriate detoxification and consideration of the relationship between the mental illness and substance use.

A person receiving community mental health treatment may require a residential detoxification, which would be planned and provided in collaboration with a partner drug treatment service. An individual treatment plan would be agreed.

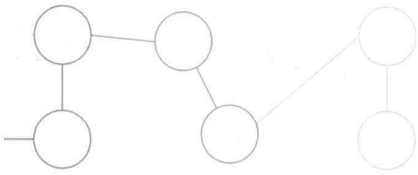
PDRSS will be required to provide programs that respond to dual diagnosis as part of core business, requiring strong links with clinical mental health services and alcohol and other drug services.

Clinicians within specialist clinical mental health services also provide support through co-consultation, secondary consultation and education and training to drug and alcohol and primary care providers, including GPs, regarding the treatment of dual diagnosis.

Dual diagnosis capable staff in specialist mental health services should provide integrated treatment to the majority of clients with severe mental illness and substance use disorders; collaborate with alcohol and other drug services in service provision for those whose needs are best met in this way; and provide secondary consultation to other sectors regarding the treatment of mental health disorders.

Tier 2 services for people experiencing severe substance use disorders with lower severity mental health problems and disorders

People with a severe substance use disorders and mental health problems or disorders of less severity and complexity typically require a response from staff with high level drug and alcohol knowledge and skills who are also capable of providing mental health treatment for the most commonly occurring disorders such as anxiety and depression. People treated by this sector experience a significant incidence of relapse (in both mental health problems and drug and alcohol use) and services incorporate long-term psychosocial interventions to assist people overcome addictions. Polydrug use is increasing the complexity of presentations.



People in this group may have significant co-occurring mental health problems with their drug and alcohol use that can be managed effectively with consultation from, and in some instances transfer to, specialist mental health services. An individual treatment plan would be agreed which may include short-term shared care arrangements to be put in place to respond to crises.

For example, a person attending an alcohol and drug service with a severe substance use problem would receive treatment by a dual diagnosis capable AOD worker for their depression and anxiety.

Part of the function of clinicians in alcohol and other drug services is to provide support through co-consultation, secondary consultation and training and education to the Tier 3 services.

Dual diagnosis capable staff in alcohol and other drug services should provide integrated treatment to clients who experience severe substance use problems and lower severity mental health problems; collaborate with mental health services in service provision; and provide secondary consultation regarding the treatment of problematic drug and alcohol use to other sectors.

Tier 1 service for people experiencing lower severity mental health problems and lower severity drug and alcohol problems

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

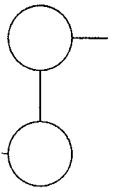
People in this group have low severity mental health and drug and alcohol problems. Dual diagnosis capable clinicians within the primary health care system provide a range of generic treatment options as part of their core business. Brief interventions can be effective for this group as cognitive functioning is generally good and case presentations are less complicated than with the other two groups.

Primary care services are assisted by both primary mental health and early intervention teams from the specialist mental health sector and alcohol and other drug services staff with training and development, and the provision of secondary and tertiary consultation.

Primary care services are often the first point of contact for someone seeking help for either a mental health problem or a drug and alcohol problem including those in need of more specialist services. Timely consultation and clear referral pathways between these services and more specialist mental health and drug and alcohol services is essential.

The Medicare rebates for psychological and allied health services that commenced 1 November 2006 offer general practitioners, paediatricians and psychiatrists working in the private sector further options for interventions.

Dual diagnosis capable primary care services staff, including general practitioners, counsellors and community health services, should provide integrated responses to people experiencing low level mental health and drug and alcohol problems; collaborate with mental health and alcohol and other drug services in joint service provision (for example shared care arrangements); and refer those in need of more intensive services.



Implications and challenges of the schema

The systematic implementation of such an approach has implications for policy and service development centrally and locally in both sectors. Key challenges include:

- policy and service system development
- workforce development
- improved coordination between mental health and alcohol and other drug services
- partnerships with other services, consumers and carers
- consumer and carer involvement
- data collection

Policy and service system development

The Mental Health Branch and Drugs Policy and Services Branch within the Department of Human Services have responsibility for policy and service system development for their respective program areas. Mental health and alcohol and other drug services are funded as separate program entities. Each program uses different funding models and contractual arrangements with providers of services.

Clinical mental health services are input funded using an equivalent full-time (EFT) unit price for community services and bed-day rates for inpatient and community residential care settings. PDRSS are output funded with allocated prices for activity types. Alcohol and other drug services are also funded on an output basis using an episode of care model with prices for different activity types. Services have commented that the case management model used by mental health services and the episode of care approach employed by alcohol and other drug services can sometimes impede collaborative practice.

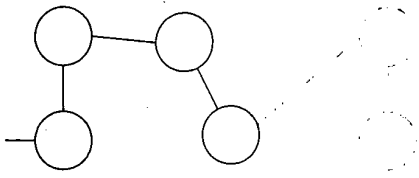
While a complex system of programs offers a broad range of service options, equally they can be difficult to navigate and can mitigate against functional integration of care. However, the development of collaborative practices are not solely dependent upon funding in the main and can be significantly improved where there is joint interest in the endeavour.

The Department, through the Mental Health Branch and Drugs Policy and Services Branch, has agreed that working towards 'dual diagnosis as core business' and achieving 'no wrong door to appropriate services' will be the priority for service development across the State. It is recognised that working together on the implementation of these directions may bring to light issues about current funding approaches and service governance arrangements that will be addressed as they emerge.

Workforce development

The specialist mental health and drug and alcohol workforces have developed independently. Historically each sector has separate educational approaches and training pathways resulting in knowledge and skills being focused on responding to either mental health or drug and alcohol problems, which can promote segregation rather than integration of treatment.

The specialist mental health workforce comprises approximately 4,500 clinical full time position and approximately 850 PDRSS positions (Mental Health Branch). The drug and alcohol workforce comprises approximately 700 positions (Drugs Policy and Services Branch).



Ensuring that staff in both mental health and drug and alcohol workforces have accurate, up-to-date knowledge and skills that enable high quality treatment and care is fundamental to achieving optimal outcomes for consumers. These skills must be developmentally appropriate in order to address the differing needs of children, young people, adults and older people.

Both sectors require staff to have an understanding of the operation of the other sector and a common set of service principles to facilitate working together.

The education and training of staff must take into account the diverse practice settings and treatment approaches employed in each sector and be delivered in ways that are seen as relevant, building upon existing knowledge and skills and be useful in working with the different populations served.

Dual diagnosis capable staff

The development of dual diagnosis capable staff is a fundamental requirement for establishing dual diagnosis as core business in each sector and is the primary service development task. All staff in both mental health and alcohol and other drug services should, at the most basic level, be able to administer a screening tool appropriate to their service age group, undertake a dual diagnosis assessment, and consult others with more advanced knowledge and skills in making decisions about the most appropriate course of action to be taken.

At the advanced level, dual diagnosis capable will mean being able to assess and effectively treat dual diagnosis clients in an integrated manner within service and practice guidelines.

Leadership

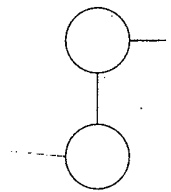
Dual diagnosis leadership is required locally in each sector as well as centrally in Mental Health Branch and Drugs Policy and Services Branch. Encouraging and developing dual diagnosis champions to lead service innovation, mentor and support staff, and establish quality integrated assessment, treatment and recovery at the individual service level is now a priority.

While the dual diagnosis initiatives have raised awareness of the necessity for service development, the responsibility for further development now sits with the leadership in each mental health and alcohol and other drug service.

Clinical accountability within mental health services ultimately rests with the psychiatrist in charge of the service. Accountability for professional or discipline-specific practice rests with discipline seniors, and program or team managers are responsible for the work of staff in their teams. Issues of service and practice (clinical) accountability both within and across services need to be agreed to facilitate an integrated approach.

Supervision

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



Dual diagnosis workforce development initiatives

Victoria has in place a range of activities aimed at strengthening staff knowledge and skills in relation to dual diagnosis that have recently been strengthened by additional funding.

New projects funded in 2005–06 include:

- reciprocal rotations between mental health and alcohol and other drug services that will rotate staff between the two sectors with a target of 156 staff rotations over three years.
- expansion of consultant psychiatrist time and increased input into the training of psychiatrists and other senior clinical staff in dual diagnosis that will also address concerns about clinical accountability
- strengthening of dual diagnosis education and training capacity through the establishment of a statewide training coordinator and increased educator capacity to enable a more systematic and comprehensive approach to training across both workforces.

These projects will engage with existing workforce and professional development infrastructure within services as well as the education and training clusters in mental health and the alcohol and other drug Workforce Development Unit.

Dual diagnosis was identified as a statewide training priority in the mental health education and training clusters in 2006. The service membership of the three mental health education and training clusters involve all clinical mental health services (child and adolescent, adult and aged) and collectively cover Victoria.

As the peak organisation for PDRSS, VICSERV has an important role to play in the education of PDRSS staff and is already providing training in dual diagnosis.

Improved coordination between services

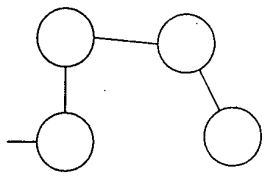
Partnerships between specialist mental health and alcohol and other drug services, that deliver operationally useful relationships at the local level, underpin continuity of care and integrated treatment and recovery. This requires the development of mechanisms for clear communication between sectors and to address issues that may hinder agreement on collaborative action.

The bio-psycho-social framework for understanding mental health problems embraced by the National Mental Health Strategy and specialist mental health services acknowledges the contributions of biological, psychological, social and economic factors to mental health problems. The alcohol and other drug services sector also takes into account social and environmental factors in assessment and treatment.

Shared understandings about the needs of the target group, how best to address them and the roles that services in each sector will play, are essential requirements underpinning effective collaboration and protocol development.

Referral pathways and protocols

Partnerships will need to agree on common intake and assessment arrangements, joint management plans and case management work. Work in this area has already commenced with the commitment to the Primary Care Partnership Service Coordination Tool Templates by alcohol and other drug treatment services and the encouragement of participation in such approaches from mental health. Such tools provide opportunity to minimise repeated assessment and allow for appropriate exchange of information between services.



Partnerships with other service sectors, carers and consumers

Mental health and alcohol and other drug services are not alone in working towards improved dual diagnosis outcomes. Carers, non-government support agencies, community and acute health services and other services provided outside the mental health and drug and alcohol sectors play key roles and are key partners if needs are to be effectively responded to. Some examples of these service areas are child and family community support, sexual assault, family violence, child protection, aged care, private psychiatrists, housing, disability support, domiciliary care, income support, education, employment and juvenile justice.

Both sectors will have established relationships with these other services in delivering their models of care.

The behaviours of some people with a dual diagnosis can be confronting and challenging. Individuals displaying such behaviour risk rejection or exclusion from services that can feel ill-equipped to respond effectively to both their mental health and alcohol and other drug services. Effective service planning requires these partner agencies to define collaborative approaches prior to developing and implementing programs.

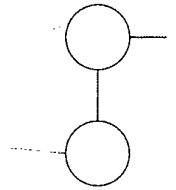
Although tensions may exist between the differing professional, consumer and carer conceptions of mental health and wellbeing, if effectively managed these differences can result in services being made more responsive to need and provided in ways that engage and retain consumers in treatment.

Consumer and carer involvement

The participation of consumers and carers in service development and design is now recognised as good practice and a key to the success of programs. Service design and development must take account of how mental health and drug and alcohol use varies across ages and impacts on both consumers and carers. Issues of engagement and retention in services are particularly challenging around marginalised young people with dual diagnosis. 'Youth friendly' models of care that take into account first episode experiences and minimise institutional approaches are most effective.

The inclusion of consumers and carers in the education and training of staff will assist in the ongoing development of respectful approaches through better understanding of their experiences.

Existing structures and mechanisms for consumer and carer input into the planning and evaluation of services will need review to ensure that they reflect these new directions.

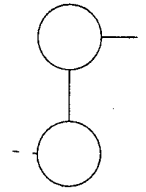


Data collection

Reliable data is a requirement for policy and service development, ongoing service monitoring and evaluation. It is clear that dual diagnosis is significantly under-reported by services, impeding effective planning and the development of sustainable approaches tailored to need.

The development of a common minimum data set for use by both mental health and drug treatment services would enable information to be shared, service performance to be better understood, and information about client outcomes more reliably collected.

The process of implementing collaborative approaches to information gathering through information technology can contribute to changes in service and enhance collaboration. Developing such an approach requires commitment between programs centrally and locally. Technological developments being undertaken by the Department of Human Services (such as healthSMART) offer opportunity to review how this might be achieved. Services can agree locally on the common information they require to inform planning and service review.



Service development outcomes

The systematic establishment of dual diagnosis as core business within both mental health and alcohol and other drug services requires high level commitment and leadership in both policy and service development. Local leaders work within their own and partner services to better facilitate the changes in practice and service provision required, and to ensure development of the necessary knowledge and skills within their workforce.

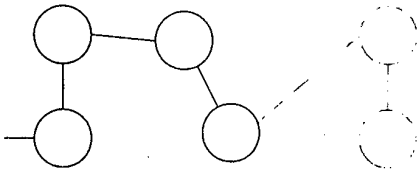
Centrally this challenge is being taken up by the Mental Health Branch and the Drugs Policy and Services Branch within the Department of Human Services. The development of this document and the Dual Diagnosis Action Plan (that will identify priorities for implementation over the next three years) is a demonstration of the acceptance of this challenge.

Locally this challenge is being taken up by some service leaders and managers who are drawing upon the existing service enhancement investments in this area. These enhancements include the education, training and consultation provided by the Dual Diagnosis Teams.

Both sectors have agreed on the following five service development outcomes that need to be achieved for effective responses to dual diagnosis within mental health and alcohol and other drug services to be delivered as core business.

1. Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as core business in both mental health and alcohol and other drug services.
2. Staff in mental health and alcohol and other drug services are 'dual diagnosis capable', that is, they have the knowledge and skills necessary to identify and provide integrated assessment, treatment and recovery.
3. Specialist mental health and alcohol and other drug services establish effective partnerships and agreed mechanisms that support integrated care and collaborative practice.
4. Outcomes and service quality for dual diagnosis clients are monitored and regularly reviewed.
5. Consumers and carers are involved in the planning and evaluation of service responses.

Each of these outcomes requires services, singularly and together, to take action at the local level. The service objectives that follow are seen as being minimum requirements for each of the outcomes to be achieved.



Service development outcome 1:

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

Service objectives

Mental health and alcohol and other drug services:

- 1.1 Develop and administer common screening approaches for drug and alcohol and mental health problems for clients seeking help from or referred to their services.
- 1.2 Develop intake and assessment approaches that promote integrated dual diagnosis treatment and recovery programs as core aspects of service, including case management practices, and document interventions and outcomes in individual management plans.
- 1.3 Align treatment, care and psychosocial support with the best available evidence and national and international standards and guidelines.
- 1.4 Develop recovery programs and models of psychiatric disability rehabilitation and support as an integral part of service responses for people with dual diagnosis.

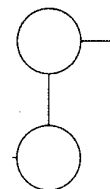
Service outcome 2:

Staff in mental health and alcohol and other drug services are 'dual diagnosis capable', that is, have the knowledge and skills necessary to identify and respond appropriately to dual diagnosis clients and advanced practitioners are able to provide integrated assessment, treatment and recovery.

Service objectives

Mental health and alcohol and other drug services:

- 2.1 Orient all staff entering employment in both sectors to basic dual diagnosis practices including the administration of a screening tool, preliminary assessment and appropriate pathways for referral within and between services.
- 2.2 Develop a hierarchy of knowledge and skill levels in their workforce from baseline capability to advanced dual diagnosis practice delivering integrated treatment, psychosocial rehabilitation and recovery.
- 2.3 Provide dual diagnosis training of senior staff to promote leadership and take up of dual diagnosis portfolio positions.
- 2.4 Provide training that takes account of the requirements of staff in different service settings (community, residential, acute inpatient/withdrawal) working with different age groups (youth, adults, aged persons).
- 2.5 Utilize existing workforce development activities and programs (including the mental health education and training clusters, the alcohol and other drug workforce development unit and in-service and professional development activities) to enhance dual diagnosis competency.
- 2.6 Create and/or strengthen career opportunities and academic recognition of education and training in both addiction medicine and mental health treatment.



Service outcome 3:

Specialist mental health and alcohol and other drug services establish effective partnerships and agreed mechanisms that support integrated assessment, treatment and recovery.

Service objectives

Mental health and alcohol and other drug services:

- 3.1 Develop and agree on referral pathways within and between services to implement a 'no wrong door' policy for dual diagnosis clients seeking help from either service.
- 3.2 Agree pathways with primary care services for those requiring specialist treatment and care or returning to primary care management.
- 3.3 Regularly monitor and evaluate compliance with, and the effectiveness of, agreed partnerships and pathways as part of quality assurance activities.
- 3.4 Develop and maintain collaborative service relationships that result in clients receiving integrated assessment, treatment and recovery.
- 3.5 Establish functional relationships with other service sectors that provide acute physical health care, housing, education, and employment for this group of clients.

Service outcome 4:

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

Service objectives

Mental health and alcohol and other drug services:

- 4.1 Systematically collect common dual diagnosis service utilisation and client outcome data.
- 4.2 Use this data to inform planning, service development and evaluation.

Service outcome 5:

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

Service objectives

Mental health and alcohol and other drug services:

- 5.1 Establish mechanisms for the involvement of clients, families and carers in the planning, review and ongoing development of services
- 5.2 Develop mechanisms whereby people with dual diagnosis, their families and carers have input into the education and training of the staff in both sectors and primary care sectors.

Dual Diagnosis Action Plan 2007–2010

Service development outcome 1

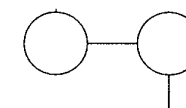
Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as 'core business' in both mental health and alcohol and other drug services.

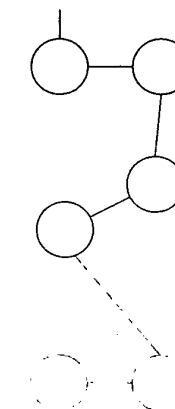
A priority is to establish mechanisms and processes that ensure that dual diagnosis is systematically recognised and assessed in both mental health (clinical and PDRSS) and alcohol and other drug services. A screening approach that provides sufficient information to identify the need for further, more detailed assessment, should be incorporated in early assessment activities.

Service objective	Responsibilities	Dual Diagnosis Initiatives	Key performance indicators	Target	Timelines
People seeking assistance from services are screened for mental illness and problematic substance use using an accepted screening approach.	Mental health service managers. Alcohol and other drug service managers.	Provide direct care, advice, training and support regarding screening, assessment and evidence-based treatment.	Percentage of people screened for mental illness and substance misuse at entry to service (triage and intake).	100%	June 2008
Where indicated, clients receive a full dual diagnosis assessment resulting in integrated assessment, treatment and recovery documented in an individual treatment and care plan.		Encourage the use of common language, tools and standards so that information exchange between sectors is accurate and timely.	Percentage of dual diagnosis clients receiving integrated assessment and treatment.	100%	Dec 2010

Notes:

- In order to achieve the KPIs, services will need to amend a range of work practices including triage and intake procedures to include dual diagnosis screening and assessment. Other client transitions within services (eg: community to inpatient or residential care) and at different stages of recovery will also need to be reviewed.
- The identification of dual diagnosis is only the first stage of the treatment process, and services will be required to determine actions arising from positive screens that are addressed in part by the following service development outcomes.





28 Dual diagnosis

Service development outcome 2

Staff in mental health and alcohol and other drug services are *dual diagnosis capable*, that is, they have the knowledge and skills necessary to identify and respond appropriately to dual diagnosis clients and advanced practitioners provide integrated assessment, treatment and recovery.

A prerequisite for the delivery of quality responses for dual diagnosis clients is appropriately trained staff in each service sector. Dual diagnosis education and training must focus on assisting all staff to become dual diagnosis capable and to enable more advanced practitioners to provide integrated assessment, treatment and care.

Service objective	Responsibilities	Dual Diagnosis Initiatives	Key performance indicators	Target	Timelines
Staff in both mental health (clinical and PDRSS) and alcohol and other drug services are appropriately educated and are dual diagnosis capable.	Mental health service managers. Alcohol and other drug service managers.	Develop and provide education and training to enable staff in each sector to become dual diagnosis capable.	Numbers of staff (in each service sector) working with high risk groups who are <i>dual diagnosis capable</i> .	100%	June 2010
Services in each sector have developed an advanced practitioner capability that delivers dual diagnosis leadership and provides integrated assessment, treatment and care for dual diagnosis clients.		Assist in the development of incentives for advanced practice and dual diagnosis post graduate training activities.	Number of advanced practitioners	To be negotiated	June 2009

Notes:

- **Dual diagnosis capable* means being able to screen for dual diagnosis; where indicated, conduct a more detailed assessment that enables the development of an integrated treatment and care plan; and be aware of and able to use agreed referral pathways within and between services in order to provide a seamless service for dual diagnosis clients.
- Advanced practitioners in both mental health and alcohol and other drug services have the necessary knowledge and skills to plan and deliver dual diagnosis treatment and care and provide supervision and support to other staff providing treatment and care to these clients.
- At least one senior staff member per service, having relevant experience and training, is identified as a dual diagnosis portfolio holder. Opportunities exist through the Reciprocal Rotations initiative and post graduate training to meet these KPI's.

Service development outcome 3

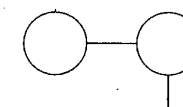
Specialist mental health and alcohol and other drug services establish effective partnerships and agreed mechanisms that support integrated assessment, treatment and recovery and ensure 'no wrong door' to treatment and care.

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

Service objective	Responsibilities	Dual Diagnosis Initiatives	Key performance indicators	Target	Timelines
Mental health and alcohol and other drug services develop arrangements that ensure 'no wrong door' entry to the appropriate service.	Mental health service managers. Alcohol and other drug service managers.	Support services in each sector to develop collaborative practice arrangements.	Percentage of services in each sector that have in place partnership agreements and protocols that define client care pathways within and between service sectors.	100%	Dec 2008
		Incorporate models and mechanisms for collaborative practice in education and training provided.	Percentage of services in each sector that can demonstrate integrated assessment, treatment and care through policies and procedures and individual care planning.	100%	June 2009

Notes

- To achieve KPIs, services will first need to ensure internal service pathways are appropriate, for example, community care-inpatient care.
- Mental health and alcohol and other drug services need to develop documented collaborative practice agreements.
- Services need to have a treatment plan that takes account of wider aspects of consumers' current situation and the impact on the dual diagnosis.



Service development outcome 4

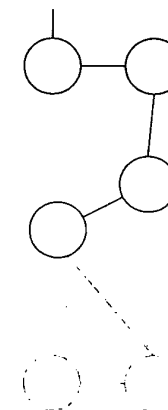
Outcomes and service responsiveness for dual diagnosis clients are monitored and regularly reviewed.

Systematic collection of dual diagnosis service use and client outcome data is essential to service planning, development and evaluation at both local and central levels.

Service objective	Responsibilities	Dual Diagnosis Initiatives	Key performance indicators	Target	Timelines
Data about problematic drug use among clients of mental health services and mental health problems among clients of alcohol and other drug services is systematically collected in: <ul style="list-style-type: none"> • RAPID (mental health services) • ADIS (alcohol and other drug services). 	Mental health service managers. Alcohol and other drug service managers.	Provides education and training on data collection in accord with the Department of Human Services guidelines. <ul style="list-style-type: none"> • New staff in orientation programs. • All staff in services over time. 	Number and percentage of services in each sector routinely collecting and reporting on dual diagnosis as part of core service data collection and in accord with DHS business rules.	100%	June 2008
Data is used to inform local service planning and development at the individual service level and at intersectoral levels.			Number and percentage of services using dual diagnosis data to inform service planning and development and to improve service access and responsiveness.	100%	Dec 2009

Notes

- Services may need to modify data collection and recording processes to achieve KPIs.
- The Mental Health Branch and Drugs Policy and Services Branches will work together with the sector to define a dual diagnosis minimum data set and business rules to support systematic collection of data across the state.



30 Dual diagnosis

Service development outcome 5

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

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

Service objective	Responsibilities	Dual Diagnosis Initiatives	Key performance indicators	Target	Timelines
Establish or strengthen mechanisms and processes that enable systematic input by dual diagnosis clients, families and carers in service planning and evaluation and the education and training of staff in each sector.	Mental health service managers. Alcohol and other drug service managers.	Develop mechanisms and processes in consultation with consumers and carers that enable the involvement of consumers and carers in education and training and service development.	Percentage of services developing mechanisms and processes that enable consumer and carer input into advisory and planning activities.	100%	Dec 2007
			Percentage of services with consumer and carer involvement in education and training of staff.	100%	June 2009

Notes:

- Dual diagnosis consumers and their carers need to be supported and empowered to be advocates so that their views are expressed and included in the development of services. The Mental Health Branch and the Drugs Policy and Services Branch will assist services to explore the most appropriate mechanisms by which this can be achieved.

