IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT 'LB-3' TO STATEMENT OF LEANNE BEAGLEY

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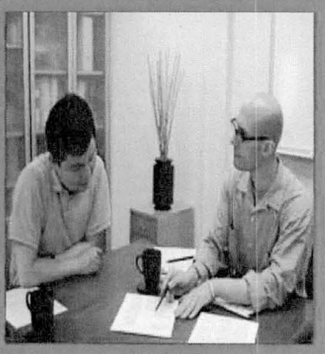
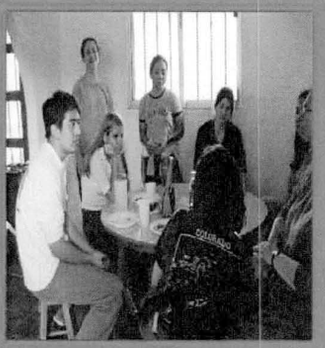
This is attachment **'LB-3'** produced and shown to **LEANNE BEAGLEY** at the time of signing her statement on 9 October 2015.

Attachment LB-3





Australian Healthcare Associates

Evaluation of the Victorian Dual Diagnosis Initiative

Final Report

March 2011

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Abbreviations

ACHS	Australian Council on Healthcare Standards
ADIS	Alcohol and Drug Information System
AHA	Australian Healthcare Associates
AIHW	Australian Institute of Health and Wellbeing
AOD	Alcohol and other drug
AODTS	Alcohol and Other Drug Treatment Services
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
BASIS 32	Behavior and Symptom Identification Scale (32 item version)
CAGE-AID	Not an abbreviation, rather name of a conjoint screening questionnaire for alcohol and drug abuse
CAMHS	Child and Adolescent Mental Health Service
CEP	Co-existing Mental Health and Addiction Problems
CMI	Client Management Interface of RAPID
COMPASS	Comorbidity Program Audit and Self-Survey for Behavioral Health Services
CPI	Consumer Price Index
CQI	Continuous Quality Improvement
DACAS	Drug and Alcohol Clinical Advisory Service
DD	Dual Diagnosis
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DHS	Department of Human Services
EDDS	Eastern Dual Diagnosis Service
EFT	Equivalent full time
EHDDS	Eastern Hume Dual Diagnosis Service
ETU	Education and Training Unit
GP	General Practitioner
HEC	Hume Education Collaborative
HIV	Human Immunodeficiency Virus
HONOS	Health of the Nation Outcome Scales
HPD	High prevalence disorder
HYDDI	Homeless Youth Dual Diagnosis Initiative
ICD-10	International Classification of Diseases, tenth version
ISI	Improved Services Initiative
ISO	International Standards Organisation
K-10	Kessler Psychological Distress Scale (10 item questionnaire)
KPI	Key Performance Indicators
LGA	Local Government Areas
MH	Mental Health
MHS	Mental Health Services
MMS	Modified Mini Screen
MSE	Mental State Examinations
NDARC	National Drug and Alcohol Research Centre
NOCC	National Outcomes and Casemix Collection
NSW	New South Wales

Abbreviations

NWD	No Wrong Door
NWMH	NorthWestern Mental Health
PARC	Prevention and Recovery Care Services
PCP	Primary Care Partnerships
PD	Professional development
PDRSS	Psychiatric Disability Rehabilitation and Support Services
PTSD	Post Traumatic Stress Disorder
QIC	Quality Improvement Council
RANZCP	Royal Australian and New Zealand College of Psychiatry
RAPID	Redevelopment of Acute & Psychiatric Information Directions
RTO	Registered Training Organisation
SDDS	Southern Dual Diagnosis Service
SDO	Service Development Outcomes
SHADE	Self Help for Alcohol/other drug use and Depression
SUMITT	Substance Use and Mental Illness Treatment Team
TAFE	Technical and Further Education
VDDI	Victorian Dual Diagnosis Initiative
VDDIRF	Victorian Dual Diagnosis Initiative Rural Forum
VET	Vocational Education and Training
VICSERV	Not an abbreviation, rather name of a peak body representing community managed mental health services in Victoria
VRDDF	Victorian Rural Dual Diagnosis Forum
VSSP	VDDI Statewide Strategic Plan

1. Executive Summary

1 EXECUTIVE SUMMARY

1.1 Introduction

The Department of Health, Mental Health, Drugs and Regions Division has commissioned this evaluation of the Victorian Dual Diagnosis Initiative (VDDI). The initiative was first formally funded in 2001, which saw four VDDI teams established each with a rural component. Since the inception of VDDI, some additional strategies have been added, including youth specific positions, additional psychiatric time, funding to support rotations between sectors and the establishment of an education and training unit. A major policy document on Dual Diagnosis was released in 2007 by the Department of Health.

The purpose of the initiative is to deliver an improved service response for people that experience dual diagnosis issues.

1.2 Context

Dual diagnosis in this instance refers to people who have concurrent mental health and substance use disorders. There are a number of compelling reasons for focusing on building improved responses to people with dual diagnosis issues and these include:

- The high prevalence of dual diagnosis issues; between one third and one half of clients of mental health and alcohol and other drug (AOD) services are affected
- People with dual diagnosis are more likely to experience poorer health outcomes across a range of key indicators
- Treatment of dual diagnosis is challenging because of the chronic, relapsing, and impairing nature of both issues
- Traditionally people with dual diagnosis have been very poorly serviced, often being rejected by clinical mental health or AOD services because of the presence of the 'other' disorder

It was in recognition of these major concerns that VDDI was funded by the Victorian Government. Three sectors are the target of the initiative, clinical mental health, Psychiatric Disability and Rehabilitation Support Services and Alcohol and Other Drug Services. There is a total of approximately 6,000 workers across the three sectors, of which around 4,500 are employed in clinical mental health.

The three sectors provide quite diverse functions, use different frameworks for working with their client groups and employ staff with differing qualifications and/or professional backgrounds.

The evidence on responding to dual diagnosis issues is still emerging and this makes the task more challenging. Generally the acceptance is that responses that ensure that both disorders are identified and taken account of, is the best approach. There is some consensus that integrated care offers the most options for treatment particularly when the range of required services are located in the one setting.

There is some complexity in the service environment around responding to mental health issues. People with the most acute presentations of mental illness, and in particular those experiencing psychosis are the target group for clinical mental health services. However the great majority of people

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with dual diagnosis issues will have mental disorders such as anxiety, depression, trauma related conditions, and personality disorders. This means that the majority of people being seen by AOD services will not be able to be assisted by clinical mental health and so the option for assistance with these types of mental health issues is via primary care, a relatively complex pathway.

The *Dual Diagnosis: Key Directions and Priorities for Service Provision* policy document outlined dual diagnosis specific Service Development Outcomes (SDOs) to be achieved by organisations across the three sectors, and this has proven to be a significant lever for change. The SDOs included expectations regarding screening, assessment and treating dual diagnosis issues.

1.3 Methodology

As indicated in the 'Request for Quotation' specifications, this evaluation has five specific purposes. They are:

1. To review the goals and objectives of the VDDI and three sub projects (VDDI funded youth positions are not in scope)
2. To measure the impact of the Victorian Dual Diagnosis Initiative on the screening, assessment, treatment and care of dual diagnosis clients in mental health and alcohol and drug treatment services
3. To provide advice that will improve the effectiveness of the Victorian Dual Diagnosis Initiative within the context of the Dual Diagnosis Key Directions and Priorities for Service Provision
4. To inform policy planning activities that will be undertaken by Mental Health, Drugs and Regions Division, the Dual Diagnosis Teams and Education and Training Unit
5. Ascertain gaps in data collection mechanisms, reporting and identify further data analysis that may be required to accurately describe the activities of the Initiative

The evaluation findings have largely rested on data gathered during the project from a number of sources, because the datasets collected by the three sectors were not able to contribute to an understanding of progress on responding to dual diagnosis issues.

The primary source of quantitative data was provided by the VDDI Team Leaders, who were asked to complete a survey about the 'target organisations' that are in their catchment areas. The same was asked of the Rural VDDI Clinicians. These surveys were then cross referenced against a sample of thirty eight organisations that were interviewed by telephone and a further ten services that were visited for a series of face to face consultations.

A range of other stakeholders were consulted from across the sectors, peak bodies and within the Department of Health (Victoria) and the Commonwealth Department of Health and Ageing.

A literature review was also conducted, along with an examination of Department of Health files and relevant documents.

The evaluation commenced in March 2010 and data collection was concluded by November 2010.

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1.4 Victorian Dual Diagnosis Initiative

The initiative has entailed a number of major strategies, as follows:

- VDDI teams
- Rural Dual Diagnosis Clinicians
- Education and Training Unit
- Additional Psychiatrist Support
- Reciprocal Rotations.

There are four VDDI teams distributed across metropolitan Melbourne, one for each of the adult clinical mental health regions. Attached to the teams are Rural Dual Diagnosis Clinicians that are distributed across the rural adult clinical mental health regions. Their role is to facilitate change in the way that organisations respond to people with dual diagnosis issues through education and training, provision of primary and secondary consultation, assisting organisations to change policies and procedures, and a range of other activities as negotiated with organisations.

An Education and Training Unit is charged with the coordination of statewide training activities, and building common approaches to education and training.

Additional Psychiatrist Support is targeted particularly towards medical staff in psychiatric settings and entails Psychiatrists and Psychiatric Registrars with a specialisation in Addiction Medicine, providing primary, secondary and tertiary consultations.

The Reciprocal Rotations project provides funding to an employing organisation to backfill staff who vacate their role for a three month period in order to undertake a placement in a different sector to the one in which they work (although it must be one of the three sectors).

As a result of these strategies and the expectations placed on organisations by *Key Directions*, organisations are expected to screen all clients for dual diagnosis issues and either assess or arrange for an assessment of people who screen positively. Those, for whom an assessment indicates the presence of dual diagnosis issues, should then have an integrated treatment plan developed which outlines how both substance use and mental health needs will be met. If the treatment involves two organisations, then the expectation is that the two organisations, work to the one treatment plan. Such arrangements are expected to be underpinned by changes to policies and procedures within organisations and formal agreements between sectors to work collaboratively in meeting people's dual diagnosis needs.

Further to this it is also expected that services will collect data on dual diagnosis and review it on a regular basis with consumer and carer input, to determine progress.

A number of different governance arrangements for the initiative have been attempted in order to establish a consistent approach to the initiative across all regions, including VDDI teams and workers. The most consistent components have been the VDDI Leaders Group and the Rural Forum.

1.5 Impact of VDDI

The initiative has had a dramatic impact with regard to building recognition that dual diagnosis is everyone's business. This is significant given that some years earlier, the rigid demarcation between

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AOD and clinical mental health services was a significant barrier and many people with dual diagnosis issues did not have their full range of needs met. *Key Directions* has been central to the shift in practice through the Dual Diagnosis Action Plan and accompanying Service Development Outcomes (SDOs).

The five SDOs apply to both mental health and AOD services and stipulate that:

1. Dual diagnosis is systematically identified and responded to as core business
2. Staff in mental health and alcohol and other drug services are 'dual diagnosis capable'
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

Of these, there is progress on the first three points, and the last, although the progress is variable. At least half and probably many more organisations are screening all clients for the presence of dual diagnosis issues, with AOD being the most prominent sector in conducting screening. It then decreases with somewhere between 35 – 60% of organisations assessing all of those requiring assessment, depending on the sector.

Integrated treatment is an area where there is far less progress. This is most likely because it requires a number of things to be in place such as screening, assessment, intersectoral partnerships and the capacity to develop appropriate treatment plans for someone with a dual diagnosis presentation.

Whilst there is some progress on the development of partnerships, there is much work that still needs to be done. Consumer and carer involvement is strongest in mental health organisations and is an area that AOD will need to focus on.

The fourth SDO requires data collection tools that collect dual diagnosis specific data, which is not the case for the Alcohol and Drug Information System (ADIS), the AOD sector's tool, and not readily the case with Redevelopment of Acute & Psychiatric Information Directions (RAPID, used by clinical mental health. PDRSS meanwhile have a diversity of data collection tools.

The VDDI strategies have largely provided a useful to very useful role as reported by key stakeholders and as evidenced through the shifts in practice that have occurred. People reported the value of the consultations, training and other support provided by VDDI workers and through the online training facilitated by ETU, or consultations with psychiatrists.

The variable progress is attributable to a number of key factors of which the major ones include:

- Change has been very slow until the relatively recent release of the *Key Directions* policy initiative which has provided the much needed lever to drive reform
- VDDI's governance structure has not been effective in driving a statewide initiative that uses common approaches
- Decision by the Department not to mandate specific screening and assessment tools
- A lack of a clear definition of the scope of practice for each sector, the competencies required and the training that is necessary
- A lack of willingness of some organisations to drive the reform in their own organisation, particularly in clinical mental health.

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1.6 Completion of the Reform Process

Whilst the reform process has made good progress, the establishment of quality responses to people with dual diagnosis issues, by clinical mental health, PDRSS and AOD services is not yet complete. It is also important to note that substantial progress has only occurred since 2007 with the release of *Key Directions*. Up until that point VDDI teams had struggled to engage the interest of organisations, and to some extent, define their roles.

It is crucial to maintain the change momentum over the next three years, although with some significant refinement to the strategies employed, otherwise the gains will rapidly dissipate. There is also a substantial body of work to be done to complete the reform process.

With regard to the mental health sector, mental health nurses from the United Kingdom and New Zealand have commented with some surprise on the demarcation that still exists between intervening to support a person's mental health and supporting them to address their substance use issues. Ultimately the endgame is that good quality care is inclusive of all aspects that impact on mental health which means that alcohol and other drug misuse cannot be excluded.

The AOD sector needs to continue to build its capacity to respond to the full spectrum of mental health disorders through the development of clinical and supportive skills specific to different disorders as well as a greater awareness of online mental health interventions that can offer high quality assistance to people. This includes ensuring that there is a sufficient level of highly qualified and skilled clinical capacity in each organisation to provide adequate supervision for staff working with these very complex presentations. This may necessitate a review of current funding practices in relation to very small programs.

Any remaining barriers between clinical mental health and AOD services need to be overcome so that people with psychotic and/or high acuity presentations can be readily identified and supportively referred by AOD services. Similarly, effective pathways between AOD services and PDRSSs need to be established.

There is a diversity of programs available across PDRSS, which will mean that the level of active involvement by workers with supporting a person's recovery from dual diagnosis issues will be variable. However all should be able to engage with service users to assist them to identify the impact of substance use issues on their wellbeing and then support their engagement with AOD services.

1.6.1 Recommendations

The potential areas for enhancement of the reform process are discussed below under the following headings:

1. Governance
2. Systems Management
3. Workforce development.

The following recommendations are proposed in order to see the realisation of the long advocated for vision of dual diagnosis becoming everyday practice across mental health and AOD. These recommendations are drafted in response to the three major areas listed above.

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1. Governance recommendations

It is proposed that the Department of Health adopt the following recommendations in relation to the governance of VDDI:

1.1 Policy

Recommendation 1.1	A new framework document be developed that clearly specifies the vision for responding to people with dual diagnosis issues across mental health and alcohol and other drugs sectors.

It is also recommended that the document:

R.1.1.1 Specify worker competencies across clinical mental health, alcohol and other drugs and psychiatric disability rehabilitation and support services as well as a single workforce development plan.

R.1.1.2 Include a commitment to a single set of screening and assessment tools.

R.1.1.3 Include a commitment to the development of clinical and practice guidelines.

R.1.1.4 Promote service integration through co-location and other strategies.

1.2 Governance structures

Recommendation 1.2	That the governance structures of the initiative be addressed as outlined below to clarify relationships and roles as well as to ensure consistency of approach and content, in the implementation of the dual diagnosis reforms.

R.1.2.1 The Department of Health develop a single VDDI Statewide Strategic Plan (VSSP) covering all of the VDDI strategies with specified KPIs for all teams and each component of the program. The VSSP would inform the development of local regional plans. This process would best be supported by a Central Steering Committee appointed by the Department and local committees that include regional and central departmental staff representation to guide the development of regional plans.

R.1.2.2 Rural practitioners to be brought under the direct auspice of their linked auspice organisation and be supported through the Rural Forum.

R.1.2.3 The ETU be retained and lead and coordinate the development and delivery of statewide education and training and facilitate the sharing of resources across VDDI.

R.1.2.4 Department to provide some additional resources in the short term to assist the ETU to become an RTO.

1.3 Performance monitoring and screening and assessment tools

Recommendation 1.3	As a matter of priority, the Department move to support effective information sharing and appropriate data collection for monitoring of performance against dual diagnosis KPIs, by establishing an integrated electronic data collection and reporting system across the three sectors.

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R.1.3.1 In the interim, clinical mental health teams to undertake a CAGE-AID screen with all clients, ASSIST with those that require further assessment and use CMI to complete ICD-10 and Z-codes (refer Appendix F) to capture AOD information.

R.1.3.2 In the interim AOD to complete a K-10 in hard copy and record findings from conducting a MSE in client files.

R.1.3.3 In the interim PDRSS to complete CAGE-AID for all clients and ASSIST for those that require further assessment or refer to AOD for assessment.

R.1.3.4 The Department appoint a working group under the aegis of the VSSP Central Steering Group to develop a set of dual diagnosis client outcomes for each of the three sectors.

R.1.3.5 Over the next 2 years, organisations should be required to report against progress on an audit tool such as DDCAT or that developed by the North East Hume Dual Diagnosis worker on an annual basis (as determined by the Department), down to the level of each team. Ideally reports to be provided to regional departmental staff, who collate the findings and then a forum of regional and central departmental staff could reflect on the progress by organisations against their audit, and what might be needed to assist the final progression to integrating dual diagnosis as core, everyday practice. After two years organisations should be able to demonstrate how accountability measures have been put in place in an ongoing way as part of their standard quality improvement and accountability measures.

2. Systems change management

It is proposed that the Department of Health adopt the following recommendations in relation to systems change management in relation to VDDI:

2.1 Capacity

Recommendation 2.1	The Department review the ability of organisations with small numbers of AOD and PDRSS staff to build and sustain the necessary workforce and supervisory capacity along with the required change in practice, policies and procedures.

2.2 Establishing cross sectoral partnerships

Recommendation 2.2	The development of the VSSP and linked local plans to give careful consideration to the identification of existing network vehicles such as PCPs for the purpose of forming effective cross sectoral partnerships to drive the required dual diagnosis reforms.

It is also recommended that these partnerships give priority to:

R.2.2.1 Establishment of No Wrong Door agreements such as the No Wrong Door 2 Protocol.

R.2.2.2 Investigate and support opportunities for co-location of AOD and mental health staff to afford better access for dual diagnosis clients and strengthened opportunities for the integration of care.

It is also recommended that the Department:

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R.2.2.3 Review the referral and information sharing arrangements between detoxification units and clinical mental health teams, particularly in relation to high risk clients.

2.3 Change management roles

Recommendation 2.3	The Department include in any new framework document and other communication with the three sectors a description of the functions required by each change agent in relation to the implementation of the dual diagnosis reforms

3. Workforce development recommendations

It is proposed that the Department of Health adopt the following recommendations in relation to workforce development in relation to VDDI:

3.1 Scope of practice and dual diagnosis capability

Recommendation 3.1	As a matter of priority, the Department work closely with the ETU and the VDDI teams to conduct a process that defines the required scope and capability of dual diagnosis practice for each sector

In addition it is proposed that:

R.3.1.1 The scope for AOD include that appropriately qualified AOD clinicians[1] should provide clinical interventions with dual diagnosis clients that have high prevalence disorders or be able to facilitate client participation in online support options such as Mood Gym, SHADE and Virtual Clinic.

R.3.1.2 The scope for appropriately qualified clinical MH[2] should include the delivery of AOD interventions in clinical mental health settings as a core component of clinical work.

R.3.1.3 The scope for PDRSS should include the provision of AOD clinical interventions by appropriately qualified PDRSS workers[3] and non-clinical AOD support to clients by all workers.

R.3.1.4 A clinical subcommittee of the VSSP Central Steering Committee be established by the Department to identify and/or develop appropriate care models and treatment frameworks for people with substance use issues and high prevalence, trauma and personality disorders. The subcommittee would ideally have significant VDDI Psychiatrist involvement along with representation by clinical psychologists experienced in high prevalence and other non-psychotic disorders and substance use issues as well as highly experienced and qualified AOD clinicians. The National Drug and Alcohol Research Centre could provide highly valuable input to such a process. The subcommittee should also be well placed to provide guidance on the areas of training that will be required as well as informing development of treatment guidelines.

[1] Practitioners with Psychology, Social Work, Occupational Therapy, Mental Health Nursing qualification plus DD competencies, and recognised training in Motivational Interviewing and other evidence-based AOD interventions and who have been provided with specific training in CBT and other therapeutic interventions

[2] Clinicians with training in DD competencies, Motivational Interviewing and other evidence-based AOD interventions

[3] Practitioners with Psychology, Social Work, Occupational Therapy, Mental Health Nursing qualification plus DD competencies, and recognised training in Motivational Interviewing and other evidence-based AOD interventions

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3.2 Workforce development strategy

Recommendation 3.2	The Department of Health to undertake the development of a workforce development strategy which will form a significant component of the VSSP

In addition it is also proposed that:

R.3.2.1 The workforce development strategy gives careful consideration to the development of training packages for senior managers, team leaders/supervisors and clinicians and workers (that are relevant to individual sectors).

R.3.2.2 The training programs use the most efficient means to deliver the program before the end of 2012, which most likely will entail a combination of strategies and that new training be developed as units of competency under VET accreditation system, wherever possible.

R.3.2.3 Funding for Reciprocal Rotations be reallocated to support the implementation of a substantial workforce development strategy, which may also include additional resources for some of the VDDI teams.

R.3.2.4 A much stronger emphasis on the establishment of the capacity to deliver clinical and non-clinical interventions to be included. Hence appropriate training units of competency should be developed along with a set of clinical and non-clinical guidelines for guiding interventions by workers across the three sectors that are ideally consistent with existing national guidelines. This includes the need to provide clinical interventions for clients with high prevalence, personality and trauma-related disorders, that attend AOD services, as well as the need to intervene with AOD issues in mental health settings.

R.3.2.5 The ETU to provide a leadership and coordination role in the implementation of the strategy.

R.3.2.6 The Department engage the professional bodies and colleges in a round table dialogue around the incorporation of dual diagnosis specific units and the establishment of placements across both AOD and mental health settings as routine practice.

R.3.2.7 The ongoing role in fostering dual diagnosis capability of the 'soon to be established' Victorian Institute of Mental Health Workforce Development and Innovation be clarified as a matter of priority in its establishment.

3.3 VDDI teams and Psychiatric Support

Recommendation 3.3	VDDI teams and Psychiatric Support continue to be funded for a further 3 years, with the following modifications

It is proposed that the VDDI teams' core role become inclusive of the following:

R.3.3.1 Supporting AOD organisations with implementing appropriate responses to high prevalence, as well as personality and trauma-related issues.

R.3.3.2 Prioritising support to clinical and/or team leaders with the inclusion of dual diagnosis as a core part of their supervisory practice (training be undertaken by VDDI team members to build their capacity in this area).

R.3.3.3 Being very well versed in online options for intervening with high prevalence disorders and work with AOD services to facilitate their promotion of these options to clients.

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R.3.3.4 Primary consultations to occur only where it involves modelling particular aspects of practice and even this approach will need to be applied sparingly.

And in addition it is proposed that:

R.3.3.5 Allocation of funds to VDDI teams to be reviewed by the Department in order to redress any inequities.

And in relation to Psychiatric Support, it is proposed that:

R.3.3.6 The dedicated psychiatric support be pooled and made equally available to all regions via video and teleconference as well as face to face sessions where the travel time is not extensive.

R.3.3.7 The Department of Health consider developing a role through the VSSP that sees the psychiatrists working in conjunction with the Chief Psychiatrist's Office, Clinical Directors of Mental Health and the Royal Australian and New Zealand College of Psychiatry to build dual diagnosis capacity and focus.

R.3.3.8 The Department of Health consider continued support for the Psychiatrists' active involvement with the RACP's Addiction Medicine Chapter

2. Context

2 CONTEXT

Comorbidity of mental disorders and substance use disorders is common. Furthermore, comorbidity is often associated with poor treatment outcome, severe illness course, and high service utilisation. This presents a significant challenge with respect to the identification, prevention and management of people with comorbid disorders. The unmet need for treatment within this group is considerable, the lack of research is unacceptable and the person with comorbid mental disorders and substance use disorders is often left to fall in the gap between the relevant services. (Teesson and Proudfoot, 2003:1)[4]

2.1 Dual Diagnosis

Dual diagnosis or comorbidity is a generic term referring to the co-occurrence of disorders suffered by an individual, although Dual Diagnosis is coming to be the term used specifically to refer to the comorbidity of mental illness and substance abuse[5, 6].

Complex interdependencies occur between clients' mental health and substance use disorders, although the causal linkage(s) between these disorders remains incompletely understood[7]. Treatment of dual diagnosis is challenging because of the chronic, relapsing, and impairing natures of both issues. Many people with dual diagnosis disorders currently receive no treatment whatsoever for either disorder. When they do receive care, individuals with dual diagnosis often face greater difficulties in treatment and recovery, and have difficulty in following a treatment regime. They may display more challenging behaviours than people who have a mental illness without associated substance abuse. As such, these clients are often not well served in traditional health care systems where specialist services are often segregated and clients are left to negotiate required treatment across both systems[8].

Anecdotal and research evidence indicates that people with co-occurring disorders tend to 'fall between the gaps' – their co-occurring disorder going unrecognised and therefore failing to receive treatment from either service system.

2.1.1 Prevalence

Dual diagnosis disorder clients are very common in both mental health (MH) and alcohol and other drug (AOD) services. The prevalence of dual diagnosis is, however, hard to assess in the broader population

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[4] Teesson, M & Proudfoot, H, 2003, Responding to comorbid mental disorders and substance use disorders, In M. Teesson and H. Proudfoot, eds., *Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment*, National Drug and Alcohol Research Centre, University of New South Wales, Sydney

[5] Drake, R., Mueser, K., Brunette, M, & McHugo, G. (2004) 'A Review of Treatments for People with Severe Mental Illnesses and Co-Occurring Substance Use Disorders' Psychiatric Rehabilitation Journal 27(4): 360-374.

[6] Andrews, G., Issakidis, C., & Slade, T. (2003) 'How Common is Comorbidity?' in Teeson, M., & Proudfoot, H. (eds) (2003) Comorbid Mental Disorders and Substance Use Disorders: Australian Bureau of Statistics (2005) Mental Illness in Australia: A Snapshot of 2004-2005 http://www.abs.gov.au/ausstats/abs@.nsf/mf/4824.0.55.001

[7] Corrigan, P. McCracken, S., & McNeilly, C. (2004) 'Evidence Based Practices for People with Serious Mental Illness and Substance Abuse Disorders' in Stout, C., & Hayes, R. (eds) (2004) The Evidence Based Practice: Methods, Models and Tools for Mental Health Professionals Wiley: Illinois.

[8] Department of Health & Ageing (2007) Barriers and Incentives to Treatment for Illicit Drug Users with Mental Health Comorbidities and Complex Vulnerabilities: Monograph Series No. 61 Commonwealth of Australia: Canberra.

2. Context

because of its highly variable presentation across age groups and definitional difficulties related to the criteria for a 'disorder'. Nevertheless, it is estimated that dual diagnosis disorders have been found in between one third and one half of clients of mental health and AOD services[9]. They are a very common population, not only in addiction and mental health service systems, but also in the juvenile and criminal justice systems, welfare systems and amongst homeless.

In 2006 the Australian Institute of Health and Wellbeing (AIHW) reported that 'around one in five Australians aged 14 years and over consumed alcohol at "risky" or "high-risk" levels for short-term risk on at least one occasion in the last 12 months. One in ten Australians consumed alcohol at levels that are considered "risky" or "high risk" for alcohol related harm in the long term' (AIHW 2006:x)[10]. Also their survey found that '38% of Australians aged 14 years and over had used any illicit drug at least once in their lifetime, and 15% had used any illicit drug at least once in the last 12 months' (AIHW 2006:xi).

The National Survey of Mental Health and Wellbeing classifies substance use disorders as a class of mental disorder. The 2007 survey found that 'nearly half (45.5%) of the Australian population aged 16-85 years had experienced an anxiety, affective or substance use disorder at some stage in their lifetime' (Slade et al 2009:5)[11]. Substance use disorders were experienced at some stage in their lifetime by 24.7% of the population[12].

2.2 Prevalence of mental health issues in Alcohol and Other Drug service users

The experience in Victoria is that at least 30% of public mental health service consumers also experience harmful drug and alcohol use[13] although the reliability of data collected is subject to significant variation across the sectors involved.

Mills et al (2009:11)[14], in the national guidelines on managing comorbidity in AOD settings, identify mood, anxiety and personality disorders as the most common amongst people presenting to AOD services. They also point to the high prevalence of Trauma and Post Traumatic Stress Disorder particularly for heroin users.

Figure 2-1 seeks to illustrate the difference between the types of mental health issues present in AOD clients with co-morbid mental health issues, when compared with the range of mental health issues that clinical mental health services target. Given the higher prevalence of anxiety, depression, personality disorders and trauma related conditions, let alone people presenting with symptoms of these, then the number of people with dual diagnosis in AOD services that can be supported by clinical mental health, will be far fewer than the total number requiring assistance with mental health issues.

[9] Department of Health & Ageing (2003) Current practice in management of clients with comorbid mental health and substance use disorders in tertiary care National Comorbidity Project, Commonwealth of Australia: Canberra

[10] Australian Institute of Health and Welfare 2007. Statistics on drug use in Australia 2006. Drug Statistics Series No. 18. Cat. no. PHE 80. Canberra: AIHW.

[11] Slade, T, Johnston, A, Teesson, M, Whiteford, H, Burgess, P, Pirkis, J & Saw, S 2009, The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra

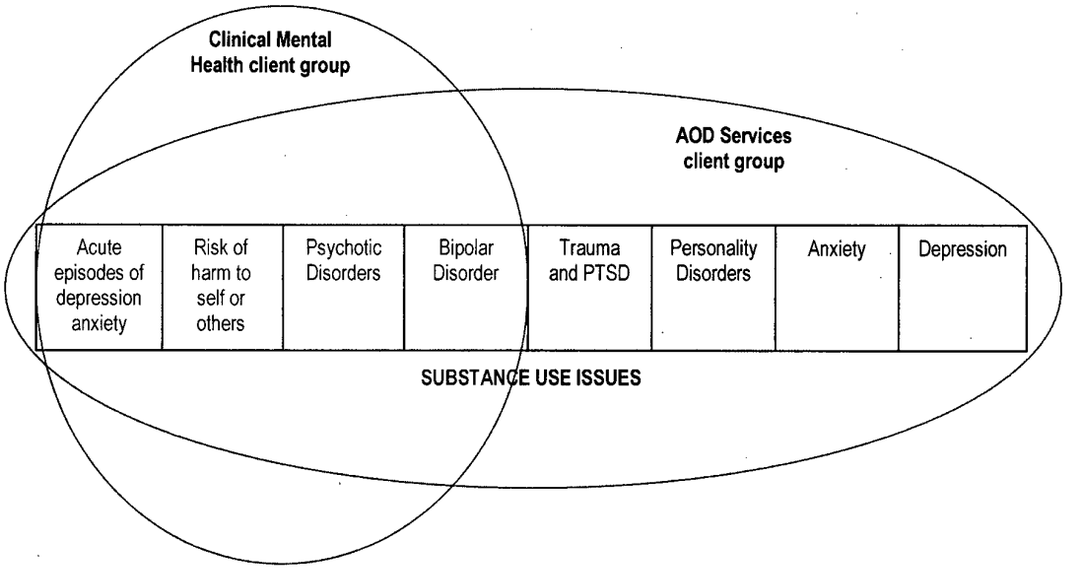
[12] Ibid

[13] Data from RAPID database, collected by Department of Human Services 2008 as cited in Because Mental Health Matters – Victorian Mental Health Reform Strategy, 2009-19

[14] Mills, K L, Deady, M, Proudfoot, H, Sannibale, C, Teesson, M, Mattick, R & Burns, L. 2009. Guidelines on management of co-occurring alcohol and other drug and mental health conditions in Alcohol and Other Drug treatment settings. National Drug and Alcohol Research Centre, UNSW, Sydney 2009

2. Context

Figure 2-1: Range of MH Disorders present in clients of Clinical MH and AOD services



2.2.1 Impact

People with dual diagnosis disorders are more likely to experience poorer health outcomes across a range of key indicators. In 2003, Begg et al (2007, p. 59) reported that 'mental disorders were responsible for 13.3% of the total burden of disease and injury in Australia[15]. With regard to the impact of substance use disorders, AIHW (2006:xi) reported that '8% of the burden of disease in Australia was attributable to tobacco use and 2% to illicit drug use'.

Within drug and alcohol services people with dual diagnosis have poorer prognosis, higher relapse rates and greater problems of exclusion and marginalisation. These poorer outcomes include:

- increased rates of suicide
- higher levels of mental health symptoms
- increased relapses, number of hospitalisations and time spent in hospital
- poorer general health, including increased rates of hepatitis C and HIV
- increased risk of violence and offending & high rates incarceration by justice systems
- unstable housing and homelessness
- loss of family supports
- financial problems
- impaired general health status
- high frequency of poor engagement with treatment
- Non-compliance with medication
- increased costs and usage of services.

[15] Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD 2007, The burden of disease and injury in Australia 2003. PHE 82. Canberra: AIHW

2. Context

In cases of dual diagnosis, mental health and substance abuse disorders often influence each other, leading to enhanced severity of both disorders, affect upon the treatment response and difficulties in diagnosing which problem arose first.

Evidence indicates some population groups and individuals are more vulnerable than others. High rates of dual diagnosis exist among Indigenous Australians, among young people who have been in foster care or other out of home care, and among the homeless. 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 also a major contributor to the poor health of Indigenous people[16].

2.3 Service landscape

A wide range of mental health and alcohol and other drug services are available in Victoria. Specialist mental health services predominately include clinical mental health and Psychiatric Disability Rehabilitation and Support Services (PDRSS) and provide treatment and care to those with the most severe and complex mental health problems and disorders.

Alcohol and other drug treatment (AOD) services are available for those who are viewed primarily as having a drug and alcohol problem.

Support for people with less severe episodes of mental illness is mostly available through primary mental health services which are provided by private psychiatric or psychological practitioners or through Divisions of General Practice.

It is also important to note that Needle and Syringe Programs (NSP) are provided throughout Victoria, which play an important harm reduction and harm minimisation role. These services have frequent contact with thousands of intravenous drug users, however very few receive any significant core funding.

2.3.1 Clinical Mental Health Services

Clinical mental health services are provided through 21 catchment areas within Victoria. The services are segmented into teams that respond to three different age ranges, namely child and adolescent, adult and aged programs.

The majority of clinical 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. These services operate in a catchment area with the purpose of providing people with better access to a range of services within their own communities.

2.3.2 Psychiatric Disability Rehabilitation and Support Services

Psychiatric disability rehabilitation and support services (PDRSS), provide support to people with a mental health problem and their carers throughout the recovery process and forms part of the broader

[16] Department of Human Services. (2007) Dual Diagnosis. Key directions and priorities for service development. Victorian Government, Melbourne.

2. Context

Victorian specialist mental health service sector. PDRSS are commonly referred to as non-clinical services. PDRSS are predominantly funded to provide services to the adult population (16-64 years). However, there are a number of limited programs offered to the aged population (65 years and over) in some catchment areas.

Specific investments have been made in PDRSS to improve the responsiveness of services to dual diagnosis clients.

2.3.3 Alcohol and Other Drug Services

There is a range of alcohol and drug related services available in Victoria. Access to most of these services is available in regional and metropolitan Victoria. The Department funds mostly non-government organisations to provide these services across the state.

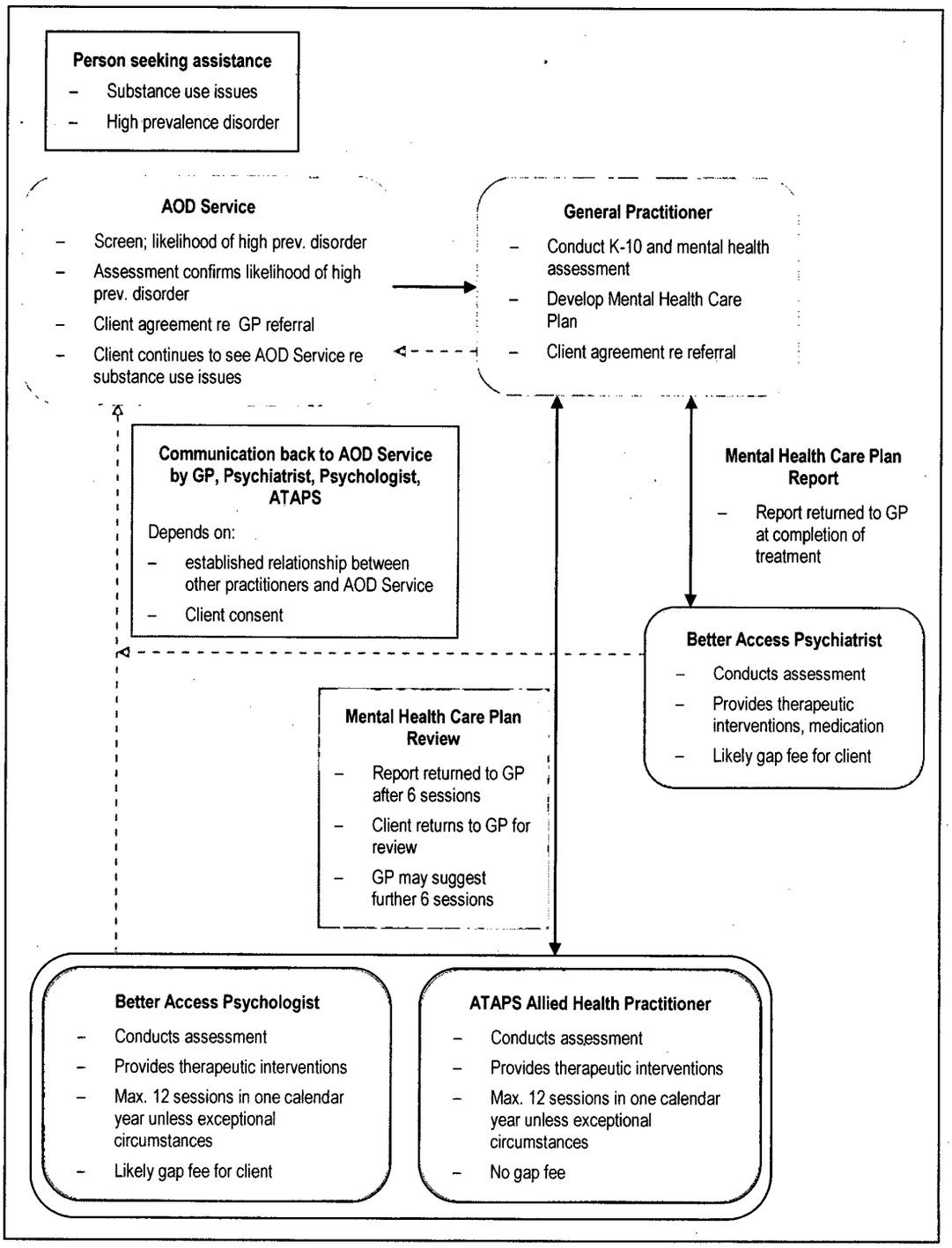
Services delivered include alcohol and drug prevention and education programs, voluntary treatment and rehabilitation services, forensic drug treatment services, and needle and syringe programs. Some services are targeted towards specific client groups, such as youth, families and Aboriginal and Torres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

2.3.4 Primary Care options for mental health support

Those people with mental health issues that fall outside the client group for clinical mental health have the primary health system as their option for support. Accessing the primary care pathway involves a number of steps as *Figure 2-2* shows. It also requires that a person with dual diagnosis issues is accepted as a referral at each step and if they are, the response provided is appropriate to their dual diagnosis issues. If they are involved with an AOD service, there may or may not be communication back to the service depending on the relationship that the service has with the doctor, allied health, psychological or psychiatric practitioner. There is also the issue of gap fees both on seeing the doctor and the therapist depending on whether or not the practitioners choose to bulkbill or the therapist is funded through the *Access to Allied Psychological Services* program, operated by Divisions of General Practice.

2. Context

Figure 2-2: Process for referral and treatment of Mental Health issues through Primary Care:



2. Context

2.4 Policy environment

A number of policy documents across the mental health and AOD sectors provide the context for this initiative, including:

Dual Diagnosis: Key Directions and Priorities for Service Provision[17]

This document outlines the priorities and directions for dual diagnosis service developments in Victoria. It highlights the issues associated with current service delivery and provides guidance for services leaders and managers to develop a greater focus on dual diagnosis within their service. It articulates a vision for dual diagnosis to be seen as core business within both mental health and alcohol and other drug services, requiring high level commitment and leadership in both policy and service development.

The document includes a dual diagnosis action plan 2007-2010, developed in consultation with the sector outlining five service development outcomes that need to be achieved for effective responses to dual diagnosis within mental health and alcohol and other drug services.

Because Mental Health Matters – Victorian Mental Health Reform Strategy, 2009-19[18]

Developed through extensive consultation with those who live with a mental illness, their friend and families and the sector, this policy document represents the Victorian government's commitment to ensuring those living with a mental illness have access to high quality, timely care to support them to live successfully in the community.

Because Mental Health Matters is a whole of Victorian government ten-year plan for mental health. It is based on four core elements:

- Prevention
- Early Intervention
- Recovery
- Social inclusion

Key directions promoted within the policy include promotion of positive mental health; early intervention, both early in life and early in the emergence of a mental health condition; and a greater emphasis on identifying and supporting children and young people at risk, with family involvement wherever possible. *Because Mental Health Matters* also supports new approaches to enable people to access mental health services at the 'right time' and in the 'right place'.

The document proposes a wide range of reforms requiring leadership, workforce capacity building, cultural change, and investment from a range of sources. The Victorian Mental Health Reform Strategy may have implications for future dual diagnosis activity. The re-organisation of mental health services around the servicing of newly configured age cohorts, and the emphasis on strengthening relationships with primary care, community health and other providers, will likely need to be accommodated by the VDDI. There are some synergies, such as strengthening local planning with an emphasis on effective partnerships, which has in part been the focus of the VDDI across mental health and alcohol and drug services.

[17] http://www.health.vic.gov.au/drugservices/downloads/dual_diagnosis_report.pdf
[18] http://www.health.vic.gov.au/mentalhealth/reformstrategy/index.htm

2. Context

A New Blueprint for Alcohol and other Drug Treatment Services 2009-2013

A new blueprint for alcohol and other drug treatment services, 2009–2013, a client-centred and service-focused framework outlines the Victorian Government's reform priorities and investment decisions for alcohol and other drug services over the next five years.

Reviews undertaken in 2003 and 2004 found existing AOD services to be fragmented and with variable connection to other health, welfare and employment systems required to support people with complex needs. The blueprint establishes a client-centred and service-focused approach across the service system to deliver better treatment outcomes to better support people who have substance abuse problems, their families and communities. It identifies six priority areas:

- Prevention
- Improving access
- Excellence and quality
- Clients
- Children and families
- Young people

The blueprint promotes an integrated service system that delivers prevention, early intervention, treatment, harm reduction and recovery responses. It recognises that individuals require a range of interventions and clear pathways to other service systems to promote effective recovery. It emphasises the need for strong collaborations and partnerships to help connect people to the wider range of health and welfare services they might need to successfully reintegrate into society. The *blueprint* therefore provides an important framework for reform that also supports future dual diagnosis activity.

Shaping the Future: The Victorian Alcohol and other Drug Quality Framework

This policy builds on the work of the previous quality plan within the overarching principles of the Department of Human Services (DHS) quality. The framework comprises six core standards: Consumer Focus, Evidence-based Practice, Continuous Quality Improvement (CQI), Corporate and Clinical Governance, Workforce Development and Partnerships. It requires AOD services to undertake a quality accreditation program through standards setting bodies, such as Quality Improvement Council (QIC), International Standards Organisation (ISO) or Australian Council on Healthcare Standards (ACHS).

The emphasis on a consumer focus and the use of evidence-based practice is echoed in the New Blueprint for Alcohol and other Drug Treatment Services, Mental Health Reform Strategy and the Victorian Alcohol and other Drug Quality Framework.

Shaping the Future: The Victorian Mental Health Workforce Strategy

This document articulates the Victorian government's commitment to developing a specialist mental health workforce and sits within the broader framework of workforce and mental health system reform provided by the Victorian Mental Health Reform Strategy.

Workforce shortages will continue to lead to challenges in meeting demand and strategies such as the Victorian Mental Health Workforce Strategy will be important in ensuring a workforce for the future. The strategy proposed that a Victorian Institute of Mental Health Workforce Development and Innovation be formed. It is unclear at this stage what role the Institute will play in relation to building and sustaining dual diagnosis capability.

2. Context

National Comorbidity Initiative – Commonwealth Department of Health and Ageing

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

- Raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models
- Providing support to general practitioners and other health workers to improve treatment outcomes for comorbid clients
- Facilitating resources and information for consumers
- Improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively.

The Improved Services Initiative (ISI) builds on the National Comorbidity Initiative and specifically focuses on building the capacity of non-government drug and alcohol treatment services to provide best-practice services that effectively identify and treat coinciding mental illness and substance abuse.

2.5 Prevailing literature

There is a substantial amount of research showing that the occurrence of substance use problems in those who have a mental illness or mental health problems in those who have a substance use disorder is now the expectation not the exception[19],[20],[21]. This has led to the determination that in both mental health and AOD Services, dual diagnosis is everyone's business.

A review of the Australian and international dual diagnosis literature was undertaken by AHA to support the evaluation of the VDDI initiative (refer to Appendix C). This review outlines the evidence regarding service delivery models for dual diagnosis.

2.5.1 Issues to be addressed

Dual Diagnosis presents challenges for people seeking treatment for drug dependence or mental health problems, and for health professionals in both the drug and alcohol and mental health sectors. Unsurprisingly, dual diagnosis conditions are more difficult to treat and manage than single drug or mental health conditions, and are associated with poorer treatment outcomes for consumers [22, 23, 24]. Care often involves parallel but separate mental health and substance abuse treatment systems and is frequently seen to be fragmented. In addition, alcohol and other drug treatment services and mental health services sometimes have different perspectives on how best to respond to the needs of dual

[19] National Comorbidity Project. National Drug Strategy. National mental Health Strategy. (Eds Teeson M, Byrnes L). Commonwealth Department of Health and Aging. Canberra. 2001.
20 Proudfoot, H., Teeson, M., Brewin, E., & Gournay, K. (2003) 'Comorbidity and Delivery of Services' in Teeson, M., & Proudfoot, H. (Eds) (2003) Comorbid Mental Disorders and Substance Use Disorders: Epidemiology, Prevention and Treatment Australian Government Department of Health and Ageing: Canberra.
21 Todd, J., Green, G., Ikuesan, B., Self, C., Pevalin, D., & Baldacchino, A. (2004) 'Social exclusion in clients with comorbid mental health and substance misuse problems' Social Psychiatry and Psychiatric Epidemiology 39: 581-587
[22] A Guide for the Management of Dual Diagnosis for Prisons. Department of Health & Ministry of Justice. UK. 2009. Pub 293983.London.
23 Birkel RC, Hall LL, Lane T, Cohan K, Miller J: Consumers and families as partners in implementing evidence-based practice. Psychiatr Clin North Am 2003, 26:867-881.
24 Todd, J., Green, G., Ikuesan, B., Self, C., Pevalin, D., & Baldacchino, A. (2004)

diagnosis clients and vice versa. As a result people with a history of illicit drug use and co-occurring anxiety or depression are still not well served by drug and alcohol or mental health services.

Many health care organisations still fail to approach concurrent psychiatric disorders and addiction as disorders requiring concurrent treatment.[25] Some estimates suggest that fewer than half of clients with recognised dual diagnosis disorders do not receive concurrent treatment for both disorders[26]. Where concurrent treatment is offered, those services are often not offered in an integrated manner, with health systems requiring that dual diagnosis clients navigate the separate mental health and AOD care systems and make sense of sometimes disparate messages about treatment and recovery.

As usual care has too often seen dual diagnosis disorder clients fall through the cracks in contemporary healthcare systems, for over 20 years many clinicians, administrators, policy makers, researchers, family organisations and clients themselves have been calling for better cohesion of mental health and substance abuse services.

A review[27] conducted by the Department of Health and Ageing identified a number of issues with the existing treatment of co-occurring drug and mental health problems:

- the adequacy of training in comorbidity
- the adequacy of support services for comorbid clients
- problems with interagency support and communication
- tensions between treatment philosophies and models of care
- establishing effective therapeutic relationships with stigmatised and disorganised consumers.

2.5.2 Recommended models

The literature usually describes 4 principal models of care for clients with dual diagnosis disorders

- Single model of care: The "primary" disease and treatment approach
- Sequential model of care: Treating one disorder at a time
- Parallel model of care: Concurrent treatment of both disorders (i.e., both disorders are treated at the same time but by different treatment teams in different places)
- Integrated model of care: Treating both disorders (i.e., both disorders are treated at the same time and at the same place or using the one treatment plan; integration can occur at the individual clinician, the program, the agency, or at the system level)

Early reviews suggested that integrated models of treatment which provide a range of therapeutic options for drug treatment, mental health support, and which treat co-occurring conditions simultaneously, were likely to be more effective in handling the challenges posed by co-occurring drug

[25] Cleary M , Hunt G.E. , Matheson S. & Walter G. (2009) Psychosocial treatments for people with co-occurring severe mental illness and substance misuse: systematic review. Journal of Advanced Nursing 65(2), 238–258.
[26] Wells, Kenneth B., Roland Sturm, and Audrey Burnam. National Survey of Alcohol, Drug, and Mental Health Problems [Healthcare For Communities], 1997-1998 [Computer file]. 2nd ICPSR version. Los Angeles, CA: University of California, Los Angeles, Health Services Research Center [producer], 2003. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2003
27 Department of Health & Ageing (2007) Barriers and Incentives to Treatment for Illicit Drug Users with Mental Health Comorbidities and Complex Vulnerabilities: Monograph Series No. 61 Commonwealth of Australia: Canberra.

and mental health problems. It was suggested that the needs of dual diagnosis disorder clients would be better addressed by more integrated approaches to the provision of care than by less integrated approaches.

This progressive accumulation of evidence supporting a range of integrated treatment models of interventions in the dual diagnosis population has convinced many observers that integrated treatment offers "best practice" care for patients and patients' families. Such 'high quality' integrated treatment programs are said to ensure coordination of substance abuse and mental health interventions, treat individual clients more effectively, improve client engagement, reduce substance abuse, improve mental health status, and reduce relapses for all age groups [28]. More recently other reviews have reported fewer advantages to recommend integrated care models[29, 30, 31], specifically in relation to serious mental illness and comorbid substance use disorders, where the most widely referenced meta-analysis of care for dual diagnosis disorders[20] found no compelling evidence to support any one psychosocial treatment over another to reduce substance use (or improve mental state).

In summary, there is growing consensus that effective care for the majority of clients with dual diagnosis disorders requires access to a variety of models of care and a range of skilled, professional carers. The literature highlights that it is likely that integrated services are better suited to providing flexible treatment arrangements for consumers than separated drug and mental health services[32].

2.6 Treatment guidelines and audit tools

A number of different guidelines have been produced by different jurisdictions and targeting different sections of the workforce. Five examples are provided below along with some of the audit tools that have been used.

2.6.1 National guidelines on co-morbid mental health and AOD issues

In 2007 the Australian Government Department of Health and Ageing funded the National Drug and Alcohol Research Centre (NDARC) to develop *Guidelines on the management of co-occurring mental health conditions in alcohol and other drug (AOD) treatment settings*[33].

The Guidelines have been developed primarily for AOD workers working in AOD treatment settings such as those services providing inpatient or outpatient detoxification, residential rehabilitation, substitution therapies or outpatient counselling services.

The Guidelines are based on a comprehensive review of the best available evidence and the experience of an expert panel of academic researchers, clinicians, consumers, and carers. They aim to:

- Increase AOD workers' knowledge and awareness of mental health conditions

[28] Kavanagh, D., Mueser, K., & Baker, A. (2003) 'Management of Comorbidity' in Teeson, M., & Proudfoot, H. (eds) (2003) Comorbid Mental Disorders and Substance Use Disorders:
[29] Centre for Substance Abuse Treatment (2007) Services Integration: COCE Overview Paper 6 Substance Abuse and Mental Health Services Administration: Rockville, MD.
[30] Graham H. Comorbidity towards evidence based practice in the ATOD sector. Comorbidity Improved Services Project, School of Sociology & Social Work, University of Tasmania. 2008.
[31] Greenhalgh T, Robert G, MacFarlane F, Bate P, Kyriakidou O: Diffusion of innovations in service organizations: systematic review and recommendations. Milbank Q 2004, 82:581-629.
[32] Greig, R. L., Baker, A., Lewin, T. J., Webster, R. A., & Carr, V. J. (2006). Long-term follow-up of people with co-existing psychiatric and substance use disorders: patterns of use and outcomes. *Drug and Alcohol Review, 25*, 249-258.
[33] http://www.med.unsw.edu.au/NDARCWeb.nsf/page/Comorbidity+Guidelines

2. Context

- Improve the confidence and skills of AOD workers working with clients with comorbid mental health conditions
- Provide guiding principles for working with clients with comorbid mental health conditions
- Improve AOD workers' ability to identify mental health conditions
- Provide practical information on the management of comorbid mental health conditions
- Provide information regarding the treatment of comorbid mental health conditions
- Provide information regarding referral processes.

Prior to publication, the Guidelines were pilot tested in non-government AOD treatment services across Australia.

2.6.2 *NSW Department of Health guidelines on co-morbid mental health and AOD issues*

In 2009, the New South Wales (NSW) Department of Health developed the *NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings*[34]. The guidelines were developed for practitioners working in the AOD and/or mental health sectors who provide care for people with comorbid, mental health and substance use disorders and who work in the following environments:

- Acute
- Non acute
- Community settings
- Hospitals
- Government
- Non-government.

Based on the premise that all clients should receive care that addresses the full spectrum of their illness(es), regardless of where they present (i.e. there is no wrong door), these guidelines articulate that responsibility for providing care that addresses the range of client needs is the responsibility of the care provider/service where the client presents. These guidelines are intended to be a resource for practitioners and to be used in line with other clinical treatment guidelines.

2.6.3 *Victorian Dual Diagnosis guidelines*[35]

In Victoria, the Victorian Dual Diagnosis Initiative and Turning Point Alcohol and Drug Centre have developed the *Working with dual diagnoses: guidelines for alcohol and other drugs workers* on behalf of the Drug Policy and Services Branch of the Department of Human Services. These guidelines aim to support AOD workers and services in becoming dual diagnosis capable. They also seek to assist AOD workers in a range of AOD treatment settings to respond effectively to clients' comorbid mental health symptoms or problems when they arise.

At this stage there are no specific guidelines for mental health workers working with clients with comorbidity. The *National Practice Standards for Mental Health Services* (currently under revision) and

[34] http://www.health.nsw.gov.au/pubs/2009/pdf/comorbidity_report.pdf
[35] http://www.dualdiagnosis.org.au/home/

2. Context

the *National Practice Standards for the Mental Health Workforce* provide guidance to services and professionals working with people who have mental health conditions, although these do not specifically address dual diagnosis issues.

2.6.4 New Zealand guidelines on co-morbid mental health and AOD issues

New Zealand's Ministry of Health has released two publications this year that are focused on responding to dual diagnosis issues. *Te Ariari o te Oranga The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems*[36] provides a detailed framework for working with dual diagnosis issues. The framework consists of seven key principles.

- Cultural considerations:
- Well-being
- Engagement
- Motivation
- Assessment
- Management
- Integrated care

These principles are underpinned by the following set of assumptions:

- CEP [Co-existing Mental Health and Addiction Problems] are heterogeneous - there are as many different types as there are combinations of mental health problems and psychoactive substances.
- Care should be driven by the needs of tangata whaiora [Màori term for a person, or people, seeking health] rather than the needs of the system.
- Well-being is a state linked to the processes of recovery, is a valid outcome goal, and is a construct understood by a range of systems, and therefore helps integration and is a powerful motivating factor.
- Comprehensive or holistic understanding of the person is essential to develop care that enhances well-being.
- Integrated care involves bringing together a full range of problem domains, not just alcohol and drug problems, driven by the needs of tangata whaiora and supported rather than dictated by service- and systems-level integration.

Service Delivery for People with Co-existing Mental Health and Addiction Problems: Integrated Solutions, the companion publication to *Te Ariari o te Oranga* targets service planners, providing information on client centred work, service development, integrated models of care and workforce development.

[36] http://www.moh.govt.nz/moh.nsf/pagesmh/10055/$File/te-ariari-o-te-orang-teariari-13-04-10.pdf

2. Context

2.6.5 *United Kingdom, Department of Health Dual diagnosis in mental health inpatient and day hospital settings*[37]

This guide, released in 2006, covers the assessment and clinical management of patients with mental illness, being cared for in psychiatric inpatient or day care settings, who also use or misuse alcohol and/or illicit or other drugs. It also covers organisational and management issues to help mental health services manage these patients effectively.

The key message is that the assessment and management of drug and alcohol use are core competences required by clinical staff in mental health services.

2.6.6 *Audit tools*

There are a number of audit tools (non-validated) that are being used to assist Victorian organisations with determining their dual diagnosis capability, and areas for improvement. Some of these are pitched at the organisational level, with others for individual workers to undertake a self assessment of their capacity. Examples of these include:

- Dual Diagnosis Capability in Treatment (DDCAT)
- Comorbidity Program Audit and Self-Survey for Behavioral Health Services (COMPASS)
- Dual Diagnosis Capability Checklist – Agency/Service Level
- Dual Diagnosis Capability Checklist – Alcohol, Tobacco and Other Drug Workers
- Dual Diagnosis Capability Checklist – Clinical Mental Health Workers.

[37] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_062652.pdf

3. Victorian Dual Diagnosis Initiative

3 VICTORIAN DUAL DIAGNOSIS INITIATIVE

3.1 History

The first pilot dual diagnosis team, Substance Use and Mental Illness Treatment Team (SUMITT), was funded by the Department of Human Services, in 1998. This led to the commencement of the Victorian Dual Diagnosis Initiative (VDDI) in mid 2001, which saw the 'establishment of four Dual Diagnosis teams and linked rural workers in Victoria, jointly funded by the Mental Health Branch and Drugs Policy and Services Branch' (Roberts, et al 2004:14)[38] of the Department of Human Services.

The initiative has continued to evolve and grow since its establishment in 2001, with 'eight new youth dual diagnosis positions focusing on 12–18 year olds' added to the Dual Diagnosis teams and an 'additional 21 positions...funded in Mobile Support and Treatment Teams to enhance the responsiveness of services to dual diagnosis clients' (DHS 2007:13)[39]. Neither of these developments is within the specific scope of this evaluation.

In 2003 the Department provided a small amount of funds for the establishment of the VDDI Rural Forum, which brings together the rural practitioners. This funding has continued through to the current financial year.

New projects funded in 2005–06 included:

- Reciprocal rotations between mental health and alcohol and other drug services
- Expansion of consultant psychiatrist time
- Establishment of the Education and Training Unit (ETU).

The Department has also provided one off funding to the ETU for specific pieces of work.

Key Directions was released in 2007 in order to clarify expectations of the three sectors in relation to service development and as described in the previous chapter, this included setting service development outcomes that were expected to be met.

3.2 Major VDDI strategies

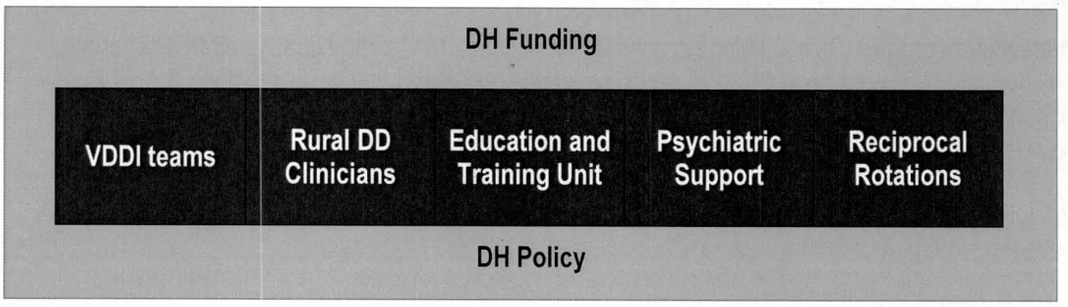
This section provides an overview of the major VDDI strategies in scope of the evaluation as summarised in *Figure 3-1*. This section does not comment on the effectiveness, achievements and impact of the strategies; this is addressed in the subsequent chapter concerning the Service Delivery Outcomes and also in *Chapter 5*.

[38] Roberts, B, Berends, L, Ritter, A. 2004. *Statewide Dual Diagnosis Initiative Evaluation: Final Report.* Turning Point Alcohol and Drug Centre, Melbourne, October 2004. P 14

[39] Department of Human Services. 2007. *Dual Diagnosis; Key directions and priorities for service development.* Victorian Government, Melbourne. P 13

3. Victorian Dual Diagnosis Initiative

Figure 3-1: Major VDDI Strategies



3.2.1 Current Funding

The total funding for VDDI funding is over $10 million of which around half is committed to work with adult related programs.

3.2.2 VDDI teams

The successful implementation of the VDDI is underpinned by the four metropolitan dual diagnosis teams. The role of the teams is essentially one of supporting and developing the alcohol and drug, mental health and PDRSS provider's capacity to manage dual diagnosis clients. This is achieved through the following activities:

- Education and Training
- Primary Clinical Consultations
- Secondary Consultations
- Tertiary consultations
- Supervision and case reviews
- Organisational change management
- Network facilitation and partnership development.

Priority activities for the Dual Diagnosis Teams 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 ETU 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

A key function is the identification and promotion of collaborative service relationships between mental health and drug treatment services within the relevant regional catchment. In particular the teams are to address issues of access, assessment and the development of effective treatment planning, with a

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strong focus on building capacity within the services to respond more effectively to people with a dual diagnosis.

Primary and secondary consultation services to alcohol and drug, mental health and PDRS service providers are for the purpose of providing assessments and making recommendations about the management of dual diagnosis clients, but responsibility for ongoing client management remains with the relevant mainstream service.

The following map illustrates the geographical coverage of each of the four metropolitan teams as per the legend in *Figure 3-2*.

Figure 3-2: Map of Metropolitan VDDI team coverage

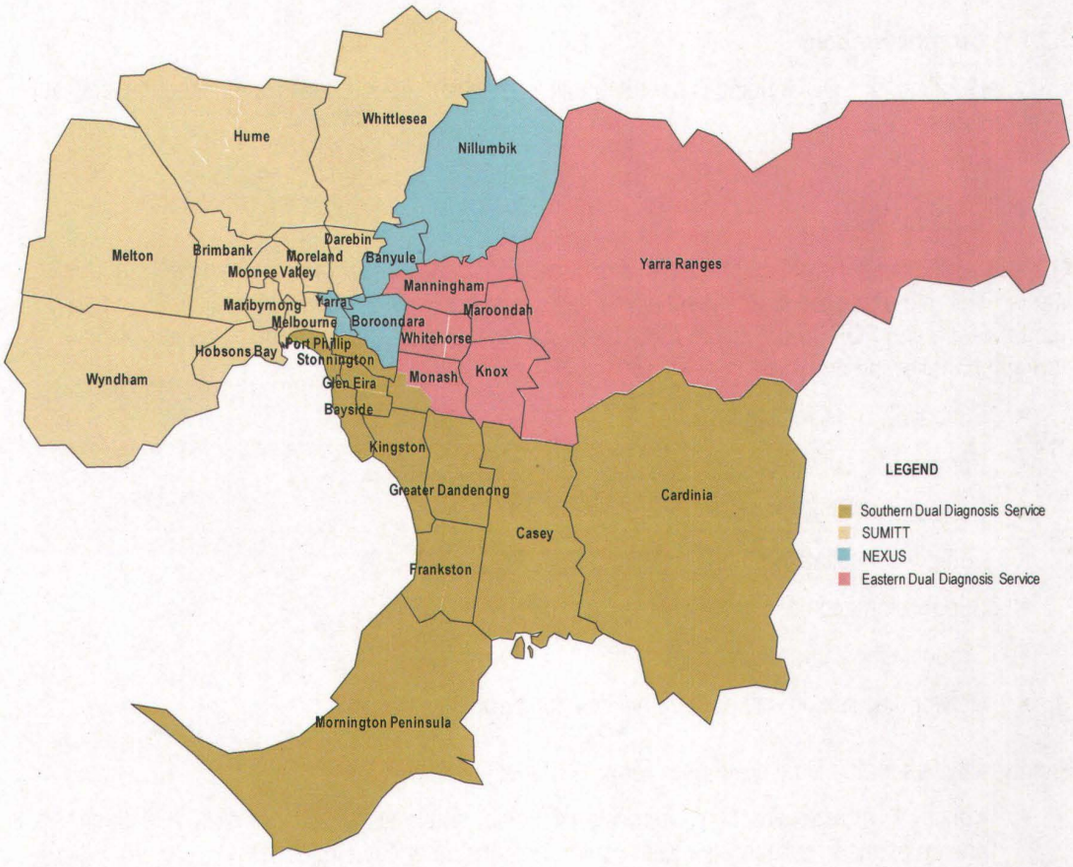

Table 3-2 below, provides the following information in relation to each of the four metropolitan teams:

- Name of team
- Auspice organisation
- Local Government Areas (LGAs)
- Total area allocated
- Total population

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- Capacity of team
- Number of:
  - PDRSS
  - Clinical Mental Health Teams
  - AOD organisations[40]

Table 3-1: Metropolitan VDDI teams

Team name	*Auspice organisation*	*LGAs covered*	*Total area (km²)*	*Total population*	*Capacity of team (eft)*
SUMITT Dual Diagnosis Team	Melbourne Health (NorthWestern Mental Health)	Maribyrnong, Wyndham, Brimbank, Hobsons Bay, Melton, Moonee Valley, Moreland, Hume, Darebin, Melbourne City, and Whittlesea	2,465	1,272,544	1.0 Team leader 5.0 Adult 2.0 Youth 2.0 Children 0.4 Consultant Psychiatrist 0.6 Psychiatric Registrar
Nexus Dual Diagnosis Service	St Vincent's Hospital	Yarra, Boroondara, Banyule, Nillumbik	576	416,082	1.0 Team leader 2.0 Adult 2.0 Youth 0.4 Consultant Psychiatrist 0.5 Psychiatric Registrar
Eastern Dual Diagnosis Service	Eastern Health	Eastern Metropolitan Region (excluding Boroondara and parts of Monash)	3,604	1,001,479	0.5 Team leader 1.6 Adult 0.8 Youth 0.5 Consultant Psychiatrist 0.5 Psychiatric Registrar (Commonwealth funds)
Southern Dual Diagnosis Service	Southern Health	Port Phillip, Kingston, Bayside, Greater Dandenong, Casey, Cardinia, Mornington Peninsula, Frankston, Parts of Monash, Glen Eira, Stonnington	2,187	1,053,530	1.0 Team leader 3.4 Adult 1.6 Youth 0.2 Consultant Psychiatrist

3.2.3 Rural Dual Diagnosis Clinicians

Attached to each of the four dual diagnosis teams are nine rural dual diagnosis clinicians. The rural clinician program is a microcosm of the four dual diagnosis teams, operating within regional area mental health services in each of the five Department of Health, rural regions.

Their activities involve:

- Identification and promotion of collaborative service relationships between mental health and drug treatment services within the relevant regional catchment. This should particularly address issues of access, assessment and the development of effective treatment planning, with a strong focus on building capacity within the services to respond more effectively to people with a dual diagnosis

[40] NB, this does not indicate the actual size of each team or organisation

3. Victorian Dual Diagnosis Initiative

- The provision of a direct service to clients with a serious mental illness and substance use problems with a focus on developing and modelling good practice. This may be through providing a limited direct service and intensive support/consultation to case managers on specific cases

The following table identifies the metropolitan team that the Rural Clinicians are attached to, area serviced and 'host organisation' (the area mental health service from which the clinician operates).

Table 3-2: Rural Dual Diagnosis Clinicians

Team name	Linked host organisation	Area covered	Total area (km^2)	Total population	Capacity of team (eft)
SUMITT Dual Diagnosis Team	Grampians Psychiatric Services, Ballarat Health Service	Grampians	48610	214,733	1
	Bellarine Mental Health Team, Barwon Health	Barwon	6241	252,678	1
	South West Health Care	South West / Glenelg	22865	102,505	1
	Goulburn Valley Health - Adult Community Psychiatry	Goulburn Valley	16504	143,300	1
Nexus Dual Diagnosis Service	Bendigo Health Care Group	Loddon	36874	252,490	1
	Mildura Base Hospital, Ramsay Health	Northern Mallee	22087	51,590	1
Eastern Dual Diagnosis Service	Northeast Health, Wangaratta	North East Hume	23771	117,146	1
Southern Dual Diagnosis Service	Latrobe Regional Hospital	Gippsland	41353	247,693	2

The primary activities of the rural dual diagnosis clinicians largely emulate the work of the metropolitan teams. Although the numbers of organisations supported by rural clinicians are smaller than the numbers of organisations supported in the metropolitan regions, the geographical area rural clinicians must cover is far greater, as shown on the following map.

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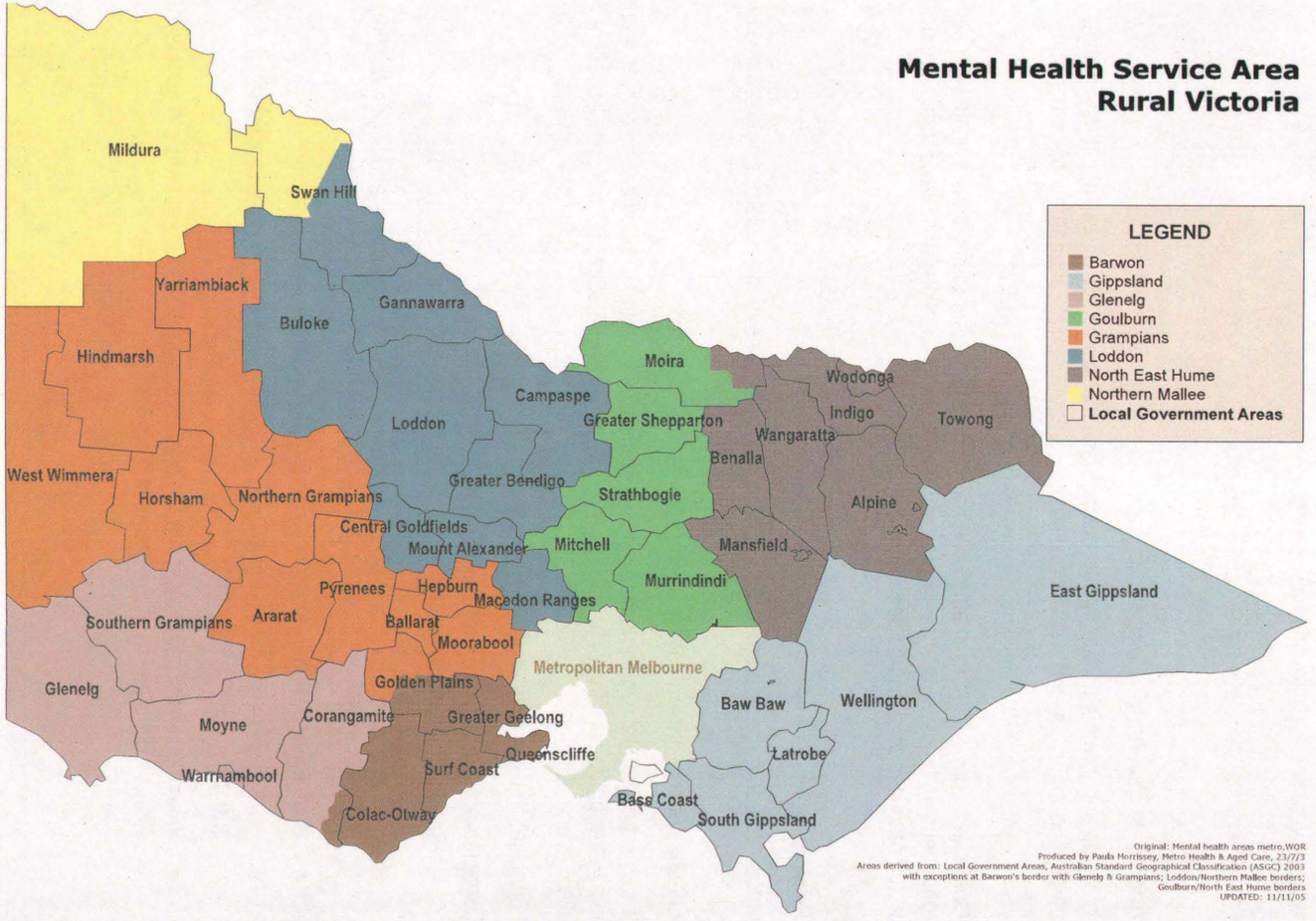
Figure 3-3: Map of Adult Mental Health Services



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3.2.4 Education and Training Unit

The ETU develops and delivers dual diagnosis education programs to Victorian AOD and mental health services. The ETU comprises dual diagnosis clinicians and educational experts and is expected to work closely with the four VDDI teams and the rural VDDI clinicians. Activities include:

- Development/negotiation with relevant tertiary institutions of related undergraduate and post-graduate education curriculum
- Design of training programs for mental health and AOD service providers to be implemented by specialist dual diagnosis practitioners at the local level
- Practice development, including identification/implementation of models of best practice and facilitation of service innovation and practice research.

The total number of staff employed in the unit is 2.5 eft.

3.2.5 Additional Psychiatric Support

The aim of increasing psychiatric support was to increase the availability of consultant psychiatrist advice and support for bio/psycho/social assessment, treatment and management of clients with complex needs.

A priority focus was supporting psychiatrists, senior medical and other staff working within both sectors, with a strong focus on those in rural settings, in order to promote dual diagnosis leadership and uptake of mainstream practices at individual service levels.

3.2.6 Reciprocal Rotations

The reciprocal rotation project commenced in 2005. The objectives of the reciprocal rotations were twofold:

- Enhanced direct care capability of practitioners

  It was expected that clinicians would gain experience in a number of different services leading to a better understanding of how that service system may be better used for the benefit of the client by the clinicians.
- Organisational capacity building

  Expected outcomes for organisations included:
  - An increasing pool of dual diagnosis capable staff in each sector
  - Staff in each participating service will gain a greater knowledge and understanding of the policies, procedures and practices of the reciprocal sector.
  - Staff will better understand the "culture" of the partner service sector.
  - Co-operation and collaboration leading to improved service pathways for referral and integrated care.
  - Increased direct service capacity of agencies to respond appropriately to dual diagnosis clients for the period of the placement/s.

Reciprocal Rotations was designed to enable clinicians to be placed into an organisation in the "other" sector for a period of 12 weeks. Funding is provided to backfill clinicians' positions in their parent organisation.

Staff members from participating services are seconded for the duration of the placement, to the Dual Diagnosis Team that has responsibility for their area. Staff that are selected are managed by one of the four VDDI services. Each VDDI team designs an experiential program to suit the needs of each participant that maximises their exposure to the alternate services whilst allowing them to also engage as a practitioner in that service, consistent within their knowledge and skill levels. The Dual Diagnosis Team provides supervision to the practitioner.

3.3 Governance

Governance of the initiative as a whole has been considered important because of the statewide focus. The intention has been to form a governance structure that can provide a base for driving comparable reform across the whole of Victoria. However there is an inherent complexity to the establishment of a single governance framework, because of the way the funding arrangements have been structured, as is apparent from *Figure 3-4* below.

3.3.1 Governance structures

A number of structures have been explored throughout the period of implementation of VDDI. The structures have included an overarching group comprised of the four metropolitan auspice organisations, a statewide reference group, a leadership group and the rural forum. Of these, two groups have met with some consistency:

- **VDDI Leadership Group**

  The VDDI Leadership Group was established by the four dual diagnosis teams to actively participate and contribute to discussions and planning concerning future dual diagnosis planning and activity in Victoria. The Mental Health and Drugs Division have drawn on the Leadership Group to:

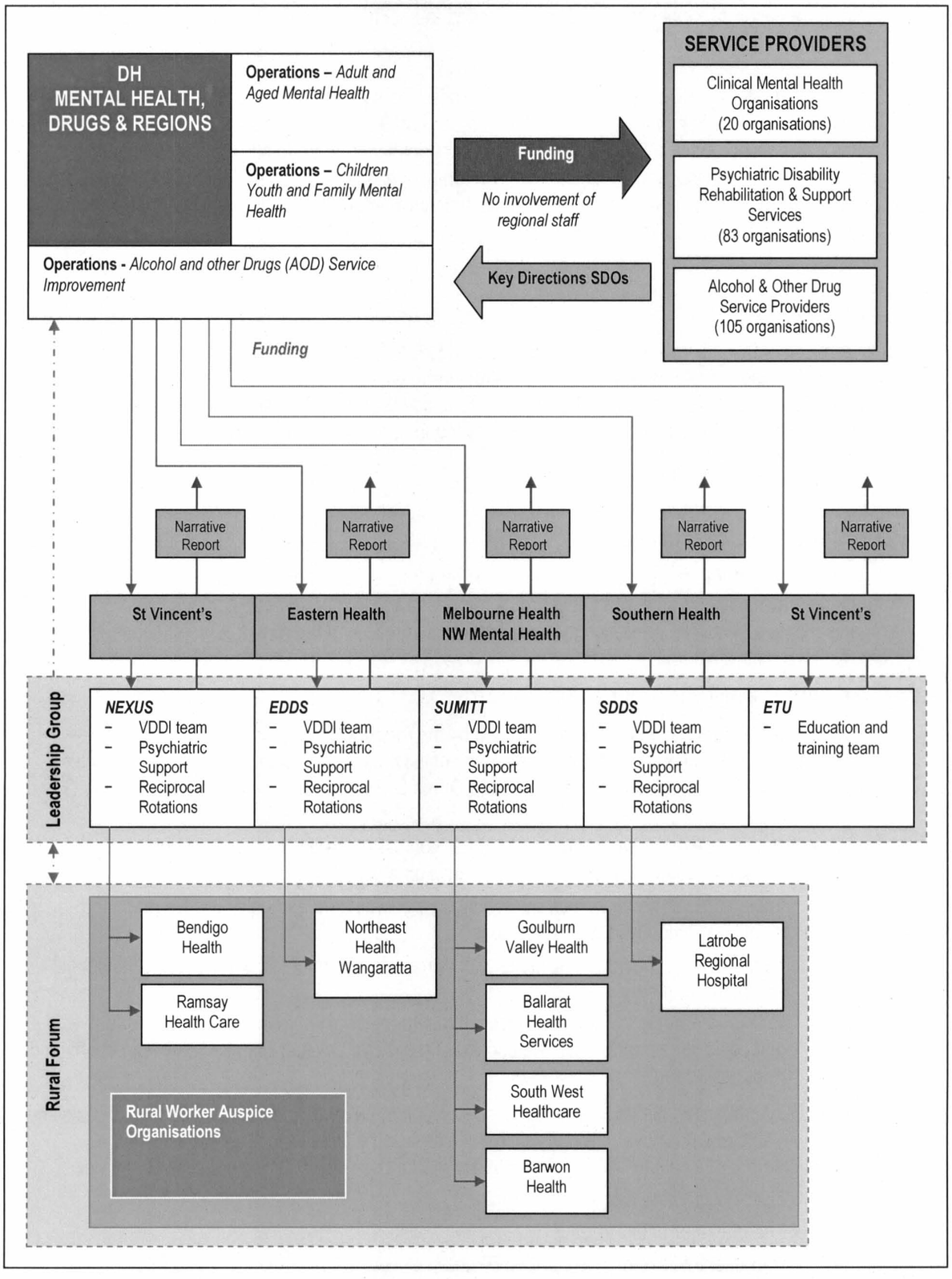
  - Provide clear leadership to develop and promote a shared vision for a robust, cohesive, consumer centred service for consumers with a dual diagnosis
  - Implement the shared vision by working in a coordinated and collaborative manner to identify common issues and solutions
  - Identify and utilise opportunities for workforce development in mental health and alcohol and other drug services
  - Build and progress working alliances in the interests of improved outcomes for dual diagnosis consumers within the context of the Victorian Dual Diagnosis Key Directions and Priorities Action Plan.

  The VDDI Leadership Group was established to monitor, develop and provide direction for existing VDDI projects and promote activities which will increase the Dual Diagnosis capacity of the stakeholders – Clinical MH, AOD & PDRSS. The VDDI Leadership Group consists of:

  - The four managers of the VDDI teams
  - The manager of the VDDI ETU
  - Representatives from the rural VDDI group
  - Representatives from the Department of Human Services.

3. Victorian Dual Diagnosis Initiative

Figure 3-4: VDDI funding and accountability relationships



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- **VDDI Rural Forum**

The Victorian Dual Diagnosis Initiative Rural Forum (VDDIRF) formally the Victorian Rural Dual Diagnosis Forum (VRDDF) was established in April 2001. Initially specialists within the Western part of the state of Victoria participated, with the forum expanding to include all Rural VDDI Clinicians.

The forum was granted financial support in 2004 from the Department of Human Services for accommodation and general costs. Further funding from the mental health and drugs division, Department of Human Services Victoria has subsequently been granted. The value of the rural forum was recognised in the 2004 Turning Point Victorian Dual Diagnosis Initiative Evaluation, with the recommendation that the rural dual diagnosis forum continue to be supported, with the main aims of improving the model and supporting the workforce.

4 SERVICE DEVELOPMENT OUTCOMES

4.1 Dual Diagnosis Action Plan 2007–2010

As described previously, *Key Directions* set out a plan for reform. The plan specifies five performance indicators, called 'service development outcomes' (SDOs) to which performance levels are attached along with a timeframe for completion.

This chapter explores the progress made against each of the SDOs and compares movement across the sectors. The data that is provided is drawn from the survey that was distributed to the VDDI leaders as part of the evaluation. The survey collected information about the combined total of 361 clinical mental health teams, AOD services and PDRSS. There is a small but significant proportion of services/teams for whom the response was unknown in relation to one or more of the questions about their progress. The results from the telephone interview with managers of individual teams or services are also used to indicate the extent to which the survey data accords with service provider perceptions.

4.2 SDO 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 number of major changes in practice are required, including:

- Everyone will be screened for possible dual diagnosis issues at triage/intake/entry
- Those identified at risk of dual diagnosis, should undergo integrated assessment
- An integrated treatment plan is developed for those identified as having dual diagnosis issues
- Integrated treatment is provided.

It is important to note that there was no single screening and/or assessment tool that was mandated in the *Key Directions* policy, rather it was specified that an 'accepted screening approach' is used. It was then left to the VDDI teams to 'encourage the use of common language, tools and standards'. In response the Victorian Dual Diagnosis Screening Tools working group was formed, which led to the development of *Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol & Other Drug and Mental Health Services*. The paper recommended the following:

> *Screens for mental health symptoms and disorders outlines four key tools available for use in screening for mental health symptoms and disorders and is aimed at clinicians currently working in the Victorian AOD sector. These include:*
>
> - *K10*
> - *PsyCheck*
> - *Modified Mini Screen*
> - *Mental Health Screening Form.*
>
> *Screens for substance use disorders introduces Victorian mental health clinicians to four key tools that may be used when screening for substance use disorders. These include:*
>
> - *Sensitive questioning*

- *AUDIT*
- *ASSIST*
- *Cage / CageAid.*[41]

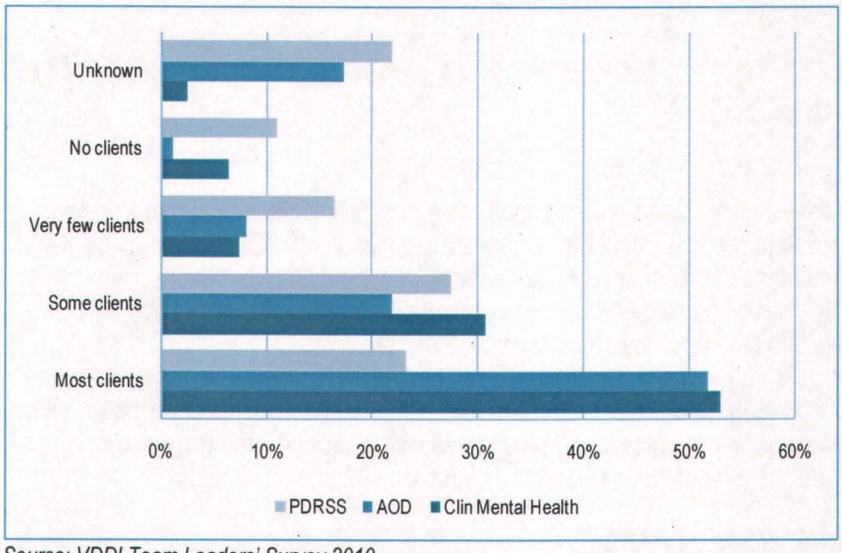
Whilst some of the services/teams have adopted one of these tools, there are still a significant number of hybrids of these or other tools that have emerged, although some effort has been made through network meetings either with a specific dual diagnosis focus or through the mental health Alliance groups, to try and align some of the information collected across sectors.

Hence findings in relation to progress on screening and assessment need to be read with the understanding in mind, that whilst services are reporting that they are undertaking screening and/or assessment, exactly what information is collected and how, is highly variable.

4.2.1 Screening

There has been a strong focus on training workers in screening and assessment, which will be discussed further in *Section 4.3*. So not surprisingly, the findings from the survey regarding screening, suggest that over half of the clinical mental health and AOD services are screening most clients for dual diagnosis issues. The survey may even be an underestimate as the proportion of respondents to the telephone survey across the three sectors suggests that over three quarters of the sample are screening most clients. PDRSS numbers are significantly lower than the other two, which is possibly due to less access to training and VDDI support in some localities, than the other two sectors.

Figure 4-1: Proportion of clients provided with integrated screening



Source: VDDI Team Leaders' Survey 2010

It is worth noting that the outcomes for clinical mental health are not evenly distributed across aged, adult and CAMHS teams. The VDDI leaders reported that this is because the initiative was initially set up around the adult teams, with youth being added later and the aged, much later. This is consistent with reports from the aged teams that were consulted that dual diagnosis has not been a strong focus

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

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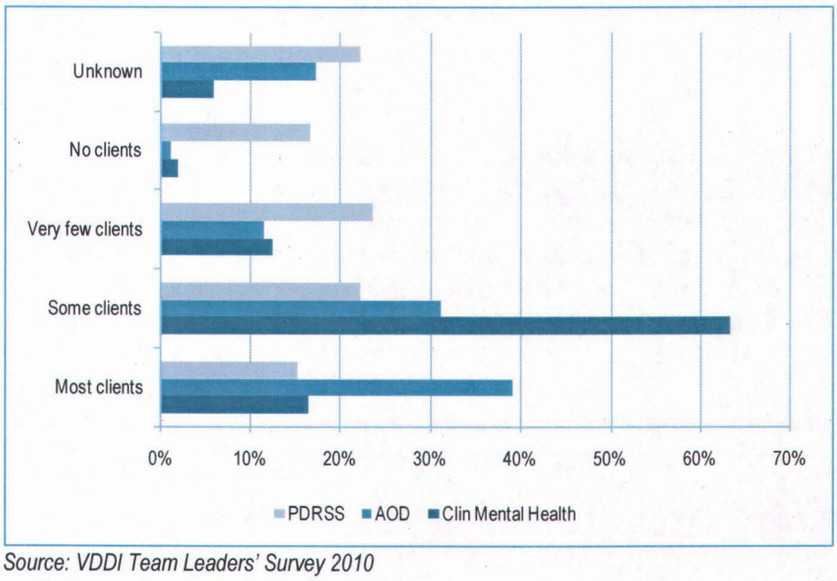
for them so far. CAMHS reported some focus on dual diagnosis but this in part was also affected by the age range that they cover and the frameworks that they use.

4.2.2 Assessment

The results in Figure 4-2 suggest a significant shift down in the proportion of clinical mental health services that are conducting assessments, in comparison with the screening results. However, this was not reflected by the responses to the telephone survey findings. Whilst the telephone based findings suggest a shift down, the likely reality is somewhere between 30-40% of clients being assessed in PDRSS, 35-45% for clinical mental health and 50-60% for AOD services.

Figure 4-2: Proportion of clients provided with integrated assessment



Source: VDDI Team Leaders' Survey 2010

In relation to the type of assessment, it was reported by a small number of managers/team leaders of AOD services that their workers are now doing Mental State Examinations (MSE), not to provide clients with a diagnosis but to determine the most appropriate pathway and to facilitate better communication with clinical mental health. This was confirmed by some of the VDDI teams who commented on the ability of the AOD workers that they were in contact with, to undertake a MSE.

Of the clinical mental health organisations that were consulted, there were three that described a 'whole of organisation' reform process, where policies and procedures were modified, staff trained and expectations of staff increased. One of these is included as a case study.

CASE STUDY – ORGANISATIONAL CHANGE

Dual Diagnosis is now mandated as core business and is included in the overall policy direction for NorthWestern Mental Health, the mental health arm of Melbourne Health. This is a process that has been strongly supported by the Clinical Director and the wider senior executive group.

A key element in the process was the establishment and ongoing role of the North West Dual Diagnosis Committee which oversees dual diagnosis implementation for the Area Mental Health Service. The committee provides reports to the Executive and also reports to the quality processes within Melbourne Health. An Action

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Plan (2009-10) was developed through the committee that is aligned with the SDOs from *Key Directions*.

The strategies that have been implemented to date include the following:

- Development of a range of policies including one on *Dual Diagnosis capability for mental health services* that covers:
  - Training
  - Recruitment
  - Research and evaluation
  - AOD Screening and Assessment
  - Shared care with AOD services
  - Care planning and Treatment
  - Review, secondary consultation and discharge
  - Outcomes
  - Key performance indicators
- Addition of AOD CAGEAID (Screen) and AOD Assessment template to the MH – Assessment form
- Mandatory minimum Dual Diagnosis specific training for all staff via intranet
- Collection and monitoring of data on Dual Diagnosis screening and assessment KPIs
- Online staff survey
- Dual Diagnosis organisational (COMPASS) and file audits
- Development of an evaluation plan for the Dual Diagnosis project.

Progress is monitored and reports are sent to managers of units/teams which identify who has been trained and where they are up to. Screening of all clients has been mandated with a 100% target. KPIs are attached to all teams, with tracking tools in place to measure progress.

To assist in achieving these targets, screening is embedded into the CMI data collection via fields in the registration form. Diagnostic, assessment/screening and intervention information is collected at Assessment, Clinical Review and Discharge. Documentation of AOD related information at each of these points is through completion of ICD-10 and relevant Z-codes that cover screening, assessment and intervention type.

NWMH is now moving towards sustainability of changes in practice through a six month plan to move all the DD monitoring processes into core business, for example, conducting regular Dual Diagnosis file audits as part of normal quality mechanisms. Regular reports to the Executive on screening and assessment will also continue.

4.2.3 Integrated Treatment Plans

The proportion of clients provided with integrated treatment plans, shown in Figure 4-3 is not consistent with reports from the team leaders/managers of PDRSS and clinical mental health, who reported a much lower occurrence of integrated treatment planning, whilst AOD services indicated a higher level.

Integrated treatment plans require treatment options for their development, which in turn is reliant on partnerships and referral pathways between sectors or the capacity to respond within the organisation to the dual diagnosis issues. Planning is also contingent on the capacity to conduct dual diagnosis assessments, which as indicated in the previous section, is likely to be occurring in less than half of most organisations/teams. It also needs to be acknowledged that some integrated treatment plans are being developed through informal but reasonably effective working relationships between organisations across different sectors. This is based on a readiness to share information in order to better support the treatment of some of their clients with dual diagnosis issues.

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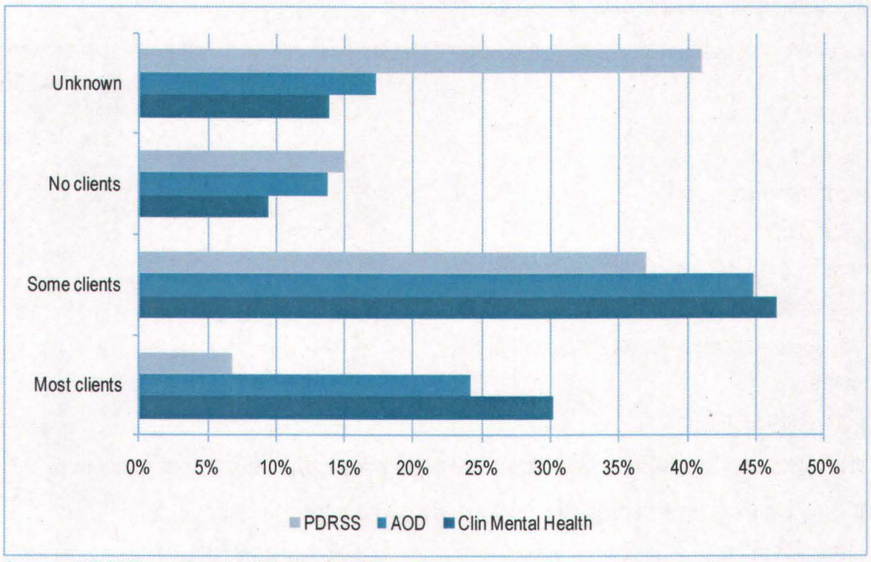
Figure 4-3: Proportion of clients provided with integrated treatment plans



Source: VDDI Team Leaders' Survey 2010

4.2.4 Integrated treatment

Integrated treatment for most situations requires two or more organisations across different sectors to work together to develop a single treatment plan for a person with dual diagnosis issues, which addresses both mental health and dual diagnosis issues.

The extent of integrated treatment planning was generally described by most people interviewed as an area where much more needs to be done, particularly if it involved two or more sectors providing input to the one plan. Barriers that interviewees referred to included time to see people in different settings other than their own, difficulty for the client to see different providers in different locations, and lack of formal agreements between sectors. However examples were still provided of this occurring in a variety of settings. In some instances these examples were greatly enhanced by the application of ISI funding to the AOD service that was involved in the treatment.

In the Loddon Mallee region, work undertaken by VDDI through the local Primary Care Partnership, has seen an integrated model of treatment emerge around the needs of people undergoing detoxification, either at home or mental health patients with substance use issues, admitted to Mildura Base Hospital. The following case study provides some details of how the model operates.

CASE STUDY – INTEGRATED MODEL OF CARE

The Northern Mallee Dual Diagnosis Service worked with Sunraysia Community Health Services to develop a model for integrated dual diagnosis withdrawal. Models were developed for Enhanced Home Based Withdrawal and Hospital Based Withdrawal.

The **Enhanced Home Based Withdrawal Model** provides a supported withdrawal process which monitors the individual's physical and mental health status. Support is provided in the home by a support person or carer, and enhanced service support is provided from Alcohol and Other Drug Treatment Services (AODTS), mental health services (MHS), and other primary care agencies. A General Practitioner (GP) or medical officer is also involved.

This program provides a client-centred approach, which also addresses social issues of poverty, unemployment,

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housing and social isolation. The model addresses the changing needs of individuals during the pre-withdrawal, withdrawal and post withdrawal phase.

People seeking assistance from both MHS and AODTS are screened for mental health and problematic substance use utilising accepted screening approaches. Secondary consultations occur between MHS and AODTS key clinicians and agreed AODTS and MHS referral protocols are utilised.

A combined assessment is conducted by both MHS and AODTS. Acceptance into the program requires the agreed participation of both key agencies, and the agreed involvement of a GP or medical officer. Patient rights information is provided both agencies, and participants are informed that each agency has ownership of their own client files and that consent is required for sharing of information regarding the withdrawal. All clients are registered with both the mental health service and AODTS.

A support plan is developed, with the case planning meeting attended by the participant, the carer, case manager/worker, the clinician from the AODTS and mental health service and any other relevant agencies. The GP or medical officer must also be involved.

During treatment, the AODTS is primarily responsible for the management of the withdrawal and MHS is primarily responsible for the management of the mental health status of the client. Both services have a responsibility to maintain communication with the other.

Both the AODTS and mental health service collate program monitoring data and statistics. Staff must follow the policy and protocols of their agency of employment and staff supervision is the responsibility of the agency of employment. Grievance processes are managed in accordance with the individual agencies' policies and protocols.
The dual diagnosis portfolio holder or consultant is responsible for contacting the consumer following completion of the withdrawal to monitor and obtain feedback from the consumer and carer. The dual diagnosis service will obtain feedback from clinicians after each withdrawal.

Barwon Health has focused on addressing the issue of integration by co-locating AOD and clinical mental health expertise together in the one team and the same sites. This has facilitated the building of greater confidence and competence in responding to both issues across the whole of the team to the point where there is far less distinction made between workers with regard to the issues that they respond to.

CASE STUDY – INTEGRATED MODEL OF CARE (Co-located service)

Jigsaw is a service for young people aged15-25 years, operated by Barwon Health. It was created approximately eight years ago by bringing together Barwon Health clinical mental health and AOD practitioners to form a single team. This was done in recognition of the high prevalence of substance use issues in young people that present with mental health disorders. The service is located in a precinct with the local headspace and other services. Jigsaw teams have recently been consolidated into two hubs in central Geelong and a location in Colac, resulting in more specialised resources in each team.

There is a generic job description for all clinicians; clinicians are not identified as 'AOD' or 'Mental Health' clinicians. New clinicians are expected to have Mental Health and AOD knowledge. If this is not the case, new clinicians are supported and encouraged to obtain new knowledge i.e. Mental Health Clinicians supported to do Certificate IV in AOD.

Clients are screened for mental health, AOD, family history etc over the phone. A decision is made in conjunction with the psychiatrist whether a person comes in for a full psychosocial assessment.

Allocation of clients to case managers occurs daily at team meetings. The intake team will consider the main reason for the young person's presentation. If the young person is looking at changing substance use, they will be allocated to a case manager with recognised experience in AOD, and similarly for young people whose primary presentation is mental health issues. However, a clinician's ability to pick up a client is determined by more factors than simply the case manager's expertise. No client has two case managers; two to three years ago this would not have been uncommon. There is better continuity of care for the client to have one worker.

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Gradually all clinicians are starting to do the same role and they are getting to be on par with each other.

In addition, Jigsaw clinicians have very good access to medical staff, with four consultant psychiatrists and two registrars. Psychiatrists are not treating AOD and mental health issues separately. DACAS and Adult Mental Health workers are available for secondary consultations.

It has been a slow transition since bringing AOD and MH together; the change process has been gradual and has developed and evolved. Barwon Health has been supportive and everyone has found it exciting to do further study and have opportunities for PD.

The challenges however have not been so great in youth mental health as they have been in adult mental health, where people have been used to treating one issue and 'outsourcing' treatment of other issues. Jigsaw had recognised for a long time that clients were presented with comorbid issues.

The model has seen a better use of resources and time with more EFT to go around to service young people. Overall there's a strong focus on integrated treatment.

4.3 SDO 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.

This required:

- All staff to be appropriately educated
- Development of advanced practitioners (portfolio holders).

4.3.1 Appropriate education

As indicated in Figure 4-4, a significant level of training that has some connection to dual diagnosis has occurred, although interviewees suggest the level is somewhat more substantial than determined through the team leaders' survey results. Again the PDRSS result is lower, though as mentioned earlier under SDO 1, some PDRSSs in specific localities did not have ready access to VDDI support (as will be discussed chapter 5). Also a statewide training program has been rolled out to PDRSS, much of it after the point in time when the VDDI team leaders' survey was conducted.

The disparity between team leader survey results and interviewees can be attributed to the diversity of training providers that have been used across the sectors, and so the VDDI team leaders will know about those organisations that they have provided training to, but not necessarily about training provided from elsewhere.

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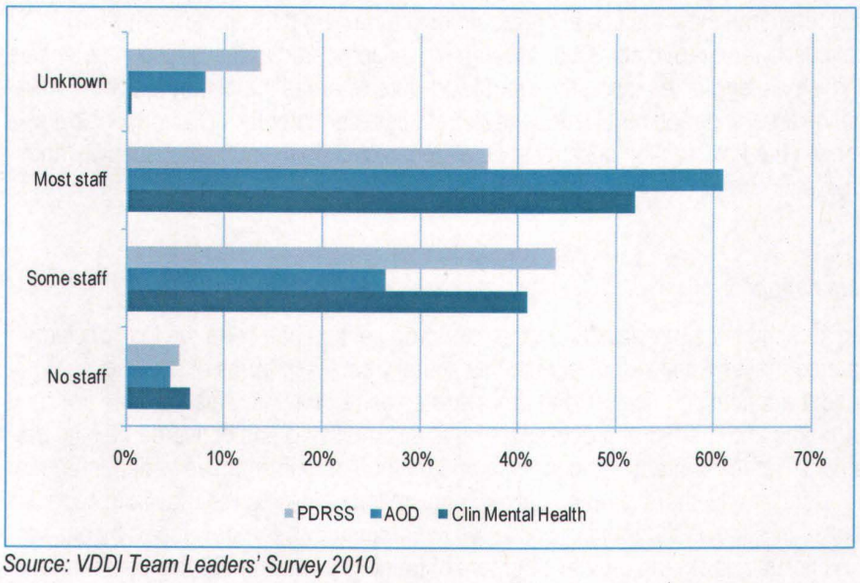
Figure 4-4: Proportion of staff provided with Dual Diagnosis related training



Source: VDDI Team Leaders' Survey 2010

Training in screening and assessment of dual diagnosis issues and the use of different screening tools, has been a major focus for the VDDI teams amongst other topics. When the ETU commenced it developed a training package that focused on these two subjects for AOD services, along with audiovisual material and distributed the package to the VDDI teams and the materials to 100 AOD services.

The breadth of topics covered across the three sectors has been substantial. As an example of this diversity, the 27 AOD services that received ISI funding have undertaken training across: screening and assessment; understanding mental health; specific mental health disorders; models/strategies for therapeutic intervention (such as Cognitive Behavioural Therapy, Mindfulness - Acceptance Commitment Therapy, Brief Intervention, Motivational Interviewing, Family Therapy); dual diagnosis competencies; AOD specific topics; medication; and supervision, amongst other topics.

As discussed in the next section, much of the training undertaken across all sectors has not been constructed around a defined set of core competencies, and therefore it can only be said that dual diagnosis related training has occurred. The content is highly variable and there has been little assessment of participants' knowledge and skill gain. However, there are stand out exceptions and these are the online units of competency developed by ETU and the statewide training, developed for and rolled out to the PDRSS sector (partnership between EDDS, VICSERV and ETU).

Building dual diagnosis capability, hasn't only been reliant on training, other strategies have been implemented such as VDDI clinicians and psychiatrists modelling dual diagnosis work, providing secondary consultations, conducting case reviews groups, providing supervision and other approaches. Also the Reciprocal Rotations strategy, described in the previous chapter, was seen as a potential way of building skills, knowledge and confidence by placing someone in the 'opposite' setting.

The other factor impacting on training has been the consideration of cost. The competencies delivered online through Gippsland TAFE cost around $1,000 per participant that has already attained a Certificate IV or higher qualification, which means that any mental health organisation would potentially need to pay this cost for any of their staff that undertake this training. In order to reduce this barrier, the

4. Service Development Outcomes

Department of Health has provided some scholarship funds through ETU, for a small number of people to meet the training costs of the online course. Consequently one of the mental health organisations has supported the VDDI team that they auspice to create an online training package for new staff, although the difference in time required to complete this version as compared to the ETU competencies is markedly different. This package takes a person about two hours whereas the competencies involve many more hours of online time and reading. Hence the debate between internal VDDI stakeholders has become focused on, as the next section describes, what constitutes dual diagnosis capability and what is required to achieve it.

4.3.2 Dual diagnosis capability

The difficulty in building 'dual diagnosis capability' across the three sectors has been the lack of clarity throughout VDDI, regarding the 'end point', that is what this actually entails in terms of specific knowledge and skills and the training curriculum and other strategies required to impart these. For example the four VDDI teams and their rural practitioners have all developed and delivered training on screening and assessment, but the content of the training and method of delivery have varied, more so in the earlier days, and significantly, there is no actual mechanism for assessing the growth in capability of participants that results. In addition the training packages have primarily been developed by people whose core skill base is clinical rather than the development of training curriculum for this context.

The ETU sought to address some of these issues through the development of units of competency which reflect at least some of the core competencies that are required for different sectors to progress towards being dual diagnosis capable.

A partnership with Gippsland TAFE by ETU on the development of the curriculum meant that these units have been accredited at the Vocational Education and Training (VET) Certificate IV level. They also provide a pathway to a Graduate Certificate/Diploma in Alcohol and Other Drug Studies, through Turning Point, where credit can be gained for one subject under Recognition of Prior Learning. An online format, which involves live facilitation, was selected for delivering the content, meaning that a maximum of 30 can be trained during any single semester. Given this, ETU has sought to increase access by providing the competencies curriculum, along with some support to Registered Training Organisations which resulted in around 1,000 people undertake this type of training in the period 2007-2010.

In order to define the end point of being 'dual diagnosis capable', the competencies and/or qualifications required by a PDRSS, AOD or clinical mental health worker need to be determined. This in turn relates to the 'scope of practice' for workers in each of the sectors, that is, the full spread of role-related activities that a worker in each sector might be required to do.

Consideration also needs to be given to a context where very little time is given to dual diagnosis issues as part of professional training for psychiatrists, doctors, psychologists and social workers. In regard to nursing though, there is at least one educational institution that includes an AOD subject, developed by ETU, within their mental health major.

There is also a wider context that has a bearing, which is the diverse skill base across PDRSS and AOD, with no minimum qualification required for PDRSS and Certificate IV in AOD being the base requirement for the AOD sector. Debate is currently taking place across the AOD sector regarding whether or not the minimum qualification should in fact be raised from Certificate IV to a VET Diploma level. The context includes the diversity in client work that occurs across the three sectors and the extent to which specialist knowledge in relation to working with dual diagnosis in a particular setting or

role, might be required, an example being a mental health inpatient unit undertaking detoxification of a patient.

A further set of challenges identified by clinical mental health team leaders and the VDDI teams is what they term as the shift in culture and focus that is required in mental health, in order to adopt identifying and responding to dual diagnosis as core business. The other concern raised by clinical mental health team leaders is the very high turnover in staff, with a continuous cycle of trained staff moving on and new recruits needing training.

4.3.3 Advanced Practitioners

Almost every organisation interviewed either has at least one dedicated portfolio holder, the term used to describe the advanced practitioner role, or had rebadged it as a dual diagnosis champion. However people in this role did not necessarily have additional expertise in responding to dual diagnosis. It had originally been anticipated that people would undertake a Reciprocal Rotation and then return to take up the advanced practitioner role with support from a VDDI worker, however as described previously, the number of organisations that have participated in a Reciprocal Rotation strategy is likely to be less than half.

Some organisations have people in these roles that have completed the online dual diagnosis competencies or other training such as a post graduate diploma, and they turn to them during case planning and review sessions for their input.

There has also been debate across the VDDI teams regarding what 'higher' level training for advanced practitioners should constitute and the method of delivery. At this point it remains undefined.

CASE STUDY – ADVANCED PRACTITIONERS

Norwood is a non-profit organisation which provides community based mental health services to young people and adults (16 - 64 years of age) who reside within the communities of Brimbank, Melton and Sunbury. Norwood operates from four sites across the region including co-locations with Community Health Services.

Victorian state government funded services include home-based outreach; the Pathways program, which assists people who are at risk of homelessness at the point of discharge from an acute care facility into more stable and appropriate accommodation and establishing supports to sustain housing; and the Burnside Prevention and Recovery Care Services (PARCs). The Burnside PARCs is a collaboration between North Western Mental Health, Mercy Mental Health, Norwood Association and Western Region Health Centre, a community Mental Health Service. The service provides clinical and rehabilitation services in a supportive residential setting to clients (aged 16 to 64) in a sub-acute phase of mental illness. Norwood is responsible for the recovery services for 10 beds and offers 24 hour a day supervised care.

In 2007, two of Norwood's staff members participated in reciprocal rotations, concurrently. Once the two workers returned to Norwood, they then worked in the homeless program and were also indentified as advanced DD practitioners. The workers started implementing dual diagnosis screening and assessment, and conducted an audit of staff knowledge of drug and alcohol issues. A DD portfolio group was established, with the task of implementing *Key Directions*. Executive management accepted the recommendations from the portfolio group regarding policy and procedural change. Screening and assessment tools were then selected for use. In-house training of staff in screening and assessment was conducted by the two advanced practitioners, using scenarios. In-house training was also conducted in brief interventions and about the services available. Voyage, an AOD service, assisted in the development of training and co-facilitated some sessions. An AOD resource manual has been developed.

The two advanced practitioners provide secondary consults to the extent that time allows them. The dual

diagnosis portfolio group regularly meets with the client reference group and carers group. These meetings have informed the workplan for the portfolio group, for example planning for the formation of a carer support group for carers of clients trying not to use any substances.

4.4 SDO 3

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

This required:

- Formation and formalisation of partnerships with other sectors
- Agreement on client care pathways
- Development of policies and procedures covering integrated assessment, treatment and care

4.4.1 Partnerships

The VDDI teams have played an active role in establishing or having input into stakeholder groups regarding dual diagnosis. In particular they have sought to facilitate stronger relationships and formal partnerships between sectors. There is also a coordination project funded as part of the Mental Health Reform Strategy, called Alliances that is providing a similar partnership building function, initially between clinical mental health and PDRSS but some with the encouragement of the VDDI team, have broadened to include AOD. There are examples of VDDI working through the local Primary Care Partnership arrangements to build partnerships whilst others have created independent steering groups or working parties.

Interviewees described reaching formal agreements on screening tools, client pathways and sharing information, although not always just around dual diagnosis. There are some specific examples of dual diagnosis agreements such as the No Wrong Door in the Hume Region (outlined in the next section).

4.4.2 Client care pathways

Client care pathways was seen as the way of meeting the needs of dual diagnosis clients, hence the emphasis on this being included as an SDO within the Dual Diagnosis Action Plan 2007-10. The intention is that people with dual diagnosis issues are identified regardless of which sector they present in, and then there is an agreed process for them being connected to the organisations that will provide the various types of support, which might include all three sectors delivering the required care.

The Hume Region services have taken this a step further using ISI funding to achieve a very significant region wide outcome. Essentially they built on earlier work by Eastern Hume Dual Diagnosis Group and the Central Hume Primary Care Partnership to develop an integrated dual diagnosis protocol called *No Wrong Door – Integrated Dual Diagnosis Protocol*. This is the clearest example across the state of a region-wide agreement.

4. Service Development Outcomes

CASE STUDY – REGION WIDE PROTOCOL

Background

The Eastern Hume Region has focused strongly on building relationships between sectors. This has resulted in a shared ownership for the DD reform agenda, which has been further strengthened through funding from the Commonwealth Department of Health and Ageing's Improved Services Initiative (ISI). "No Wrong Door" provides a powerful example of how the state and commonwealth initiatives can complement and enhance each other.

Ovens and King Community Health Service have been central to the *Paving the Way - No Wrong Door* project, having initiated it in 2005. At the core of *Paving the Way* is an inter-agency protocol that was signed off and launched on 8 November 2006. The protocol provided an endorsed platform upon which eleven participating organisations in the Eastern Hume region committed to embed a cultural shift. In 2008 Ovens & King Community Health Service was provided with ISI funding to extend the project across the Hume Region and broaden its suitability for all agencies. In December 2008, the original protocol was further adopted by agencies who are members of the Eastern Hume Dual Diagnosis Group.

No Wrong Door Protocol - Integrated Dual Diagnosis Protocol

The *No Wrong Door – Integrated Dual Diagnosis Protocol 2010*[42] was officially launched in July 2010. This document is a guidebook to agencies and their staff in relation to how to deliver a No Wrong Door service and how to work with neighbouring agencies within an integrated service system.

The document was developed in consultation with partner agencies and evolved through significant consultation with regional consumer and carer groups and organisations that refer to or work within mental health and drug and alcohol services. The project was overseen by a Steering Committee, comprised of representatives from the broader health and human services sector. The protocol was also endorsed by the Department of Health as well as the Department of Health and Ageing.

No Wrong Door is based on the principle that every door in the health care system should be the 'right' door and each provider within the system has a responsibility to identify needs and assist clients to gain the most appropriate care, wherever and whenever clients present for care. *No Wrong Door* supports enhanced dual diagnosis capability and integrated assessment and care.

The protocol addresses all stages of a client's journey through service provision:

- entry and referral
- intake and initial needs identification
- assessment and screening
- care coordination
- crisis management
- interventions
- communication and consent
- discharge
- secondary consultation.

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

- workforce – capacity building, education and training
- consumer and carer engagement
- dispute resolution.

[42] Ovens and King Community Health Service. 2010. *No Wrong Door 2 - Integrated Dual Diagnosis Protocol.* Available from www.nowrongdoor.org.au

4. Service Development Outcomes

One of the factors described by a number of stakeholders that has influenced the establishment of client care pathways, is the communication between the sectors, particularly the language used to describe a person's needs. Several AOD team leaders described the impact of learning how to do Mental State Examinations (MSE) on referrals to clinical mental health. They talked about the need to recognise that adopting the same approach and language as clinical mental health is necessary given they are talking about people's mental health. It has resulted in a much clearer and stronger dialogue between these AOD services and their local clinical mental health teams.

There were also a number of examples of informal relationships that facilitated access by clients to services. These relationships had come about in a number of ways, including Reciprocal Rotations, a worker changing sectors, or through inter-sectoral working groups facilitated by a VDDI team.

Examples were also provided of contrary situations. The first of these refers to access to acute mental health services by clients in detoxification units. There were several instances reported by one detoxification unit, in which the mental health state of a person was such that the unit believed that clinical mental health needed to respond. Further to this the unit reported that clinical mental health indicated that they would not respond because the client was deemed to be in a contained environment with some support. The detoxification unit then felt that their only course of action was to discharge the person from the unit to the emergency department of the hospital, in order to gain a clinical mental health response. This recurring scenario would appear to be completely at odds with the intention behind SDO 3.

Other examples were provided of clients within an AOD service that appeared to be exhibiting symptoms of acute mental illness and/or risk to themselves. The AOD service was unable to gain confirmation from the local mental health service, regarding whether or not the person was a client of theirs. One instance was provided of such a scenario where the person committed suicide.

4.5 SDO 4

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

This required:

- Services to collect data on dual diagnosis
- Use the data to inform service planning and development.

4.5.1 Collection of Dual Diagnosis related data

Generally this has not occurred because the main data collection systems mandated by the Department of Health, *Australian Drug Information Service (ADIS)* and *Redevelopment of Acute & Psychiatric Information Directions (RAPID)* are not specifically geared to readily capture and provide this information as reports. The challenge in the PDRSS sector is that there is no single mandated tool and so a variety is used. ADIS in particular only has one field allocated to the capture of mental health information, which is simply whether or not the person has a psychiatric diagnosis.

However one mental health service has used the *Client Management Interface (CMI)* component of RAPID to monitor progress across mental health teams on numbers of clients screen and/or assessed

for dual diagnosis issues. Team leaders are required by the service to report regularly on this information (see earlier case study on organisational change). As indicated in the case study the service has been using ICD-10 and Z-codes, to record dual diagnosis information in CMI. This is also being promoted across the clinical mental health services in the Eastern Hume Region.

The other potential area for capturing AOD information by clinical mental health services is the HONOS and BASIS 32 data, which is expected to be collected as part of the National Outcomes and Casemix Collection (NOCC) (refer Appendix F), however this has not been utilised for reviewing dual diagnosis activity in any systematic way, and completion is reported to be variable.

Those AOD services that received funding from ISI have been required to conduct an organisational audit of their dual diagnosis capacity using a tool called *Dual Diagnosis Capability in Addiction Treatment (DDCAT)* for each of the three years that they were funded for. They also undertook snapshots of client data during short periods to try and assist with their knowledge of how they were progressing in this area. This has enabled them to grow in their knowledge about the areas they needed to work on as well as their confidence as they have seen improvements on their DDCAT scores. It is worth noting though that there is no independent auditing of these processes, they are completely self assessed unless a service has chosen to involve another party in the process.

4.6 SDO 5

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

This required consumers and carers to be involved in:

- Service review and improvements
- Education and training activities.

4.6.1 Consumer and Carer involvement in service improvement

The involvement of consumers and carers as reported through the leaders' survey indicated an unknown result for 40% of the PDRSSs so these findings haven't been used. Instead, the interviews suggest that overall, around 60% have formal mechanisms for consumer and carer involvement, with this strongest in mental health because of a strong history of consumer/carer consultants and other participation strategies, whilst it is an area of learning and growth for the AOD services.

4.6.2 Consumer and Carer involvement in education and training

Fewer organisations reported involving consumers and carers in training activities, although ETU has been active in trying to develop this as part of the online competency training.

5 IMPACT OF THE VDDI STRATEGIES

The combined impact of policy and VDDI strategies has seen Victoria arrive at the stage where the great majority of workers across the three sectors have received training related to dual diagnosis and the majority of clients of AOD and clinical mental health services are screened for dual diagnosis issues. This is a major shift from the rigid demarcation that existed between each of the sectors not so long ago. Added to this has been a growth in the assessment of clients and to a lesser extent, the development of integrated treatment plans. In the latter area of integrated practice, there is still substantial work to be done, and therefore this is the focus for recommendations detailed in the next chapter.

The critical turning point for change occurred in 2007 with the Victorian Government releasing the *Key Directions* policy. This included a Dual Diagnosis Action Plan that specified five SDOs to be met by AOD, clinical mental health and PDRSS, within designated timeframes. These requirements on organisations provided a significant impetus, particularly for AOD organisations, to engage with the VDDI strategies as well as undertaking their own, to build dual diagnosis capacity. Changes also occurred across mental health but with less consistency. Indeed, when speaking to services about their dual diagnosis work, most did not identify the existence of VDDI prior to *Key Directions*. In effect, it is almost as if the initiative has largely been in place for two to three rather than nine years. It is also important to bear in mind that change is continuing to occur, with the findings of this report likely to have been surpassed already, particularly as the wave of training rolled out to workers in the PDRSS sector has only recently been completed.

The timeframes for change in practice outlined in *Key Directions* were ambitious and were hindered by a number of factors including: the need for a more clearly specified vision in terms of worker dual diagnosis competencies; lack of an overall workforce strategy; lack of mandated screening and/or assessment tools; and the limitations of the existing data tools to collect dual diagnosis data. The prevailing beliefs and culture within mental health have also made it difficult for AOD issues to be seen as part of 'core business'. This can also be coupled to the lack of clarity regarding competencies and the lack of specific treatment guidelines that have been developed with Victorian mental health workers in mind.

It also needs to be recognised that a Commonwealth comorbidity measure, targeting non-government AOD organisations, called the *Improved Services Initiative*, also commenced in 2007. This saw funding go to 27 AOD organisations to assist them with building their capacity to respond to people with dual diagnosis issues in the period 2007-2010. Up to $500,000 was provided to assist, mostly individual organisations, with this work.

The final reflection on this significant reform process, is that the remaining window for change is narrowing as the change agenda for organisations becomes increasingly crowded, by seemingly competing interests.

The impact of the five VDDI strategies as described in detail in Chapter 3, is explored in the following sections.

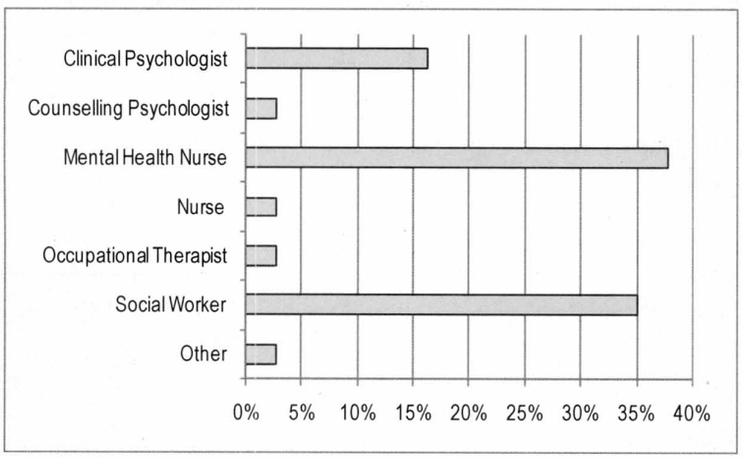
5. Impact of the VDDI strategies

5.1 VDDI Teams and Rural Clinicians

5.1.1 Professional training

The professional background of clinicians is illustrated in *Figure 5-1.* There are a similar number of mental health nurses and social work trained staff and together these make up 71% of the VDDI team members, including rural workers.

Figure 5-1: Professional training



5.1.2 VDDI Worker Role

The VDDI teams and their rural practitioners have generally been very well regarded by the organisations and teams to whom they have delivered a diversity of activities. Through these activities, these organisations reported changes in their understanding and practice regarding dual diagnosis.

The actual role has been described by VDDI leaders and team members as complex because of the skills that are required in addition to clinical expertise in both mental health and AOD. Project management and change management skills have been found to be essential, along with the capacity to negotiate across and within sectors.

A diversity of localised projects and specific activities have been undertaken in response to specific requests from local stakeholders or which VDDI workers have initiated. In particular it has required workers and teams to be strategic in the way that they have impacted on existing processes or in the creation of new structures in order to drive the Dual Diagnosis reform agenda. Examples of the work undertaken include:

- Leading organisational change across mental health organisations, including revision of policies and procedures including screening and assessment of AOD issues, data collection, mandatory training as well as procedures for monitoring progress
- Establishing clinical review partnerships between clinical mental health and medical practitioners in an AOD setting
- Provision of primary and secondary consultations
- Mentoring of people on Reciprocal Rotations as well as others

5. Impact of the VDDI strategies

- Formal arrangements regarding use of AOD Detoxification workers in mental health inpatient units
- Establishment of No Wrong Door agreements across a region
- Development and implementation of different therapeutic approaches
- Engaging organisations in reviewing their dual diagnosis capability through organisational and file audits
- Establishment of regional and subregional dual diagnosis network meetings
- Meeting with teams of AOD, PDRSS or clinical mental health workers on a regular basis to review cases or discuss common issues.
- Organising and conducting training sessions.

The following case study, whilst illustrating the work of one rural clinician, in some respects reflects work undertaken in part by most VDDI workers.

CASE STUDY – VDDI RURAL CLINICIAN

The Eastern Hume Dual Diagnosis Service has used a number of approaches to facilitate change including:

- Establishment of Eastern Hume Dual Diagnosis Group
- Establishment of Hume Dual Diagnosis Education Collaborative
- Establishment of Eastern Hume Dual Diagnosis Portfolio Holders Group
- Development of subregional Dual Diagnosis plans
- Attracting additional funding

An important element would also appear to be the high level of communication with the Hume Region Department of Health throughout the process and in return the Regional Office has provided a substantial level of funds to support local education and training.

Screening and assessment
Screening has been implemented across the whole region. In 2010, clinical mental health, alcohol and other drug treatment services and PDRSS moved to a mostly common documentation suite. This saw routine assessment of both substance use and mental health issues being conducted across the three sectors.

Integrated Care Planning
Integrated care planning is another area where significant change has occurred. Integrated care planning is occurring routinely across the region in response to the work undertaken by the EHDDS and Ovens and King Community Health Service.

Education and Training
The Hume Education Collaborative (HEC) is an educational alliance which was formed to enable equitable and tailored education and training to be developed and delivered to all relevant agencies in the whole Hume region. The Department of Human Services Regional Office has endorsed the HEC to oversee coordination and distribution of Postgraduate study scholarship funds to the sector.

Expected outcomes of the collaborative include:

- Training delivered to meet specific needs of each sector

5. Impact of the VDDI strategies

- Training catered towards experience and skills
- Cross sector delivery, increasing collaborative and networking opportunities
- Development of resources
- Dissemination of manuals and course material.

Supervision groups
Two supervision groups have been established.

Subregional planning
The Eastern Hume region has just completed its second subregional plan, which sets out goals, strategies, and timeframes with responsibility for the different strategies allocated appropriately. The subregional plans have provided an effective vehicle for driving collaborative change processes.

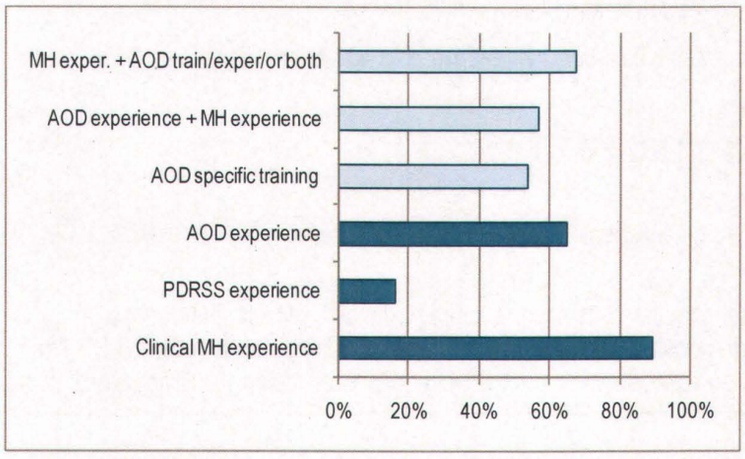
The service provider organisations that were consulted particularly valued being able to speak to a VDDI clinician for secondary consultation on a complex client or to confirm their mental state examination findings. There was also appreciation of the opportunity to come together with other organisations (from within or across sectors) for case reviews with a VDDI psychiatrist or worker and they also found VDDI input around organisational change processes helpful. The same organisations want continued access to this type of support.

Some would prefer the teams to provide more of a specialist clinical service, with the VDDI team members providing the primary clinical support to people with dual diagnosis issues. This is occurring with primary consultations being undertaken by some team members who carry a small caseload. There are however some difficulties with this approach, in that the number of teams and organisations to be serviced means that this type of support is not going to be available to everyone, and particularly when some organisations have had little or no support from VDDI yet. The approach also has limited value in building capacity in the longer term unless it is applied strictly as a modelling exercise with a VDDI clinician undertaking a primary consultation in partnership with an AOD or mental health worker; although the focus needs to be on transitioning care to the worker as soon as possible, and then providing ongoing support to the worker via secondary consultation.

An area that a few services commented on was the extent to which some of the VDDI clinicians had expertise in both AOD and mental health. *Figure 5-2*Figure 5-2 below details the experience and training of the VDDI workers in relation to each of the sectors. Almost 90% have experience with working in clinical mental health settings, and just over 60% also have worked in AOD service environments. Very few had PDRSS specific experience. However in relation to the concern that was raised, it would appear to be applicable to just over 30% of team members. Even when AOD specific training is taken into consideration as well as experience, just short of 70% of workers have either background experience or knowledge of AOD.

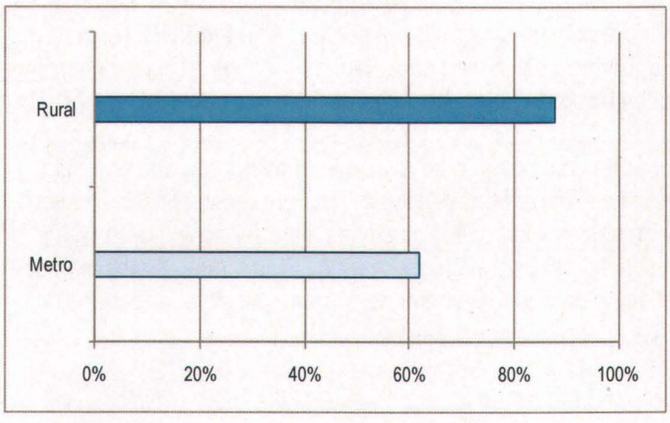
5. Impact of the VDDI strategies

Figure 5-2: VDDI workers' experience and/or training related to the three target sectors



This lack of expertise in both is a little more pronounced in the metropolitan teams than rural clinicians, as *Figure 5-3* shows, although the small number of rural clinicians means of course that one more or less could change the percentages by a factor of ten.

Figure 5-3: Proportion of workers with MH training and/or experience in MH and AOD



The issue of relevant expertise needs to be viewed in the context that all of the team leaders described the challenge of filling vacant positions in part because the expectations in relation to the role are high (although the perspective of one service provider on this issue was that the teams should be actively grooming people to take on the roles, in the knowledge that there will be turnover). Ultimately, VDDI workers need to have expertise in both AOD and mental health that has been built ideally on a practice base in both sectors as well as appropriate training in both areas.

A further challenge again identified by some AOD service providers is the need for the teams to be able to support their organisations with responding to high prevalence. This of course, has not been a requirement of VDDI workers to date.

5.1.3 Equitability of access and resourcing

A matter to be immediately attended to is equitable sector access. Whilst there are a substantial number of clinical mental health teams and non-government organisations to respond to and/or

5. Impact of the VDDI strategies

distances to be covered by rural workers, the PDRSS sector has not had comparable access to VDDI team support, although more so in some regions than others. This has been confirmed by both PDRSS and VDDI teams. For example, one VDDI team was directed by its auspice organisation to prioritise the clinical mental health sector with a plan to progress to the other sectors in the future.

As described in *section 4.2.1* the VDDI teams reported that the adult clinical mental health teams were the focus for the teams initially, and that aged clinical mental health teams were added via the Key Directions document, without any communication with the teams regarding their inclusion.

In regard to the distribution of VDDI resources, these are tabled in *Table 5-1* and *Table 5-2* along with the number of organisations/teams to be assisted and the areas and populations of the localities that they cover.

Table 5-1: Number of services to be assisted vs capacity of metro VDDI teams

Team name	Total area (km^2)	Total population	No. of PDRSS providers	No. of Clinical Mental Health teams	No. of AOD service providers	Capacity of team (eft)
SUMITT Dual Diagnosis Team	2,465	1,272,544	8	44	10	1.0 Team leader 5.0 Adult 2.0 Youth 2.0 Children 0.4 Consultant Psychiatrist 0.6 Psychiatric Registrar
Nexus Dual Diagnosis Service	576	416,082	16	17	14	1.0 Team leader 2.0 Adult 2.0 Youth 0.4 Consultant Psychiatrist 0.5 Psychiatric Registrar
Eastern Dual Diagnosis Service	3,604	1,001,479	17	29	16	0.5 Team leader 1.6 Adult 0.8 Youth 0.5 Consultant Psychiatrist 0.5 Psychiatric Registrar (Commonwealth funds)
Southern Dual Diagnosis Service	2,187	1,053,530	12	22	39	1.0 Team leader 3.4 Adult 1.6 Youth 0.2 Consultant Psychiatrist

5. Impact of the VDDI strategies

Table 5-2: Number of services to be assisted vs capacity of rural VDDI workers

Linked auspice organisation	Total area (km^2)	Total population	No. of PDRSS providers	No. of Clinical Mental Health teams	No. of AOD service providers	Capacity of team (eft)
Grampians Psychiatric Services, Ballarat Health Service	48,610	214,733	4	18	4	1
Bellarine Mental Health Team, Barwon Health	6,241	252,678	3	13	5	1
South West Health Care	22,865	102,505	1	21	2	1
Goulburn Valley Health - Adult Community Psychiatry	16,504	143,300	10	10	2	1
Bendigo Health Care Group	36,874	252,490	3	20	9	1
Mildura Base Hospital, Ramsay Health	22,087	51,590	1	7	1	1
Northeast Health, Wangaratta	23,771	117,146	3	8	2	1
Latrobe Regional Hospital	41,353	247,693	7	14	6	2

The rural resources are slim in comparison to the metropolitan teams, though workers have generally been able to be effective in engaging local players because they are fewer in number and opportunities for collaboration are sometimes greater in rural areas.

There is significant variability across the metropolitan teams in regard to the number of teams and organisations serviced and the number of VDDI workers, even between those with comparable areas and populations. Rural distributions are more comparable, although Grampians is potentially a region that needs reconsideration of resources. Overall there would seem to be a reasonable case for the review of the allocation of resources.

5.2 Education and Training Unit

To date, the ETU has been involved in a broad range of activities including:

- Seminars and workshops within training calendars for the AOD and Mental Health sectors
- Development of Dual Diagnosis Clinical Treatment Guidelines for the AOD sector, in partnership with Turning Point
- Assisting in the development of Screening and Assessment Guidelines
- Ongoing professional development for workers taking part in the Reciprocal Rotations Project
- Development and delivery of Dual Diagnosis curricula for a range of health related accredited, undergraduate and postgraduate courses
- Development and delivery of Screening and Assessment Training for AOD workers across the state

5. Impact of the VDDI strategies

- Development and delivery of Dual Diagnosis training for indigenous health workers across the state
- Development and maintenance of Dual Diagnosis Support Victoria website (http://dualdiagnosis.ning.com)
- Development of training for PDRSS in partnership with EDDS and delivered in conjunction with VICSERV and VDDI teams.

Curriculum development within accredited training, undergraduate and postgraduate frameworks, undertaken by the ETU include:

- **Accredited Training**
  - Development of Dual Diagnosis Competencies in conjunction with GippsTAFE. Available online throughout Victoria (see Appendix D)
  - Competencies have also been offered by GippsTAFE, Odyssey House, Moreland Hall, Gordon TAFE, South West TAFE and Ballarat University TAFE.
  - Recognition can be gained within the Diploma in Alcohol and Other Drug Studies, Turning Point Alcohol and Drug Centre
- **Postgraduate subjects**
  - Graduate Certificate/Diploma in Alcohol and Other Drug Studies, Turning Point Alcohol and Drug Centre – two subjects; *Introduction to Mental Health* and *Dual Diagnosis: Context and Response*
  - Bachelor of Nursing (Mental Health Major) – one subject; *Mental Health Nursing Practice: Drug & Alcohol*
  - Bachelor of Community Health (Mental Health and Alcohol and Drugs) Chisholm Institute –AOD and Dual Diagnosis subjects.

Whilst the ETU has provided a level of leadership within the VDDI with regard to curriculum development and strengthening the focus on the development of statewide strategies, this has not overcome the differences in the approaches to training undertaken by individual teams. Until more recently, teams continued to operate quite independently of the ETU on training development and delivery, leading to the proliferation of different training packages on building dual diagnosis capability.

In addition the focus of the ETU on developing accredited training options and then delivering them in a relatively resource intensive manner has meant that some clinical mental health organisations have chosen not to access the online training because of the associated cost and the limited access, and instead have developed their own. In response, the ETU has sought to extend the reach of the Dual Diagnosis competencies by providing the curriculum to a number of RTOs along with support to assist them with rolling out training.

In spite of the challenges to date, the ETU function should continue because of the importance of having a statewide focus on training and also the need to build on the relationships that have been established with professional training providers. With the movement of Turning Point to Eastern Health, it does raise the question of what formal partnerships need to be established to add value to the work of the ETU, either in a training or research capacity.

A final point is in relation to the need to development age appropriate training packages on intervening with the aged, and young people. To date the training has mostly been relevant to those dealing with

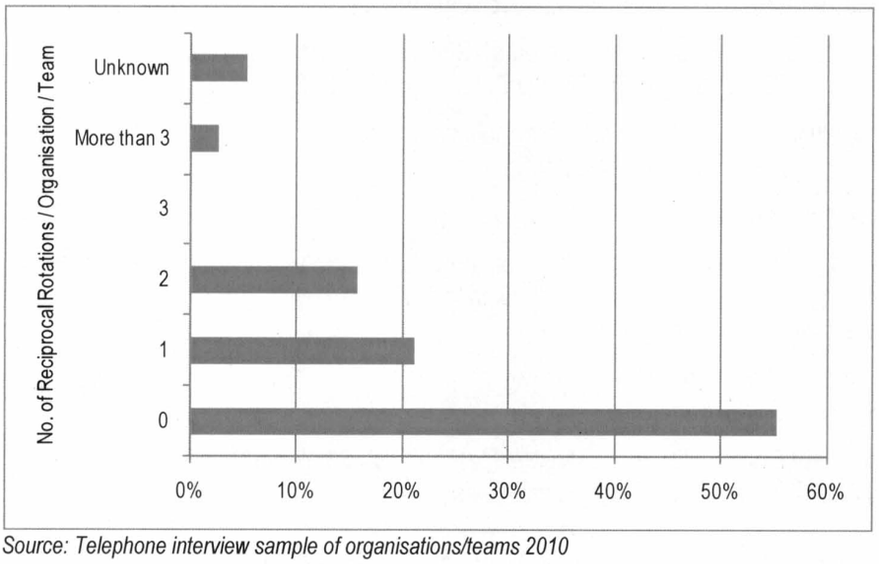
5. Impact of the VDDI strategies

the adult group. The needs of the adult group can be quite different to those who are older because of the prevalence of different substance use (eg prescription drugs and alcohol misuse). Similarly young people's issues can be quite different to the adult population and the models of service provision also need to be structure and delivered quite differently (cf headspace).

5.3 Reciprocal Rotations

As *Figure 5-4* illustrates, more than half of the organisations interviewed by telephone, indicated that they did not have anyone currently on staff that had participated in a Reciprocal Rotation, so the reach has been very limited. This in part was reported as being due to staff completing a rotation and then moving on at a later stage.

Figure 5-4: Percentage of organisations/teams involved in Reciprocal Rotations



Source: Telephone interview sample of organisations/teams 2010

Whilst the Reciprocal Rotations program has provided some workers with a unique opportunity to broaden their knowledge of another sector and build their skills, the impact for their employing organisation has been less significant overall. A relatively substantial investment in excess of $1 million has been allocated for 2010-11 for funding backfill for the organisations whose staff participate in Reciprocal Rotations. It is likely that greater value can be found from investing these funds in other workforce development activities.

5.4 Additional Psychiatric Support

Additional Psychiatric Support has meant that psychiatrists, psychiatric registrars, some general practitioners and other professional groups involved in the three sectors, have had access to psychiatric expertise. However this has been confined in its sphere of delivery because of the metropolitan location and uneven distribution of the available psychiatric time (refer *Table 5-1*), even across the greater Melbourne area. It has been strongly argued by different stakeholders that the medical profession within clinical mental health is the doorway to the adoption of dual diagnosis as core practice and hence need to be heavily targeted and supported. In general they are likely to be more responsive to input from addiction specialists such as those psychiatrists and psychiatric registrars involved in the VDDI Psychiatric component. Currently this happens in an ad hoc way and there is quite limited access for

rural practitioners to this input, so whilst the role should continue, it should be in line with the proposed changes detailed in the next chapter.

5.5 Leadership Group and Rural Forum

The Leadership Group and the Rural Forum emerged at different points and for different reasons. The Leadership Group was established earlier in an attempt to provide a governance structure for the overall initiative and thus provide a statewide emphasis. However the group has struggled in this regard, as each leader has been caught between the at times 'conflicting' pull between auspice, team and the other leaders. The lower level of seniority of these positions within their auspice body also means that there is little authority to make decisions on their auspice organisation's behalf. The Department of Health has returned to the Chair role for the group and this has assisted some important shifts regarding a more collaborative approach.

The Rural Forum has filled the vacuum of support for many of the rural practitioners, who felt quite isolated and unsupported until the development of this group. There has however been some divergence between the two forums which has added to the governance difficulties.

An important point to note is that no performance indicators have ever been set for the VDDI teams or ETU. In the absence of set KPIs, the teams and the ETU have developed their own plans and work according to those.

6. Completion of the Reform Process

6 COMPLETION OF THE REFORM PROCESS

Whilst the reform process has made good progress, the establishment of quality responses to people with dual diagnosis issues, by clinical mental health, PDRSS and AOD services is not yet complete. It is also important to note that substantial progress has only occurred since 2007 with the release of *Key Directions*. Up until that point VDDI teams had struggled to engage the interest of organisations, and to some extent, define their roles.

It is crucial to maintain the change momentum over the next three years, although with some significant refinement to the strategies employed, otherwise the gains will rapidly dissipate. There is also a substantial body of work to be done to complete the reform process.

With regard to the mental health sector, mental health nurses from the United Kingdom and New Zealand have commented with some surprise on the demarcation that still exists between intervening to support a person's mental health and supporting them to address their substance use issues. Ultimately the endgame is that good quality care is inclusive of all aspects that impact on mental health which means that alcohol and other drug misuse cannot be excluded.

The AOD sector needs to continue to build its capacity to respond to the full spectrum of mental health disorders through the development of clinical and supportive skills specific to different disorders as well as a greater awareness of online mental health interventions that can offer high quality assistance to people. This includes ensuring that there is a sufficient level of highly qualified and skilled clinical capacity in each organisation to provide adequate supervision for staff working with these very complex presentations. This may necessitate a review of current funding practices in relation to very small programs.

Any remaining barriers between clinical mental health and AOD services need to be overcome so that people with psychotic and/or high acuity presentations can be readily identified and supportively referred by AOD services. Similarly, effective pathways between AOD services and PDRSSs need to be established.

There is a diversity of programs available across PDRSS, which will mean that the level of active involvement by workers with supporting a person's recovery from dual diagnosis issues will be variable. However all should be able to engage with service users to assist them to identify the impact of substance use issues on their wellbeing and then support their engagement with AOD services.

It is necessary to recognise that the Needle and Syringe Program has not been the focus of the VDDI and realistically should not be included in the realm of the VDDI teams because of the quite diverse workforce that is involved. However given the high prevalence of dual diagnosis issues amongst the population that is serviced by NSP, it is an area that needs to be reviewed with regard to maximising opportunities for engaging these people with dual diagnosis capable responses.

6. Completion of the Reform Process

The potential areas for enhancement of the reform process are discussed below under the following headings:

1. Governance
2. Systems Management
3. Workforce development.

6.1 Governance

The discussion on governance includes the following aspects:

- Policy environment
- Contractual arrangements and governance structures
- Scope of practice for each sector
- Performance monitoring.

6.1.1 Policy environment

Key Directions is a seminal policy document. It has provided the necessary leverage for the commencement of the reform process across all three sectors. The document attempted to set out the expectations of organisations and the accompanying performance indicators that organisations are required to report on, as well as a specified timeframe, albeit a little ambitious. It is well regarded by all organisational stakeholder groups.

However it fell short in a number of key areas identified by stakeholders consulted throughout the evaluation. The vision actually required further detail, particularly regarding the following:

- Describing dual diagnosis capability for each sector in terms of specific practitioner competencies and specifying a single workforce development framework
- Mandating common screening/assessment tools
- Treatment options including the development and mandating of clinical guidelines for each of the sectors
- Promotion of integration through co-location.

Without this further information it left services unclear about what the ultimate destination of dual diagnosis capability would look like for their service and sector. It needs to be recognised though that in all likelihood this was not as possible then as it is now, because it is only with the experience to date that there is greater clarity regarding what might be appropriate for each sector, and this in turn will continue to evolve into the future. Responsibility for the implementation of the change was left to the provider organisations and the VDDI teams to negotiate between them; this included the up-skilling of workers and implementing organisational reforms. There was little involvement by the Department in the process of reform beyond the initial policy document.

The document also placed a strong emphasis on partnerships between sectors as the solution to treating dual diagnosis issues, which is one of the most difficult solutions because of the need to move either clients or workers between services. On the one hand it requires the capability of clients to be

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sufficiently organised and able to readily transport themselves between appointments in different locations. With regard to the other option of moving workers between services, the press of client throughput will generally impede the readiness to do so because time spent travelling between locations, is time spent not seeing clients. This is of course not an issue for co-located models such as Barwon Health's Jigsaw and headspace. Little attention was given in the document to the greatly increased opportunities for integration that can flow from co-location. In addition the capacity and willingness to share client information with appropriate consent is a critical component of integrated service planning and delivery. Whilst there has been some progress in specific localities, it is an area that requires significant additional commitment of all stakeholders.

A major complexity for AOD services is that they see people with mental health disorders across the spectrum from high prevalence disorders such as anxiety and depression, through personality disorders to low prevalence disorders, including schizophrenia and other psychotic disorders. *Key Directions* promoted the referral of the latter types of presentations to clinical mental health, and those with high prevalence disorders, to primary care. However it is particularly difficult for clients to be supported through the primary care pathway because of the number of steps that are required and possible cost implications (see section 2.3.4). This mostly results in the AOD sector being left to manage these issues with little input from other sectors, including the VDDI teams.

Subsequent policies such as *Mental Health Matters* recognised the need to respond to people with mental health issues right across the spectrum and also strongly endorsed the value of co-located models in addressing multiple and complex needs in an integrated way. However the resources required to drive these major reforms did not flow and so little has changed in regard to the integration of mental health and AOD services as a result of the policy statement. It has been a missed opportunity.

Hence it would be appropriate for a new Victorian Mental Health and AOD framework document to be developed that sets out a clear vision for the future and which elaborates clearly the expectations of the different sectors. There are a number of priority areas that are important to highlight in the framework document including:

- Dual diagnosis objectives, performance indicators and timeframes for achieving these
- Reform required within each team/organisation within each of the sectors and the expectations of senior executive teams and their organisations
- Scope of dual diagnosis practice in each sector, required worker competencies and the implementation of a workforce development strategy
- Expectations in relation to clinical and non-clinical interventions
- Inter-sectoral partnerships across the three sectors that support No Wrong Door, the sharing of information and joint professional development opportunities
- Sustainability measures.

Progress has occurred on the State – Commonwealth partnership on comorbidity and this should continue. To date it has seen joint conferences involving ISI and VDDI workers and the emergence of regional planning involving both initiatives. The Department of Health is also an active member of the National Comorbidity Collaborative which has been established to advise the Australian Health Ministers' Conference. This relationship has the potential to ensure alignment between federal and state policy positions and workforce strategies and in particular on the definition of dual diagnosis capability.

6. Completion of the Reform Process

6.1.2 Contractual arrangements and governance structures

The VDDI governance arrangements as summarised in *Figure 3-4* have provided a fundamental challenge to the implementation of a statewide initiative. The various structures that have been developed at different points have all added some value but have failed to address the fundamental need to drive a strong statewide focus for the initiative and the decision by the Department of Health to not mandate specific screening and assessment tools has added significantly to the challenge. Individual contracts with four different organisations as well as the lack of a unifying structure and/or strategic plan with common KPIs, has meant that the initiative has been quite fragmented and this has led to inconsistency in training and to a diversity of screening and assessment tools. It has also meant greater difficulty in promoting the initiative as a major reform across all three sectors given that some services are unaware of the initiative, although they may know the name of their local team. The structural arrangements have also allowed the auspice organisations some capacity to determine which sectors they choose to service in their region, over and above others, which has seen PDRSS not provided with input in some cases and a lack of assistance to clinical mental health teams in another case.

The VDDI team leaders, which were left with the responsibility of developing a memorandum of understanding between the four teams, including rural workers have been in a very difficult position. On the one hand their auspice has wanted them to go in a particular direction, the department another and then each team has had its own view of what training should occur and so on. The Department did not provide the necessary authorising environment for the leaders to form a single statewide VDDI plan or for the ETU in leading workforce development.

Another consequence of the fragmentation has been significant duplication in resource development between the teams, although the rural practitioners have generally sought to share ideas, approaches and materials.

The contractual arrangements for rural practitioners have not resulted in access to additional support for most of them. Moreover, it has placed workers, rural host organisations and metro teams in a difficult position at times.

It would also appear that the major drive for the initiative has come from within the AOD section of the Department and that this has not been carried as strongly through mental health and that gaining organisational commitment has been most difficult in clinical mental health. The question of where within the department the carriage of VDDI should sit, given its focus across mental health, AOD, Sector Quality and Workforce Development, is one that will need careful consideration.

Whilst *Key Directions* included the Dual Diagnosis Action Plan, there was no formal process following its release, which brought the activities undertaken through VDDI under the umbrella of a single plan. In future it is proposed that a 3 year VDDI Statewide Strategic Plan (VSSP) that covers all aspects of the initiative and which includes KPIs, be developed through a Central Steering Group appointed by the Department of Health. There are a number of areas that the VSSP could potentially address, including:

- Finalisation of scope of practice and required competencies for each of the sectors
- Workforce development priorities including an emphasis on Aged and CAMHS teams and youth for AOD
- Organisational change across clinical mental health

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- Increased focus on building clinical and non-clinical intervention capacity including workforce development for AOD on responding to high prevalence, personality and trauma related disorders and/or symptoms
- Strengthening the consumer/carer focus for AOD
- Support for the development of dual diagnosis capability in PDRSS
- Role of ETU, VDDI teams and Psychiatry Support.

The VSSP and its KPIs which would bind all of the teams would then provide the basis for local level planning and monitoring. Local Action Plans for implementing the VDDI Statewide Strategic Plan in each metropolitan and rural VDDI region and which include KPIs, would be developed through Local Steering Groups appointed in consultation with central and regional Department of Health.

6.1.3 Performance monitoring and screening and assessment tools

There are potentially a number of levels and avenues for performance measurement, only some of which have been utilised throughout VDDI. This includes performance by organisations in relation to organisational change and the establishment of strategic partnerships. It could also extend to performance by practitioners on screening, assessment, treatment planning and use of appropriate interventions, as well as changes that have been achieved by clients.

As described in the previous chapter, there are some DD capacity assessment tools that have been used to assist in this process, such as DDCAT and the Dual Diagnosis Capability tools developed in the Eastern Hume region.

Whilst the requirement to report against the SDOs has engaged the focus of organisations on dual diagnosis issues, in reality they are a relatively crude measure of progress and the total resources committed to monitoring progress and reporting back to organisations by the Department of Health has been minimal. A further shortcoming is that whilst clinical mental health services report as a whole, they don't report on the progress of each team and so it is difficult to really assess the extent of reform across these large organisations. Surprisingly, no regional Department of Health staff have been involved in monitoring or providing feedback to each of the sectors and this would appear to be an oversight. In the longer term performance by organisations on building and sustaining dual diagnosis capability needs to be monitored through its inclusion as a quality review requirement. This would see it included as an aspect of file and other audits.

In addition, the AOD sector has shown some ability to undertake mental state examinations in order to make more effective referrals to clinical mental health, as well as mental health screens such as Modified Mini Screen (MMS), but there is no means of recording this data in ADIS. PDRSS have successfully screened for AOD usage, although there is no one data collection tool in use across the sector. Clinical mental health teams have been able to screen and assess for AOD usage across a variety of teams and settings using ASSIST. An option is available for capturing some dual diagnosis related information through CMI.

Ultimately consistency between regions on screening and assessment tools, and integrated data collection systems that can capture this information, would allow the Department to more readily monitor progress on a statewide basis. It would also assist organisations to review their own dual diagnosis work. Ideally the three sectors should be using the one data collection system with access to the same

suite of screening, assessment and reporting tools as well as appropriate client treatment planning and care information.

It is also necessary to bring client outcomes into the performance monitoring frame, as no specific client outcomes have been determined in relation to dual diagnosis clients, for any of the three sectors. The governance forum, which was comprised of VDDI staff and auspice representatives as well as DH central and regional staff, suggested *measurement is required at both a systemic and client level as well as agency and clinician level* (DH 2010: 5)[43]. Hence it important that the Department appoint a working group which is linked to the VSSP Central Steering Group, to undertake the development of client specific outcomes to be achieved and monitored by each sector.

Also as mentioned previously, no performance indicators have been specified for the VDDI teams. This has meant that reporting is currently based on what activities they undertake and not around agreed targets or other performance indicators.

6.1.4 Proposed governance structural solutions

A number of options for addressing governance structural concerns have been canvassed by stakeholders including during the governance forum conducted by the Department of Health. These include changes to current arrangements which would see rural workers formally placed under the auspice of their current 'host' organisation, as well as major changes such as the creation of a Dual Diagnosis Institute that would employ all VDDI workers. Whilst there are some attractive aspects to the latter proposal, there is the risk that it could become a major distraction for teams as they sought to realign their reporting and other relationships and to establish a new organisation. It may also send a counter signal to the message that dual diagnosis reform is about establishing new ways of working that are sustainable within each sector and organisation in the longer term.

However the proposal to formally bring Rural Workers under the auspice of their local 'host' organisation rather than a metropolitan-based organisation is a sensible response to the unnecessary complexity that has emerged from the current arrangement. The rural forum could continue to provide peer support, although in line with the specified direction of the initiative.

Also the leadership provided by the ETU on workforce has been limited by the fact that the role was not accompanied by sufficient authorising power to establish a common curriculum. Over the next three years the leadership function should be strengthened but any training development should be in consultation with the Department of Health and the VDDI teams and Rural Forum. The leadership role should extend to coordinating the implementation of an overall workforce development strategy (discussed later in section 6.3). Consideration could be given to whether the ETU becomes a Registered Training Organisation (RTO) in its own right, if it is deemed that this will assist its leadership role in the training area. The alternative is to continue partnering with registered training providers in the development and delivery of accredited training to the three sectors. Such partnerships to date have included providers from both VET and higher education sectors. The longer term strategy must be to establishment a commitment by the professional training programs to the inclusion of dual diagnosis specific units and placements. However the Department will need to lead these discussions as well as working through COAG to drive reform across the professional training programs, whilst the ETU can back up the discussion with their practical expertise in developing units appropriate to the different training programs. Depending on how quickly this area of activity develops, it may be necessary to look

[43] Department of Health. 2010. *Report on the Victorian Dual Diagnosis Governance Forum.* Department of Health, Victoria, Melbourne. 2010

at some additional resources to enhance the capacity to work with the training programs on the development of units.

6.2 Systems change management

This section summarises some of the challenges in completing the reform. The discussion then moves to a consideration of the roles and the progress on the processes for driving reform within and across sectors. This includes approaches to fostering cross-sector partnerships that support the establishment and maintenance of strong referral pathways, co-location, information sharing, professional development and high quality evidence-based care.

6.2.1 Systemic differences

There are a number of differences between the three sectors that have a bearing on the implementation of the dual diagnosis reform. The three work around different needs, using different approaches and a varied skill base. Clinical mental health clinicians work with acute episodes of largely severe mental illnesses to diagnose illness type and reduce symptom impact over relatively short periods of intervention. PDRSS on the other hand collect largely non-clinical information and work with people often over quite long timeframes, whilst AOD is somewhere in between these two sectors, although with greater similarity to PDRSS in regard to information collection than clinical mental health. AOD is also interested in assessing people's readiness for change and their involvement is over a much shorter timeframe than PDRSS, and may in many instances be shorter than clinical mental health.

The range of activities that occur in each sector are highly varied, from day programs, residential care and outreach support in PDRSS, needle exchange, detoxification, education and counselling in AOD to inpatient, outreach and subacute clinical care across the full age range in clinical mental health.

The skill base for PDRSS ranges from unqualified to people with related professional training, whilst in AOD there is a requirement that as a minimum staff have or are working towards completion of Certificate IV in Alcohol and Other Drugs. In addition, around 65% of AOD practitioners have been reported by the ETU to have a health, social or behavioural science related tertiary qualification.

A further difference between clinical mental health and the other two sectors is the number of organisations involved for the number of staff employed. There are approximately:

- 25 clinical mental health organisations employing around 5,000 staff distributed amongst 201 teams
- At least 74 PDRSS organisations employing around 1,500 staff
- At least 102 AOD organisations employing around 700 staff.

Many of the AOD provider organisations have a broader focus than assistance with substance use issues. Other areas of support include welfare, housing, homelessness support, family support, problem gambling, allied health, youth work and a range of community health services such as podiatry amongst others.

The challenge for dual diagnosis service reform in this context is the extent to which organisations with small numbers of AOD or PDRSS staff and/or very small organisations can build and sustain the necessary workforce and supervisory capacity along with the change in practice, policies and procedures. The converse is true of mental health organisations, where reform in this context requires

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change on a large scale, but once it is appropriately embedded, it should be able to sustain itself relatively well. A major challenge also with clinical mental health is the cultural shift required for some practitioners to accept that AOD issues cannot be seen as separate to mental health issues.

6.2.2 Establishing cross sectoral partnerships

The relationships across the sectors have been progressing slowly. There have been some standout examples as described earlier, and there are still old themes being reported such as some AOD services feeling that they are not particularly well regarded by clinical mental health. This can mean that AOD services either are not successful with making a referral or they have to rely on the intervention of a VDDI worker for a referral to be accepted by clinical mental health. Also whilst there has been some movement on the sharing of client information (with consent), there is still some significant progress that needs to be made.

A number of network vehicles have been utilised to drive the cross-sector reforms that have occurred to date, including specially created dual diagnosis working groups, mental health alliances and Primary Care Partnership (PCP) working groups amongst others. Ideally the opportunity should be taken wherever possible to work within existing partnership development mechanisms such as PCPs so as not to create duplication in these activities and to increase the opportunity for dual diagnosis specific strategies to be incorporated into mainstream practice.

The Hume No Wrong Door 2 Protocol provides a very useful example for other regions to consider in their cross sector planning.

It is hoped that cross-sector planning can go further even than improving the flow of referrals and sharing of information, by genuinely exploring opportunities for co-location of AOD and mental health programs, to afford better access for dual diagnosis clients and strengthened opportunities for the integration of care.

There are two higher order issues in regard to cross-sector relationships that will require a review by the Department and these relate to the following, both of which involve significant risk for the wellbeing of the clients involved:

- Management of information sharing or other options between AOD, clinical mental health and PDRSS, for situations involving high risk clients, particularly in cases where there might not be informed consent but where a person is at risk of harm to themselves or others
- Support to detoxification patients in a residential detoxification facility by clinical mental health teams.

6.2.3 Change management roles

It is hoped that the specification of the systemic reform roles/functions in *Table 6-1* will assist all players in recognising the critical role that all levels play in the reform. Clinicians and support people are not listed because it is presumed that they are in fact the people that deliver the reform in its realised state.

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Table 6-1: Systems change management; roles

Change agent	Proposed role/functions
Department of Health Mental Health, Drugs & Regions	Policy development
	Leadership on policy implementation
	Modelling integration
	Funding and other resources
	Monitoring of policy implementation
	Feedback to organisations and sectors on progress
	Central and Regional leadership on policy implementation
ETU	Leadership and coordination in development and delivery of curriculum and training & workforce development implementation
	Establishment of strategic relationships with educational institutions around participation in and development and delivery of training
	Facilitating sharing of resources across VDDI
VDDI Teams and Rural Clinicians	Support workers and teams/organisations to change practice
	Provision of resources
	Support statewide training and other workforce development strategies
	Mentoring/Supervision/Secondary consultation
	Network facilitation
Psychiatric support	Provide leadership for medical staff
	Build the DD capability of medical staff
	Secondary consultation, clinical review, primary consultation
	Mentoring and training
Senior managers; Clinical MH	Driving organisational reform and practice change
	Ensuring review of policies and development of DD specific policies
	Supporting middle management to drive reforms
	Establishment of monitoring and review mechanisms
	Absorption of DD monitoring into quality review processes
	Supporting staff participation in workforce development activities
Clinical Directors/Medical staff	Clinical leadership in DD practice
	Support for staff in changes to screening, assessment, treatment planning
	Incorporation of DD into clinical review processes and supervision
	Supporting staff participation in workforce development activities
	Supporting intersectoral partnerships

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Change agent	Proposed role/functions
Senior management AOD	Overseeing organisational reform and practice change
	Ensuring review of policies and development of DD specific policies
	Supporting middle management to drive reforms
	Establishment of monitoring and review mechanisms
	Absorption of DD monitoring into quality review processes
	Supporting staff participation in workforce development activities
	Ensuring clinical and non-clinical MH support leadership in DD practice
Middle managers AOD	Driving implementation of organisational reform and practice change
	Driving implementation of DD monitoring and review
	Providing clinical and non-clinical MH support leadership in DD practice
	Support for staff in changes to screening, assessment, treatment planning
	Incorporation of DD into clinical review processes and supervision
Senior management PDRSS	Overseeing organisational reform and practice change
	Ensuring review of policies and development of DD specific policies
	Supporting middle management to drive reforms
	Establishment of monitoring and review mechanisms
	Absorption of DD monitoring into quality review processes
	Supporting staff participation in workforce development activities
Middle managers PDRSS	Driving implementation of organisational reform and practice change
	Driving implementation of DD monitoring and review
	Providing non-clinical MH and AOD support leadership in DD practice
	Support for staff in changes to screening, assessment, care planning
	Incorporation of DD into practice review processes and supervision

Change management should ultimately culminate with Dual Diagnosis practice being firmly embedded as evidenced by the development and implementation of appropriate dual diagnosis treatment plans, clinical and other review processes, ongoing workforce development, supervision, and in core quality improvement exercises such as file and organisational audits. However until this reform has been imbedded, there will need to be ongoing mechanisms for monitoring the performance of the change agents detailed in *Table 6-1*.

6.3 Workforce development

As discussed in Section 6.1, the definition of the skill base required by workers in each sector was not provided in sufficient detail within *Key Directions*. The broad parameters were made clear; that is, screening, assessment and development of integrated treatment plans, but the training competencies were not detailed, nor were there specific training packages to be developed. Rather the decision about the level and extent of training was left with the individual organisations to determine, possibly in consultation with the VDDI teams or others, along with the funding of such if required. That is the approach to building capability across the workforce was not prescribed in terms of a single 'workforce development strategy'.

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The situation has been further complicated by the failure to prescribe the domains and content that screening and assessment should address, which in turn has made the development of training on screening and assessment more difficult.

Training provided by the VDDI teams was cost free, however training in the online competencies has a cost attached for all staff with a greater than Certificate IV level qualification and this was reported as a major impediment by some large mental health organisations.

Whilst the competency based curriculum developed by ETU provides a strong foundation and the facilitated mode of delivery has merit, it is time consuming and resource intensive. Hence this approach is probably better dedicated to the delivery of a higher level set of competencies that are targeted at team leaders and others in supervisory roles. Broad workforce development is probably better tackled in much the same way as the wave of training that has been provided to PDRSS staff. That is providing it over two days, using the combined expertise of VDDI team members and other appropriate sector specific trainers, to deliver the content. There is still the option with this mode of delivery for the training to be assessed so that those that have participated in training can gain recognition under the Vocational Education and Training accreditation system, for units completed.

6.3.1 Scope of practice

In response, the following 'scope of practice' for practitioners in each of the three sectors is proposed in order to facilitate the finalisation of the vexed issue of what constitutes dual diagnosis capability. If adopted, these would inform the development of competency areas and competency based training.

Clinical Mental Health

- Rural workers to formally come under the auspice of their local 'host' organisation rather than a metro-based organisation
- Conduct AOD screening and assessment of all presentations
- Treat low prevalence disorders and high risk presentations, including accompanying AOD issues unless a complex detoxification and/or rehabilitation is involved
- Provide detoxification as part of inpatient treatment where appropriate. Commence some brief interventions regarding AOD issues and forge links with AOD services
- Community MH teams should be able to treat both AOD and MH issues unless quite complex AOD issues, in which case, they should engage and work in collaboration with an AOD service.

Alcohol and Other Drugs Sector

- Mental health screening and/or mental state examination of all presentations by appropriately qualified practitioners[44]
- Engage and support person even if have low prevalence mental health disorder whilst making supported referral to clinical mental health
- Appropriately qualified AOD staff to provide non-clinical mental health support

[44] Practitioners with Psychology, Social Work, Occupational Therapy, Mental Health Nursing qualification plus DD competencies

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- Appropriately qualified practitioners[45] to treat AOD issues and high prevalence mental health disorders, Personality Disorder issues and low level trauma symptoms and/or refer to GP for more complex mental health, or undertake secondary consultation with Primary Mental Health teams or VDDI team
- Link clients with high prevalence mental health disorders to online options for support such as *Mood Gym* (Australian National University) and *Virtual Clinic* (St Vincent's Hospital, Sydney and University of New South Wales)
- Treat complex AOD issues in partnership with Community MH Teams for people with low prevalence disorders
- Treat AOD issues in people with stabilised low prevalence disorders, in partnership with GP and/or PDRSS.

Psychiatric Disability Rehabilitation Support Service

- Screening and some assessment of AOD
- Work with more straightforward AOD otherwise assist clients to engage with AOD services and monitor and support progress
- Appropriately qualified practitioners[46] to provide AOD interventions.

The implications of these changes are highly significant, particularly in relation to an increased clinical role for AOD practitioners in response to high prevalence, trauma and personality disorders. This will require significant work both on the development of models of care/treatment models, as well as ensuring appropriate training through delivery of existing accredited training and/or development and delivery of new units. A clinical working party, which is a subgroup of the VSSP Central Steering Committee could be appointed by the department to provide the necessary clinical leadership to scope the necessary reforms.

6.3.2 Workforce development strategy

Once the scope of practice is determined, then it is proposed that the Department of Health develop a Workforce Development Strategy, which includes training objectives and requirements for the following:

- Practitioners in each sector
- Senior clinicians, portfolio holders, supervisors, team leaders and managers in each sector who will become advanced dual diagnosis practitioners
- Senior management in each sector that have responsibility for driving organisational change.

The Workforce Development Strategy should form a significant component of the VSSP, and the ETU should play a key coordinating and leadership role in its implementation, particularly in relation to developing a training program for each of the three groups outlined above. The starting point for the development of the training packages should be the online competencies developed by ETU and any new training packages, wherever possible, should be developed as units of competency within the Vocational Education and Training accreditation system. However this is not always an option with

[45] As per previous description plus recognised training in evidence-based therapies such as Cognitive Behavioural Therapy (CBT)

[46] Practitioners with Psychology, Social Work, Occupational Therapy, Mental Health Nursing qualification plus DD competencies, and recognised training in Motivational Interviewing and other evidence-based AOD interventions

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quite specific content areas, such as the training for senior management, where the area of training does not readily lend itself to being developed as a unit of competency. In this case, the main concern is that the same training package is delivered by appropriately skilled trainers across the state. A proposed outline of a training program is included at Appendix E, which would see training completed by the end of 2012. The training program is illustrative but could provide a basis for further planning.

The training program should also include a strong emphasis on assisting practitioners with the provision of evidence-based clinical and non-clinical interventions.

Once the training program is provided, there will then need to be consideration of the following with regard to developing and implementing training programs:

- Process for scoping training needs (including recognition of prior learning)
- Options for establishing pathways to higher qualifications

The Workforce Development Strategy should also take advantage where possible, of the accredited mental health, alcohol and other drug and dual diagnosis courses throughout Australia that are accessible in a variety of ways as well as other approaches.

The funding currently committed to the Reciprocal Rotations strategy should be reallocated in full to fund the statewide training program and other workforce development strategies.

Training in and of itself is not sufficient to deliver the required reform as is apparent from the previous chapter on the SDOs. As indicated in Table 6-1, all levels across the mental health and AOD systems need to play an active role in bring the reform to completion.

Further, the issue of intervention was not really addressed through *Key Directions* other than to advocate for the establishment of effective referral pathways between AOD and mental health. Whilst high prevalence disorders are acknowledged in the document, and referral to primary care as the proposed option, these disorders were not specifically addressed in the *Dual Diagnosis Plan*. The plan called for the application of evidence based interventions but in the absence of mandated treatment guidelines, this is made more difficult for individual services. It should be acknowledged though, that the Department did support the development of a set of clinical treatment guidelines for AOD workers by a VDDI working group in conjunction with Turning Point, although none of the services that were interviewed are using the document. If a clinical working group is appointed to develop the expanded role for AOD clinicians around mental health, it would be necessary for them as part of their brief to inform the creation of appropriate clinical guidelines to accompany the expanded clinical role.

Establishment of the Victorian Institute of Mental Health Workforce Development and Innovation over the next 12-18 months will necessitate the clarification of its role in relation to building the dual diagnosis capacity of the three workforces. *Shaping the future: The Victorian mental health workforce strategy*, makes very little reference to the establishment of dual diagnosis capability within the clinical mental health workforce.

The reform will not be complete however until the professional training courses recognise the significant co-occurrence and impact of AOD and mental health issues and/or are required to provide an adequate component of their courses that prepare different professionals for dual diagnosis work. Ideally this would extend to training placements in both AOD and Mental Health settings for every person trained.

6. Completion of the Reform Process

6.3.3 VDDI Teams and Psychiatric Support

The strategies that have been implemented to assist organisations with their reform should largely continue for the next 3 years although with the clarification of their roles as detailed below.

VDDI Teams

- VDDI Teams to review the capacity of all of their staff and ensure that practitioners have expertise in both AOD and mental health
- The scope of support for organisations around mental health should be broadened to include high prevalence disorders, personality disorders and post traumatic stress disorder. Accordingly training should be provided to VDDI workers on these areas as a matter of priority
- The objectives for the involvement of a VDDI team member(s) with a target organisation need to be negotiated at the outset and the timeframe for active involvement confined ideally to no longer than six months
- Over time the VDDI team's role of supporting team leaders and supervisors in their roles should be strengthened. This may require reviewing the level at which staff are appointed into at least some of the roles, to ensure that senior, experienced clinical practitioners with capability in dual diagnosis are engaged that can provide the necessary clinical input into sessions with supervisors
- VDDI teams to be well versed in online options for intervening with high prevalence disorders, such as SHADE, Mood Gym and Virtual Clinic, and be able to support AOD services around the integration of these technological options into their practice with clients
- Primary consultations to occur only where it involves modelling particular aspects of practice and even this approach will need to be applied sparingly
- The teams should continue to provide:
  - secondary consultation
  - case reviews
  - support for organisational change
  - provision of activities in accordance with the workforce strategy and ETU coordination
  - support for implementation of screening and assessment
  - facilitation of partnerships
    - Establishment of No Wrong Door approach including overcoming issues around the sharing of information where informed consent is involved
    - Establishment of secondary consultation relationships between sectors
    - Establishment of cross sector client reviews and other professional development forums.

If the Department of Health were to implement the separation of the VDDI Rural Workers from the metropolitan teams as proposed earlier, it also seems timely for the Department to consider reviewing the allocation of VDDI resources more generally across the metropolitan and rural regions. It may be possible that there could be some funds from the reallocation of the Reciprocal Rotations stream that could be directed to addressing at least part of the inequity.

VDDI Psychiatric Support

- Clarifications to the role of VDDI Psychiatric Support to include:

6. Completion of the Reform Process

- Pooling the dedicated psychiatric support and making it equally available to all regions via video and teleconference as well as face to face sessions where the travel time is not extensive. This will potentially require establishing videoconferencing facilities in locations that can be readily accessed by each of the teams and training for the psychiatrists in how to use the technology. Metropolitan VDDI teams and Rural Workers will need access to centralised calendars for the psychiatrists to book sessions for groups of their local stakeholders to consult with a psychiatrist
- Role in developing dual diagnosis capability of medical officers in accordance with the VSSP
- The Department of Health to consider developing a role through the VSSP that sees the psychiatrists working in conjunction with the Chief Psychiatrist's Office, Clinical Directors of Mental Health and the Royal Australian and New Zealand College of Psychiatry to build dual diagnosis capacity and focus
- The Department of Health to consider continued support for the Psychiatrists' active involvement with the College's Addiction Medicine Chapter.

- Activities should continue to include:
  - Secondary and tertiary consultations
  - Clinical and medication reviews
  - Training sessions for psychiatric registrars, psychiatrists and medical staff as part of the VDDI workforce development strategy
  - Seminars on intervening with particular configurations of dual diagnosis (e.g. Opioid addiction and PTSD).

6.4 Recommendations

The following recommendations are proposed in order to see the realisation of the long advocated for vision of dual diagnosis becoming everyday practice across mental health and AOD. These recommendations are drafted in response to the three major areas discussed above.

1. Governance recommendations

It is proposed that the Department of Health adopt the following recommendations in relation to the governance of VDDI:

1.1 Policy

Recommendation 1.1	A new framework document be developed that clearly specifies the vision for responding to people with dual diagnosis issues across mental health and alcohol and other drugs sectors.

It is also recommended that the document:

R.1.1.1 Specify worker competencies across clinical mental health, alcohol and other drugs and psychiatric disability rehabilitation and support services as well as a single workforce development plan.

6. Completion of the Reform Process

R.1.1.2 Include a commitment to a single set of screening and assessment tools.

R.1.1.3 Include a commitment to the development of clinical and practice guidelines.

R.1.1.4 Promote service integration through co-location and other strategies.

1.2 Governance structures

Recommendation 1.2	That the governance structures of the initiative be addressed as outlined below to clarify relationships and roles as well as to ensure consistency of approach and content, in the implementation of the dual diagnosis reforms.

R.1.2.1 The Department of Health develop a single VDDI Statewide Strategic Plan (VSSP) covering all of the VDDI strategies with specified KPIs for all teams and each component of the program. The VSSP would inform the development of local regional plans. This process would best be supported by a Central Steering Committee appointed by the Department and local committees that include regional and central departmental staff representation to guide the development of regional plans.

R.1.2.2 Rural practitioners to be brought under the direct auspice of their linked auspice organisation and be supported through the Rural Forum.

R.1.2.3 The ETU be retained and lead and coordinate the development and delivery of statewide education and training and facilitate the sharing of resources across VDDI.

R.1.2.4 Department to provide some additional resources in the short term to assist the ETU to become an RTO.

1.3 Performance monitoring and screening and assessment tools

Recommendation 1.3	As a matter of priority, the Department move to support effective information sharing and appropriate data collection for monitoring of performance against dual diagnosis KPIs, by establishing an integrated electronic data collection and reporting system across the three sectors.

R.1.3.1 In the interim, clinical mental health teams to undertake a CAGE-AID screen with all clients, ASSIST with those that require further assessment and use CMI to complete ICD-10 and Z-codes (refer Appendix F) to capture AOD information.

R.1.3.2 In the interim AOD to complete a K-10 in hard copy and record findings from conducting a MSE in client files.

R.1.3.3 In the interim PDRSS to complete CAGE-AID for all clients and ASSIST for those that require further assessment or refer to AOD for assessment.

R.1.3.4 The Department appoint a working group under the aegis of the VSSP Central Steering Group to develop a set of dual diagnosis client outcomes for each of the three sectors.

R.1.3.5 Over the next 2 years, organisations should be required to report against progress on an audit tool such as DDCAT or that developed by the North East Hume Dual Diagnosis worker on an annual basis (as determined by the Department), down to the level of each team. Ideally reports to be provided to regional departmental staff, who collate the findings and then a forum of regional and central departmental staff could reflect on the progress by organisations against their audit, and what might be needed to assist the final progression to integrating dual

6. Completion of the Reform Process

diagnosis as core, everyday practice. After two years organisations should be able to demonstrate how accountability measures have been put in place in an ongoing way as part of their standard quality improvement and accountability measures.

2. Systems change management

It is proposed that the Department of Health adopt the following recommendations in relation to systems change management in relation to VDDI:

2.1 Capacity

Recommendation 2.1	The Department review the ability of organisations with small numbers of AOD and PDRSS staff to build and sustain the necessary workforce and supervisory capacity along with the required change in practice, policies and procedures.

2.2 Establishing cross sectoral partnerships

Recommendation 2.2	The development of the VSSP and linked local plans to give careful consideration to the identification of existing network vehicles such as PCPs for the purpose of forming effective cross sectoral partnerships to drive the required dual diagnosis reforms.

It is also recommended that these partnerships give priority to:

R.2.2.1 Establishment of No Wrong Door agreements such as the No Wrong Door 2 Protocol.

R.2.2.2 Investigate and support opportunities for co-location of AOD and mental health staff to afford better access for dual diagnosis clients and strengthened opportunities for the integration of care.

It is also recommended that the Department:

R.2.2.3 Review the referral and information sharing arrangements between detoxification units and clinical mental health teams, particularly in relation to high risk clients.

2.3 Change management roles

Recommendation 2.3	The Department include in any new framework document and other communication with the three sectors a description of the functions required by each change agent in relation to the implementation of the dual diagnosis reforms

3. Workforce development recommendations

It is proposed that the Department of Health adopt the following recommendations in relation to workforce development in relation to VDDI:

6. Completion of the Reform Process

3.1 Scope of practice and dual diagnosis capability

Recommendation 3.1	As a matter of priority, the Department work closely with the ETU and the VDDI teams to conduct a process that defines the required scope and capability of dual diagnosis practice for each sector

In addition it is proposed that:

R.3.1.1 The scope for AOD include that appropriately qualified AOD clinicians[47] should provide clinical interventions with dual diagnosis clients that have high prevalence disorders or be able to facilitate client participation in online support options such as Mood Gym, SHADE and Virtual Clinic.

R.3.1.2 The scope for appropriately qualified clinical MH[48] should include the delivery of AOD interventions in clinical mental health settings as a core component of clinical work.

R.3.1.3 The scope for PDRSS should include the provision of AOD clinical interventions by appropriately qualified PDRSS workers[49] and non-clinical AOD support to clients by all workers.

R.3.1.4 A clinical subcommittee of the VSSP Central Steering Committee be established by the Department to identify and/or develop appropriate care models and treatment frameworks for people with substance use issues and high prevalence, trauma and personality disorders. The subcommittee would ideally have significant VDDI Psychiatrist involvement along with representation by clinical psychologists experienced in high prevalence and other non-psychotic disorders and substance use issues as well as highly experienced and qualified AOD clinicians. The National Drug and Alcohol Research Centre could provide highly valuable input to such a process. The subcommittee should also be well placed to provide guidance on the areas of training that will be required as well as informing development of treatment guidelines.

3.2 Workforce development strategy

Recommendation 3.2	The Department of Health to undertake the development of a workforce development strategy which will form a significant component of the VSSP

In addition it is also proposed that:

R.3.2.1 The workforce development strategy gives careful consideration to the development of training packages for senior managers, team leaders/supervisors and clinicians and workers (that are relevant to individual sectors).

R.3.2.2 The training programs use the most efficient means to deliver the program before the end of 2012, which most likely will entail a combination of strategies and that new training be developed as units of competency under VET accreditation system, wherever possible.

[47] Practitioners with Psychology, Social Work, Occupational Therapy, Mental Health Nursing qualification plus DD competencies, and recognised training in Motivational Interviewing and other evidence-based AOD interventions and who have been provided with specific training in CBT and other therapeutic interventions

[48] Clinicians with training in DD competencies, Motivational Interviewing and other evidence-based AOD interventions

[49] Practitioners with Psychology, Social Work, Occupational Therapy, Mental Health Nursing qualification plus DD competencies, and recognised training in Motivational Interviewing and other evidence-based AOD interventions

6. Completion of the Reform Process

R.3.2.3 Funding for Reciprocal Rotations be reallocated to support the implementation of a substantial workforce development strategy, which may also include additional resources for some of the VDDI teams.

R.3.2.4 A much stronger emphasis on the establishment of the capacity to deliver clinical and non-clinical interventions to be included. Hence appropriate training units of competency should be developed along with a set of clinical and non-clinical guidelines for guiding interventions by workers across the three sectors that are ideally consistent with existing national guidelines. This includes the need to provide clinical interventions for clients with high prevalence, personality and trauma-related disorders, that attend AOD services, as well as the need to intervene with AOD issues in mental health settings.

R.3.2.5 The ETU to provide a leadership and coordination role in the implementation of the strategy.

R.3.2.6 The Department engage the professional bodies and colleges in a round table dialogue around the incorporation of dual diagnosis specific units and the establishment of placements across both AOD and mental health settings as routine practice.

R.3.2.7 The ongoing role in fostering dual diagnosis capability of the 'soon to be established' Victorian Institute of Mental Health Workforce Development and Innovation be clarified as a matter of priority in its establishment.

3.3 VDDI teams and Psychiatric Support

Recommendation 3.3	VDDI teams and Psychiatric Support continue to be funded for a further 3 years, with the following modifications

It is proposed that the VDDI teams' core role become inclusive of the following:

R.3.3.1 Supporting AOD organisations with implementing appropriate responses to high prevalence, as well as personality and trauma-related issues.

R.3.3.2 Prioritising support to clinical and/or team leaders with the inclusion of dual diagnosis as a core part of their supervisory practice (training be undertaken by VDDI team members to build their capacity in this area).

R.3.3.3 Being very well versed in online options for intervening with high prevalence disorders and work with AOD services to facilitate their promotion of these options to clients.

R.3.3.4 Primary consultations to occur only where it involves modelling particular aspects of practice and even this approach will need to be applied sparingly.

And in addition it is proposed that:

R.3.3.5 Allocation of funds to VDDI teams to be reviewed by the Department in order to redress any inequities.

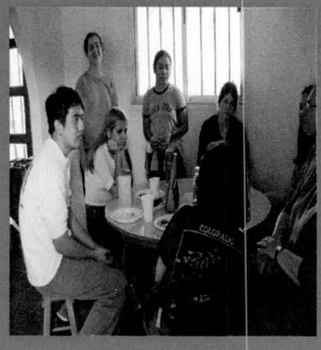
And in relation to Psychiatric Support, it is proposed that:

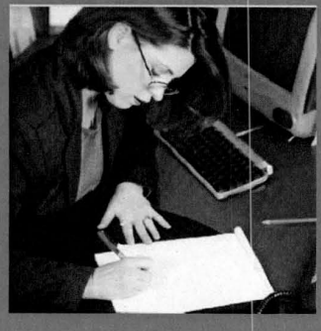
6. Completion of the Reform Process

R.3.3.6 The dedicated psychiatric support be pooled and made equally available to all regions via video and teleconference as well as face to face sessions where the travel time is not extensive.

R.3.3.7 The Department of Health consider developing a role through the VSSP that sees the psychiatrists working in conjunction with the Chief Psychiatrist's Office, Clinical Directors of Mental Health and the Royal Australian and New Zealand College of Psychiatry to build dual diagnosis capacity and focus.

R.3.3.8 The Department of Health consider continued support for the Psychiatrists' active involvement with the RACP's Addiction Medicine Chapter





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Evaluation of the Victorian Dual Diagnosis Initiative

Appendices

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Appendix A

Appendix A: Methodology

A. METHODOLOGY

A.1 Framework for the evaluation

The construction of a logic model was used to map the current implementation of the initiative. This provided greater clarity about the interplay between the strategies being implemented and the idealised impact that the Department of Health hoped to achieve. It also led to some hypotheses about the sequencing that was required in order for change to occur.

There were a number of questions that the Department of Health hoped to answer through the evaluation including:

- Alignment between the actual implementation of dual diagnosis strategies and those specified in the VDDI Key Directions and Priorities for service development document
- Workforce development that has occurred through VDDI
- Assistance provided to MH, AOD and PDRSS through VDDI to facilitate the development of common, integrated assessment, treatment planning and evidence-based interventions appropriate to the needs of people with dual diagnosis issues
- Corresponding changes that have occurred at the combined MH and AOD system level regarding the implementation of the above within services/agencies at the sector level
- Sustainability of change
- Collection of appropriate dual diagnosis data and utilisation of this data for review purposes
- Performance against the indicators set out in the Dual Diagnosis Action Plan 2007-2010
- Challenges in relation to implementation and achievement of desired outcomes
- Review of the VDDI goals, objectives and strategies in light of:
  - the findings in relation to the above
  - the findings from other reviews that are occurring
  - the emerging policy environment.

A.2 Project plan

AHA undertook the following phases in order to complete this evaluation.

- Phase 1: Project Initiation
- Phase 2: Stakeholder Consultations
- Phase 3: Analysis and interpretation
- Phase 4: Reporting

Appendix A: Methodology

A.2.1 Phase 1: Project Initiation

This phase saw the finalisation of the methodology and project plan based on some initial consultations with the Department and the VDDI Leaders' and Rural Forums and a review of the available data collected across the three sectors.

The data investigation indicated that there was limited application of this information for the evaluation. This was due to:

- Lack of relevant Dual Diagnosis data from the Alcohol and Drugs Information System (ADIS)
- Lack of consistency with which information is collected across mental health teams
- Diversity of data collection tools used by the PDRSS sector

In recognition that the data collected by each sector as part of normal business, would not fulfil the requirements of the evaluation, the VDDI teams were asked to assist with gathering data about each of the AOD services and PDRSS as well as each clinical mental health team within their catchment area. This was in effect a census of services and their progress with regard to dual diagnosis.

A literature scan (see Appendix 1) and a review of relevant policies were also undertaken.

A.2.2 Phase 2: Stakeholder Consultations

The stakeholder consultations formed a significant component of the work undertaken, with the following stakeholder groups consulted:

- Senior managers in VDDI auspice organisations, VDDI team leaders and their staff
- Rural VDDI clinicians
- Directors of Mental Health
- Senior managers of mental health, AOD services and PDRSS/teams throughout Victoria (sample only)
- Mental health, AOD and PDRSS senior clinicians and staff from services/teams (sample only)
- Department of Health program administrative staff and senior AOD and mental health management
- Department of Health regional mental health officers and AOD PASAs
- Evaluation Reference Group.

A mix of methods was used to engage and consult with the different stakeholder groups including interviews, surveys and focus groups.

The consultation methods are outlined in *Table A-1* below.

Appendix A: Methodology

Table A-1: Methods of consultation

Stakeholder Group	Telephone Interview	Individual interviews	Focus groups	Group interviews
Senior managers in organisations delivering all of the components of the VDDI, and their staff		✓		✓
Rural clinicians		✓		✓
DH program administrative staff and senior AOD and mental health bureaucrats		✓		✓
DH regional mental health officers and AOD PASAs				✓
DoHA re Services Improvement Initiative and the National Comorbidity Initiative		✓		
Directors of Mental Health			✓	
Senior managers of mental health, AOD and PDRS services/teams throughout Victoria (sample only)	✓			
Mental health, AOD and PDRS services senior clinicians, staff (sample only)		✓	✓	

The consultations with VDDI organisations provided an in-depth understanding of the scope and scale of work undertaken by the teams and each of the sub program areas. It identified successes and challenges and the most effective strategies for bringing about system change as well as opportunities for future enhancement.

Consultations with senior Department of Health staff explored the support for integration of dual diagnosis work across the three program streams, the governance arrangements for ensuring delivery against the Service Development Outcomes and the governance of the initiative more generally. It also looked at the issue of data collection and the proposed strategies for addressing this in the future. Regional staff were also consulted through their regular forums and asked for their perspective on the progress of VDDI within their region. Similarly Directors of Mental Health were asked about the perceived barriers and enablers to the progress of VDDI.

The Commonwealth Department of Health and Ageing (DoHA) and the Victorian Alcohol and Drug Association (VAADA) provided detail on the Commonwealth funded Improved Services Initiative that had been funded as part of the National Comorbidity Initiative. This funding went to 27 AOD organisations in Victoria to assist them with building their capacity to respond to people with comorbid substance use and mental illness.

A sample of 38 AOD, PDRSS and clinical mental health managers were consulted by telephone. The purpose of the interview was to understand the extent of each organisation's involvement with dual diagnosis issues and the VDDI, including number of staff trained, and the strategies implemented in response to a greater focus on working collaboratively with dual diagnosis clients. This extended to asking them about the development of policies, procedures, protocols and other mechanisms and how effective these have been. The interviews also provided some insight into the proportion of the workforce that has received recognised dual diagnosis training whether from VDDI or as part of post or

Appendix A: Methodology

undergraduate study. Additionally some assessment of the initiative and ideas for improvement were sought from the services.

The sample was selected to reflect the following characteristics:

- rural / metropolitan representation
- proportion of different types of organisations
- diversity in staffing levels
- range of levels of participation in VDDI

A further 10 sites were chosen for site visits at which time interviews and focus groups were conducted with team leaders, senior clinicians and team members. These consultations focused particularly on the extent of support provided through the initiative, input gained from other sources such as ISI, as well as the challenges more generally associated with responding to dual diagnosis issues in that context.

An additional forum on governance of the initiative was conducted by the Department of Health which involved VDDI teams, auspice representatives along with both regional and central Department of Health staff. This forum was an opportunity to canvass issues in relation to the governance of the VDDI initiative and how this in turn has affected the reform agenda across the state.

An evaluation reference group made up of members representing metropolitan and regional VDDI workers, ETU, mental health and AOD services, consumers, carers, Commonwealth Department of Health and Ageing, Victorian Department of Health, peak bodies and other key stakeholders was convened by the Department. This provided a useful opportunity to explore findings as they emerged and to seek ideas for strengthening the work of the dual diagnosis reform process.

A.2.3 Phase 3: Analysis and interpretation

Data collected from the extensive consultation process was analysed and cross-referenced against the VDDI leaders' survey. Theme saturation was attained quite quickly. These were further refined through subsequent consultations with the Department of Health Evaluation Steering Committee, governance forum and the Evaluation Reference Group.

Themes that emerged from the analysis of the consultations were contrasted with those from the literature and policy review where appropriate. These findings reflect on the acceptability of the initiative for services and the impact at a systemic and practice level regarding dual diagnosis work across the three sectors.

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Appendix B

Appendix B: Telephone Interview and Survey Comparison

B. TELEPHONE INTERVIEW AND SURVEY COMPARISON

B.1 Methodology

The methodology entailed using two methods to collect responses to a common set of questions about the same organisations and then compared the responses.

B.1.1 Areas of inquiry

The first method was comprised of a survey that was sent to the VDDI Team Leaders and which they were asked to complete on the organisations/teams in their catchment areas. There are 361 orgnisations/teams distributed across all catchment areas. The survey was comprised of 12 questions, each with a drop down list of response options as shown below in *Table B-1* below.

The second method involved phoning thirty eight of the organisations/teams and asking them the same set of questions.

Table B-1: Survey and interview questions with response options

Approx. no. of workers?	No. of staff that have received DD specific E&T?	No. of Staff have done Reciprocal Rotations?	No. of Portfolio holder(s)?	Is the organisation a DD working party member?	Organisation has conducted DD audits?
2	*No staff*	*0*	*0*	*Active*	*File*
3	*Some staff*	*1*	*1*	*Irregular*	*Organisational DD Capability*
4	*Most staff*	*2*	*2*	*Not a member*	*Both*
5	*Unknown*	*3*	*More than 2*	*Unknown*	*None*
5 to 10		*More than 3*	*Unknown*		*Unknown*
10 to 15		*Unknown*			
15 to 20					
20+					
Unknown					
Organisation has DD policies and procedures?	How extensive is DD Screening?	How extensive is DD Assessment?	Organisation has formal collaborative arrangements, including no wrong door?	How extensive is the use of Integrated Treatment Plans?	Organisation has specific DD review mechanisms and opportunities to support E&T for clients & carers?
All necessary DD P&P	*Most clients*	*Most clients*	*Yes*	*Most clients*	*Yes*
DD P&P in development	*Some clients*	*Some clients*	*No*	*Some clients*	*No*
Not commenced	*Very few clients*	*Very few clients*	*In train*	*No clients*	*In train*
Unknown	*No clients*	*No clients*	*Unknown*	*Unknown*	*Unknown*
	Unknown	*Unknown*			

B.1.2 Comparison of results

In order to determine whether or not the two sets of results were similar the following steps were taken:

1. The number of responses for each drop down option was recorded for each question by sector for each of the survey and telephone interviews

Appendix B: Telephone Interview and Survey Comparison

2. The results for the telephone interview were subtracted from the survey totals to produce a table of variations
3. The variations were plotted as a column graph against response type

B.1.3 Findings

The major areas of interest for the evaluation are the extent of:

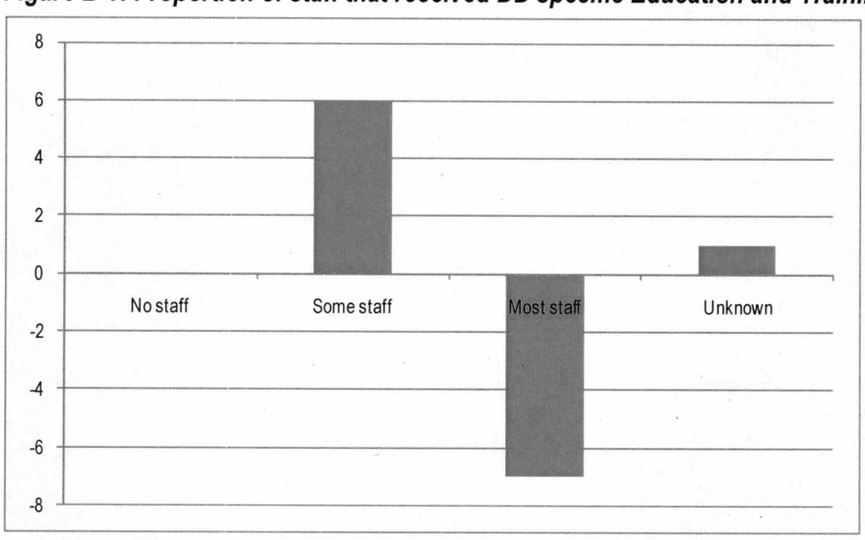
- Staff training
- Dual diagnosis specific screening of clients
- Dual diagnosis specific assessment of clients
- Development of integrated treatment plans for clients
- Development of dual diagnosis specific policies and procedures
- Involvement of consumers and carers in review mechanisms

As the graphs shown below indicate, the VDDI Team Leaders have tended to report a lower outcome overall against most of these indicators of dual diagnosis activity. Hence it is the VDDI team leaders' results that are mostly quoted throughout the evaluation report, because they have a greater understanding of dual diagnosis and their position is the more conservative view. Reference is still made to the perceptions of the people interviewed in the discussion of the results.

Staff training

As is apparent from Figure 1.1, the VDDI team leaders have underestimated the number of organisations where most staff have received dual diagnosis training. There are two possible reasons, one is the training that has been undertaken by a number of AOD organisations through ISI has been significant, but would not necessarily have involved the VDDI teams in delivery. The other is that the survey data was collected early in the evaluation and the telephone interview conducted some months later during which time PDRSS training was occurring.

Figure B-1: Proportion of staff that received DD specific Education and Training - variation

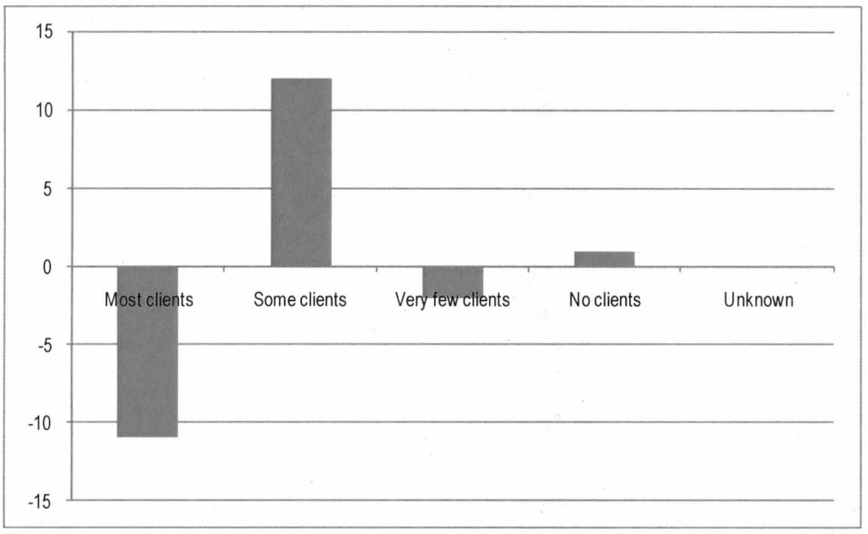


Appendix B: Telephone Interview and Survey Comparison

Dual diagnosis specific screening of clients

Again the perception of the VDDI team leaders regarding the extent, to which most clients are screened, is lower than reported by the organisations themselves. PDRSS training may have contributed to some of this variation.

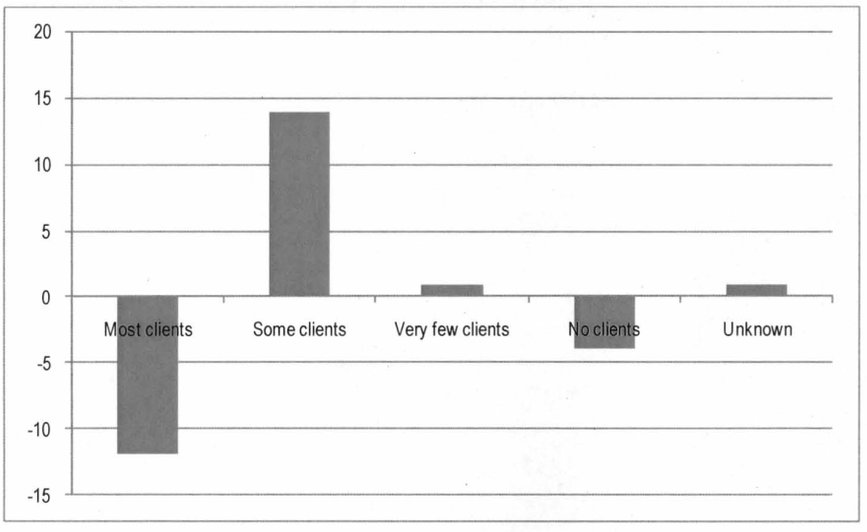
Figure B-2: Extent of DD screening - variation



Dual diagnosis specific assessment of clients

Assessment also sees the underestimation of the extent to which most clients are assessed for dual diagnosis. A number of PDRSS did not distinguish between screening and assessment and so reported as undertaking both.

Figure B-3: Extent of DD assessment - variation

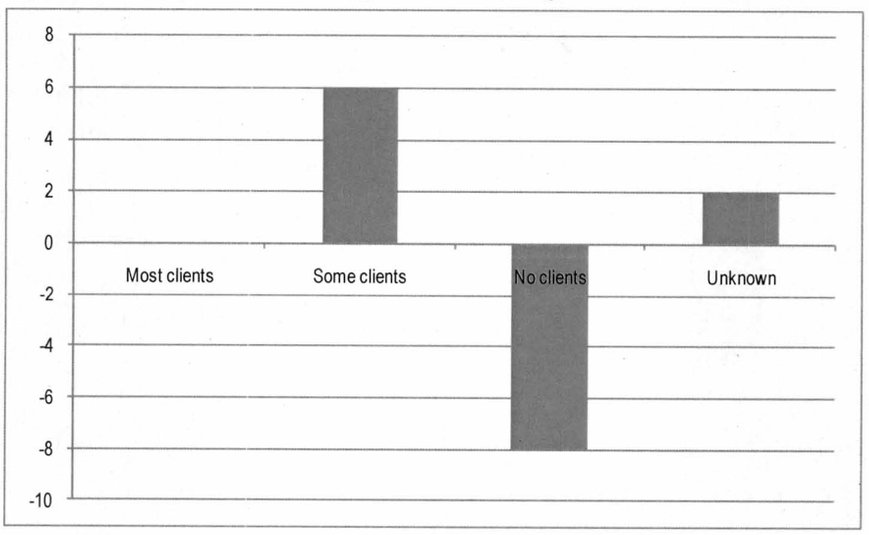


Appendix B: Telephone Interview and Survey Comparison

Development of integrated treatment plans for clients

The perception of VDDI leaders that plans are not extensively used accords with those of organisations as there is no variation between the two sets of results. On a sector by sector basis, they had underestimated on two AOD services' use of plans for most clients and overestimated their use by two mental health teams.

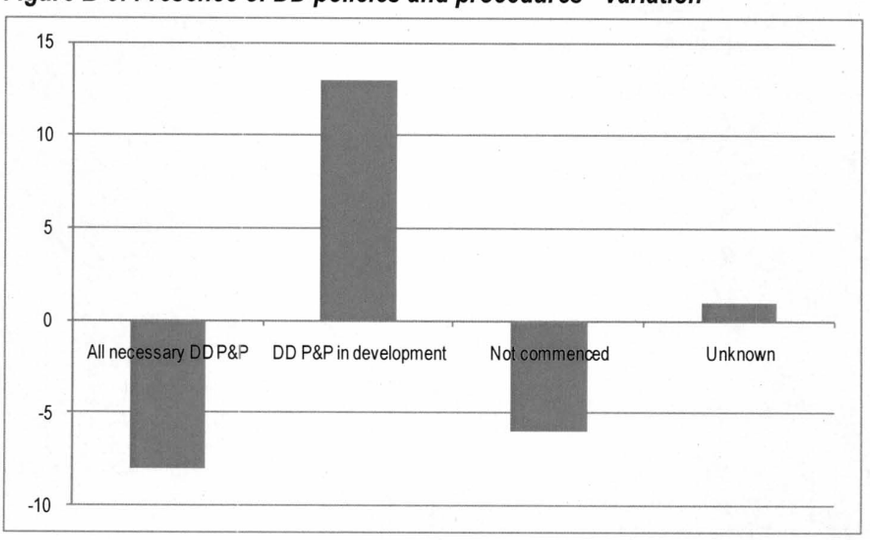
Figure B-4: Extent of use of integrated treatment plans - variation



Development of dual diagnosis specific policies and procedures

There is some variance between the two perspectives, though not as much in relation to the number of organisations/teams that haven't commenced. Overall VDDI leaders have overestimated those in development and underestimated those that have either completed the process or are yet to embark.

Figure B-5: Presence of DD policies and procedures - variation

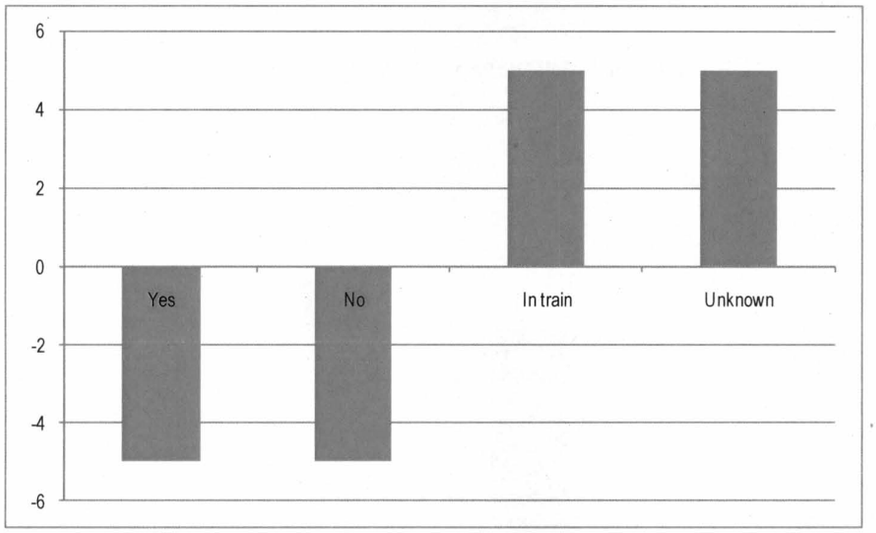


Appendix B: Telephone Interview and Survey Comparison

Involvement of consumers and carers in review mechanisms

The VDDI team leaders underestimated both those that have established these mechanisms those that are yet to do so.

Figure B-6: Specific DD review mechanisms involving carers and consumers



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Healthcare
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Appendix C

Appendix C: Dual Diagnosis Literature Scan

C. DUAL DIAGNOSIS LITERATURE SCAN

C.1 Introduction

Dual diagnosis (DD) disorder clients are very common in both mental health (MH) and alcohol & other drug (AOD) services. Dual diagnoses are made in at least one third of MH service users, in about one half of AOD service users and in up to two thirds of some prison populations. Complex interdependencies occur between clients' MH and AOD disorders, although the causal linkage(s) between these disorders remains incompletely understood [37].

An accurate appraisal of the needs of individual clients requires a comprehensive assessment that goes beyond their MH & AOD issues. People with dual diagnosis disorders are more likely to be marginalised, homeless, have a history of trauma or abuse, and be involved with the criminal justice & welfare systems. These factors all potentially impact on their ability to recover successfully from their MH & AOD disorders, underlining the need for very good collaboration between very many stakeholders when assessing & managing DD disorder clients [1, 17].

The MH and AOD services caring for clients with MH and AOD issues have evolved as separate systems of care. This presents significant challenges when it comes to providing accessible, appropriate and effective comprehensive services that meet the varying needs of very large numbers of DD disorder clients. Many people with DD disorders currently receive no treatment whatsoever for either disorder. When they do receive care, DD disorder clients have significantly worse outcomes for both their MH and AOD issues than clients receiving care for an isolated mental health and substance use issue.

DD disorders have increasingly attracted high-level interest and concern. Over the past decade various levels of governments and a number of professional bodies in Australia and elsewhere have set out to change health and welfare systems in an attempt to enhance the care of DD clients. These programs have typically used creative leadership to engage the support of key local stakeholders - including consumers and families - in advocating program redesign. While there are encouraging examples of the delivery of better, innovative, effective services, much remains to be done in the policy, program design and practice improvement implementation arenas to succeed in routinely achieving better outcomes for DD disorder clients.

The extensive DD disorder literature reviewed[1-104] lacks a cohesive or comprehensive framework with which to address the majority of the key issues for those with DD disorders [prevention, awareness, screening, assessment, treatment, and ongoing support]. Methodological challenges have resulted in little rigorous or generalisable research evidence being generated as yet on which to confidently make genuinely evidence-based decisions regarding the care of clients with DD disorder. These methodological challenges with DD disorder research include:-

- A lack of consensus on the definition of a DD disorder;
- Criteria for diagnosis of mental illness and substance misuse differ.
- Settings where studies take place differ
- Definitions or descriptions of interventions delivered are inconsistent and interventions variable (e.g. pharmacological studies, psychological and/or social interventions).
- Very many different combinations of dual diagnosis populations and interventions are possible.

Appendix C: Dual Diagnosis Literature Scan

- Substance-misuse clients and those with severe and enduring mental illness are often excluded from research studies.
- A lack of valid comparisons of outcomes of different treatment models and a resultant lack of evidence about what constitutes good practice in the provision of services to people with DD disorders.

There has been considerable debate in the literature regarding the extent to which currently available evidence proves that newer models of comprehensive care delivery (such as *integrated dual diagnosis treatment / IDDT*) constitute *evidence-based best practice* for the care of clients with DD disorders.

Models of care such as IDDT are clearly *efficacious* (i.e. deliver desired outcomes) when offered by appropriately skilled & experienced teams to populations with severe MH and AOD issues. However it is unclear if they provide superior outcomes to alternative approaches. IDDT has been shown to be extremely difficult to disseminate to new service provider teams.. In most systems of care such resource intensive, complex models of care are largely restricted to use in the most challenging client populations (those with severe MH and AOD issues). Other more relevant models care are applied for the majority of DD disorder clients who have less severe disorders.

The last decade has seen initiatives to significantly enhance the capacity of the MH, AOD and broader health workforces to care for DD disorder clients. There is also a growing availability of detailed guidance on how to go about redesigning systems of care and implementing better, *fit-for-purpose* local & regional programs of care. Such developments offer the greatest current potential for the achievement of practical, sustained improvements to services for large numbers of DD disorders clients at a reasonable cost.

C.2 Context

C.2.1 Definition

There is no international consensus on the definition for 'dual diagnosis disorders' (also commonly referred to as 'co-morbidity of mental disorders and substance use' or 'co-occurring/concurrent alcohol and other drug and mental health conditions')[1, 8, 16, 18,21, 23, 30, 31, 48, 65].

This use of varied definitions restrict the exchange of knowledge regarding DD disorders, hinder the standardisation of research methodologies, limit comparisons of experiences with particular clinical cohorts and hinder the interpretation of treatment outcomes[21, 30, 31].

Definitions of dual diagnosis disorder used by particular provider groups will need to be locally agreed and consistently applied[4, 17, 26, 31, 98].

All existing operational definitions inevitably result in the term 'dual diagnosis' capturing an enormously broad spectrum in the scope, pattern and severity of mental health and substance misuse problems under the DD disorder label.

C.2.2 Prevalence

Many individuals in western societies have both psychiatric and substance disorders[1, 8, 23, 30, 31, 72, 104]. Dual diagnosis disorders have been found in between one third and one half of clients of MH and AOD services and in up to two thirds of some prison populations in Australia[31-34]. They are a very common population, not only in addiction and mental health service systems, but also in the juvenile & criminal justice systems, welfare systems and amongst homeless persons.

Appendix C: Dual Diagnosis Literature Scan

C.2.3 Aetiology

A variety of biological, psychological and/or social theoretical frameworks have been proposed to explain the remarkably high concurrence of mental health and substance use disorders. At this point in time none of the proposed theoretical models of causation adds material value to the everyday care of DD disorder clients[8, 18, 23, 26, 73, 86, 104].

Too fervent an adherence to a particular theory of causation may occasionally get in the way of good care delivery (e.g. Practitioners may become preoccupied with establishing whether a person's substance misuse is primary or secondary to their mental health problem, or vice versa, instead of focusing on their client's needs; or access to mental health services may be restricted if mental health teams actively exclude people whose primary problem is said to be drug or alcohol misuse) [99].

Outcomes of care are worse when people have both substance misuse and mental health issues, than when they are challenged by only one of these issues[3, 6, 16, 17, 21, 24, 30, 38, 40, 60, 71].

Within drug and alcohol services they have poorer prognosis, higher relapse rates and greater problems of exclusion and marginalisation [6, 16, 17, 21, 24, 30, 38, 40, 60, 71]. These poorer outcomes include:

- increased rates of suicide
- higher levels of mental health symptoms
- increased relapses, number of hospitalisations and time spent in hospital
- poorer general health, including increased rates of hepatitis C and HIV
- Increased risk of violence and offending & high rates incarceration by justice systems
- unstable housing and homelessness
- loss of family supports
- financial problems
- impaired general health status
- high frequency of poor engagement with treatment
- Non-compliance with medication
- Increased costs and usage of services

C.2.4 Barriers to accessing appropriate care

Individuals with DD disorders have too often been cast as misfits in systems of care primarily designed to treat one disorder only, or at best- one disorder at a time[1, 11, 13, 17, 20, 21, 30, 31]. Care often involves parallel but separate mental health and substance abuse treatment systems and is frequently seen to be fragmented and ineffective [5, 11, 17, 22, 31, 32, 41, 47, 71,78, 91, 99, 104].

Instead of being prioritized for special attention, care of individuals with two challenging problems has frequently been made more difficult by the inherent features of the very systems of care on which they depend, with DD disorder clients at high risk of falling through the gaps in these systems[17, 32, 34, 91].

Community surveys suggest that many persons with DD disorders currently receive no treatment whatsoever for either condition. A survey by UCLA and RAND® found that 72 percent of people with co-occurring disorders did not receive any mental health or substance abuse treatment over the previous year[17, 103]. Fewer than 25 percent of individuals with co-occurring disorders received appropriate mental health services, and only 9 percent received supplemental substance abuse services[103].

Many health care organizations still fail to approach concurrent psychiatric disorders and addiction as disorders requiring concurrent treatment[21, 31, 32, and 91]. Some estimates suggest that fewer than half of clients with recognised DD disorders do not receive concurrent treatment for both disorders[103]. Where concurrent treatment is offered, those services are often not offered in an integrated manner, with health

Appendix C: Dual Diagnosis Literature Scan

systems requiring that DD clients navigate the separate mental health and AOD care systems and make sense of sometimes disparate messages about treatment and recovery[21, 31, 91]. They may even sometimes find themselves excluded (or extruded) from services in one system because of their co morbid disorder, being told to not to return for acre until 'the other problem is under control'.

As usual care has too often seen DD disorder clients fall through the cracks in contemporary healthcare systems, for over 20 years many clinicians, administrators, policy makers, researchers, family organizations and clients themselves have been calling for better cohesion of mental health and substance abuse services.

The growing recognition of the importance of 'dual diagnosis' disorders among health policy specialists and those who fund service delivery has resulted in the generation of a myriad of guidance documents from government agencies, advocacy groups, professional societies and expert groups[1, 3,4,14,17,18,23,28,30-35,41-43,59,60,65-67,69-74,76,77,80,87,93-96,99,102]. These typically evince a high degree of consensus on what needs to be done (i.e. Current service delivery systems must be improved, with someone taking responsibility for ensuring that every DD disorder client receives a package of care that best meets their needs).

Whilst there has been progress in improving care for clients with DD disorders over the past decade, it has been slow progress, with access to improved care services somewhat limited and approaches to care delivery patchy[17, 21,27,31,32,37,47,56,59,66,74,79,80,84,91]. As indicated above, within both MH and AOD services, client outcomes are still recognised to be significantly worse when people present with both substance misuse and mental health issues, including higher relapse rates and greater problems of exclusion and marginalisation.

A recent Australian survey of mental health service providers found that perceived barriers to better treatment of DD disorder clients included:- low client motivation to reduce substance use; poor carer communication; poor coordination between treatment services and a lack of appropriate specific services for dual diagnosis clients[21].

Almost all survey respondents identified a need a need for further professional training for themselves in the area of dual diagnosis. The authors of this study drew the following sobering conclusion[21]:-

> *"Dual diagnosis is common and the reality is that this vulnerable clientele will continue to challenge service providers and treatment approaches into the foreseeable future.*
>
> *Issues include the organization and delivery of treatment services, education and training, resource allocation, collaboration between treatment agencies and clinically relevant research evaluating the effectiveness of practice.*
>
> *It is thus surprising that with so much investment in this area the majority of stakeholders are still dissatisfied with access to and the level of care for dual diagnosis clients".*

C.2.5 Treatment approaches:

Clients with DD disorders are typically offered a therapy program that draws upon some mix of psychological, social and/or biological treatment paradigms[1, 3, 8, 15-19, 31,34,66,72,74,84,91].

Psychosocial interventions

Many recent reviews have addressed the development of psychosocial interventions for people with dual diagnosis [9,16,17,21,26,31,37-39,48,65,66,85,96,99]. These are many and varied and include:

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- Motivational Interviewing (MI) for Co-existing Disorders
- Subjective Well-being and Positive Psychology
- Mindfulness, and Acceptance and Commitment Therapy
- Temperament, Character and Personality Traits
- Multisystem therapy
- Interactional group therapy
- Family based therapy
- Individual cognitive behavioural therapy
- Ecologically based family therapy
- Seeking safety therapy Motivational interviewing.
- Relapse prevention techniques.
- Contingency management

Pharmacological interventions

Pharmacological management of both the psychiatric and the substance use disorder is an important foundation of the treatment of clients with co-occurring severe mental illness and substance use disorder, [4,23,30,31,35,51,53,64-66,69,72,84,91,104].

Thus far research indicates two important principles. First, medications shown to be effective for the treatment of alcohol disorders in the general population are probably equally effective in clients with serious mental illness. Second, some medications that treat the mental illness may lead to reduction in the severity of the substance use disorder.

C.2.6 Significant recent initiatives:

In addition to the program of work undertaken within the Victorian Dual Diagnosis Initiative[34] there have been several other significant recent activities in Australasia and elsewhere regarding DD disorders:

- The Australian Government have funded a major initiative (2003-2009) to improve the care of persons with DD disorders[70]. This 'National Comorbidity Initiative' offered a range of interventions to improve service co-ordination and treatment outcomes for people with coexisting mental health and substance use disorders.
  The initiative focused on the following priority areas[70]:
  - Raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models;
  - Providing support to general practitioners and other health workers to improve treatment outcomes for comorbid clients;
  - Facilitating resources and information for consumers; and
  - Improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively.

- *Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician*[23]. As part of its National Drug strategy the Australian government have recently released this comprehensive guide to the assessment and care of DD disorder clients in the primary care setting. It incorporates an extensive bibliography.

- *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*[65]. The National Drug and Alcohol research centre has recently released comprehensive guidance on the management of DD disorders. This resource has a comprehensive summary of current state-of-the-art approaches to care and includes an extensive bibliography.

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- The Australian Institute for Primary Care released the Final *Report on their evaluation of comorbidity treatment models in 2009*[24]. This report offers a detailed insight on contemporary knowledge and attitudes towards models of care for DD disorder clients based upon a literature review and service provider inputs.

- Also in 2009 Beyond Blue published a research report "*Looking beyond dual diagnosis: Young people speak out*" that provides valuable insights from clients with DD disorders on current systems of care in Australia[91].

- The New Zealand Health Ministry has recently issued policy guidance on the assessment and management of DD clients[66, 99]. They note that despite many years of discussion and many strategic statements urging mental health and addiction services to respond equally to mental health and addiction issues in a co-ordinated and complementary manner, surveys of the respective services have shown a variety of approaches to these issues with poor communication and coordination between the two services, with the result that clients continue to fall between the gaps.

- *Integrated* service provision is supported, based on the reality that DD disorder clients are core business for both mental health and addiction services. In general, better outcomes are felt likely to be achieved when care is well co-ordinated and complementary, where access barriers are minimised, and when agencies, services and staff understand each others' roles and work together closely. These NZ reports include an extensive bibliography and a comprehensive list of contemporary resources for those engaged in DD health service planning and delivery.

- Concerned with this gap between research and practice The Centre for Substance Abuse Treatment in the USA has instituted two major programs to bridge the gap[94-96]. The Addiction Technology Transfer Centres are charged with the dissemination of evidence based practices to the field in forms that are tailored to different disciplines or settings. The Practice Improvement Collaborative network was developed to address the adoption of evidence-based practices in the field: They have identified key lessons regarding the transfer of best practice care into everyday, usual care.

- The NHS have released 'Developing a Capable Dual Diagnosis Strategy: A Good Practice Guide' that provides a valuable tool designed to assist local healthcare providers in implementing effective care for their local DD disorder clients[33]. This builds on previous guidance documents[30] that have sought to offer implementation guidance for Community-Based Substance Abuse Treatment Agencies.

- Last year the UK Department of Health released a guide for the management of dual diagnosis for prisons[1]. This document provided good practice guidance to commissioners and practitioners on for the management of dual diagnosis within a prison setting. As such it is a good example of the frequent need to tailor the approach to DD disorder clients for the very specific context within which they are to receive their care.

C.3 Assessment

Given the prevalence of DD disorders, it can quite easily be argued that assessment for the presence of dual diagnosis should be a feature of any systematic assessment of people entering either addiction or mental health services so that appropriate treatment can be recommended[1,4,12,18,24,28,30,33,34,35,38,51,52,56,57,66,70,72,7475,83,84,93,99,104].

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Such assessments serve multiple purposes, including screening, diagnosis, the planning of treatment and outcome evaluation. They need to look beyond the relatively narrow perspectives of both the MH and AOD issues and provide a comprehensive picture of the circumstances of the individual DD disorder client.

Services delivering shared care need clear policies on joint assessments[4, 17, and 28,30,35,51,72,84,97]. They should also ensure that all necessary agencies or services involved in providing care and treatment participate in these joint assessments and are fully aware of their outcomes[35, 51,72,84,97].

In addition to direct client inputs to MH and AOD professionals, a comprehensive assessment may need to source information from client carers; other public and private healthcare providers; independent third sector service providers; social services; prisons, the courts and probation services; housing authorities; police; employment services and educational institutions[1,4,18,24,28,30,70,72,74,75,83,84,93,99,104].

Assessments need to consider a range of health and social factors. Integrated assessments go beyond separate mental health and substance use assessments. Thorough, multi-disciplinary assessment is the first step towards providing an effective package of medical and social care[1,3, 4,34, 38,51,56,57,66,70,72,74,75,83,84,93,99,104].

It is considered that important areas for a comprehensive assessment include:

- Identification and response to any emergency or acute problem
- Assessment of patterns of current, recent and past substance misuse and degree of dependence/withdrawal problems
- Assessment of physical (including sexual health), social and mental health problems
- Consideration of the relationship between substance misuse and mental health problems
- Consideration of any likely interaction between medication and other substances
- Assessment of carer involvement and need
- Assessment of knowledge of harm minimisation in relation to substance misuse
- Assessment of treatment history
- Determination of individual's perception of their situation, their reasons for using, expectations of treatment and their degree of motivation for change
- Social circumstances (including accommodation and family situation – especially children, employment or finances)
- Legal situation
- Personal and family history
- The chronology of presenting problems

Assessment should seek to ascertain how an individual's life is directly or indirectly influenced by mental illness and substance use. It must include the clients' perspective on how they would like to benefit from intervention and what areas they would like to prioritise for action[11,18,24,29-33,51,53,59,65,72,74,79].

All available evidence supports the implementation of systematic screening procedures to identify concurrent mental health and substance use problems and treatment needs in all settings in which children, youth, adults, or older adults are known to be at high risk for mental illnesses and in settings in which a high occurrence of concurrent mental illness and substance use disorders exists[1, 4, 31].

This would see systematic screening in specialty mental health and substance abuse treatment settings[56,57,66,70,72,74,75,83,84,93,99,104]. It would also see systematic screening for DD disorders when an individual enters the juvenile or criminal justice systems, child welfare systems, homeless shelters,

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women's refuges, many hospitals, aged care facilities and other settings where populations are at high risk[1,4,18,24,28,30,33,34,35,38,51]. Screening would also be repeated periodically after an individual enters any of these facilities[28, 30, 33, 34,35,38,51].

Clinicians should be alert to the possibility of a dual diagnosis, particularly when problems such as violence, treatment non-compliance and failure to respond to standard treatments are apparent.

Assessing for dual diagnosis is fraught with difficulties[18,24,28,30,33,34,35,38,51,93,99,104]. At times accurate assessment of DD disorder clients can be difficult because of the psycho-mimetic effects of substance misuse. The lack of agreed common definitions and use of non-standardised assessment tools, or tools that have been validated for distinct clinical groups, rather than for people with dual diagnosis also hamper assessment efforts.

Substance misuse currently often goes unnoticed or unrecorded in psychiatric inpatient assessments[56,57,66,70,72,74,75,83,84,93,99,104]. It is agreed that there is need for a brief, standardised substance use screening questionnaires, which could be usefully incorporated into the existing psychiatric interview format, thus increasing awareness and improving history taking[1,8,24,28,30-35,51,56].

Because of the complexities associated with people who have a dual diagnosis, existing diagnostic measurement tools are not necessarily applicable[1,8,24,28,30-35,51,56]. Many assessment instruments that have been developed to determine drug use in an individual and also to assess their mental state were developed as research tools and subsequently applied in particular clinical cohorts. These assessment tools cannot automatically be applied to dual diagnosis clients[1, 8, 24, 28, 30-35, 56]. The sensitivity of most of these tools to the complexity of dual diagnosis, and indeed their validity in this different clinical population, cannot be taken for granted.

A small number of brief self-report screening tools for substance misuse are now available to the clinician to specifically assess clients with dual diagnosis disorders[1, 8, 24, 28, 30-35, 51, 56]. These tools are usually used in combinations. Although their reliability and validity are still being established, and their predictive value may be questioned, they are nonetheless in common use.

C.4 Models of Care

The literature usually describes 4 principal models of care for clients with DD disorders[18,24,30,31,33,34,51,53,66,70,77,99]:

- Single model of care: The "primary" disease and treatment approach
- Sequential model of care: Treating one disorder at a time
- Parallel model of care: Concurrent treatment of both disorders (i.e., both disorders are treated at the same time but by different treatment teams in different places)
- Integrated model of care: Treating both disorders (i.e., both disorders are treated at the same time and at the same place, often by the same provider)

Other categorisations of models of care have been used. These include:
By the extent to which care is seamless from the point of view of the client[33, 60,

- Consultative
- Collaborative
- Coordinated
- Integrated

By the severity of the co-occurring disorders and/or the predominant location of provision of care[30, 51, 60,

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- 1-4 Levels (or tiers) of care

By the population treated

- Prisoners
- Homeless
- Youth
- Older adults
- Culturally or ethnically specific

By the nature of the care teams[30-34, 58,66, 99]

- DD enhanced services (both disorders treated by one team)
- DD capable services (separate treating teams with strong linkages)

C.4.1 Single model of care

In this model of care an assumption is made that if one disorder is addressed (e.g.an underlying mental health disorder, such as depression or anxiety) the patient would no longer suffer from the co-morbid disorder (e.g. the need to use alcohol or other drugs to cope). Treatment thus focuses on the so-called *underlying* disorder, with the belief that the co-morbid disorder would improve once the underlying disorder was resolved. Although some patients benefit from the *primary disease and treatment* approach, this approach frequently proves ineffective for both the substance use disorder and mental health problem[18,24,30,31,33,34,51,53,66,70,77,99].

C.4.2 Sequential model of care

The sequential treatment model seeks to deal with one condition at a time. For example, an addiction treatment professional may require a patient who is addicted to cocaine to be "stable psychiatrically" before addiction treatment can begin. Alternatively, in a mental health setting, a patient may be required to be *"detoxed"* in order to be included in group therapy or to be seen by a clinician. Treatment is usually provided by different clinicians, in different treatment settings. One disorder is treated in isolation, followed by treatment for the second disorder[18, 24,51,53,66,70,77,99].

Sequential models of care may or may not conceptualize one of the disorders as primary. They acknowledge that services may be necessary for both eventually, but not that they need to be offered to the client at the same time. Sequential models of care essentially require that patients "hold off" on receiving services for one disorder while the other disorder is the current focus of treatment. In some cases, the sequential approach may be said to be clinically reasonable (e.g., through withdrawal periods) and may help in confirming diagnostic impressions.

C.4.3 Parallel model of care

In this approach, specialty addiction treatment programs and mental health services concurrently treat persons for their addiction and their psychiatric disorder. This is known as parallel care (or the concurrent model of care) [18,24,30,31,33,34,51,53,66,70,77,99].

Parallel models of care intend to provide care for both mental health and substances uses disorders at the same time, but care is typically offered in different settings and by different providers.
There is usually some level of communication, collaboration or coordination of care between providers. These relationships between providers determine if parallel care is categorised as consultative, collaborative or coordinated care.

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Parallel services often require the patient to navigate from provider to provider, or from program to program. If the communication between mental health and addiction providers is poor, care can be fragmented, duplicated or even at cross purposes.

Parallel models of care can also be well organized, with providers from different programs in different locations working in concert[30, 31, 33, 34]. Indeed services offered in the parallel level can approach *integration* (vide infra) if they are particularly well coordinated and the patient's experience can become relatively seamless[18,24,30,31,33,34,51,53,66,70,77,99].

Most services in Australia, the UK and NZ have a preference for parallel models of care, generally with robust liaison, formal structures, and protocols for care and formal communication channels and even towards integration in some cases. These systems more often apply treatment innovations and partnership arrangements to a parallel model when attempting to provide a more streamlined and effective service[24,30-34,48,51,55,65,66,69,72,88,91,99].

C.4.4 Integrated model of care

Integrated models of care have been variously described [2,18,24,30,31,33,34,51,53,66,70,77,99]. *Integration* has been said to take place at the individual clinician level, the program level, the agency level, or even at the system level.

An integrated clinician is one with developed expertise in both mental health and addictive disorders. Such professionals may have advanced certification in their discipline or mastery in specific treatment approaches.

Integration at the program level happens when members of a treatment team address both mental health and substance use disorders within a single treatment location, episode, record, and experience.

Integration at the agency level may share some, but not all, of the characteristics of programmatic integration, but more navigation by the patient and between clinicians is required. In this instance, an agency may provide both addiction and mental health services but in separate programs or departments. The patient may be asked to meet with two sets of providers, who may vary in clear lines of communication about the treatment plan or the patient's response to treatment.

Integration may also exist at the system level, such as within a geographical region, where clear guidelines and linkages are seamless and formalized. In this instance, separate agencies may have a well-developed protocol for simultaneously managing patient care. Agencies may share as many of the same patients and have worked out ways to develop a common treatment plan and to monitor patient progress.

Integration requires the active collaboration of both addiction and mental health services providers in the development of a single treatment plan to address both disorders. It also requires the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client.

Some regard the widespread reference to "integrated" treatment models as problematic, given that the word *integrated* is used by various parties to describe very different models of care[63].

Others describe *integrated* treatment as a unified treatment program, in which staffs are cross-trained, and share the same treatment chart and treatment plan. Some require co-location of mental health and substance abuse services or the provision of both types of service at the primary treatment site for

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integrated treatments. Others consider *integrated* treatment to be the integration of services at a broader system level through inter-organizational linkages and referrals.

The lack of a common definition or operational taxonomy that specifies the different types of integrated treatment makes it extremely difficult to rigorously evaluate the appropriateness of these treatment models and to compare alternative approaches [50,63, 67, 85, and 89].

It is commonly now argued that *integrated* clinical care and psychosocial support can be delivered by well-coordinated, collaborative arrangements across two or more service providers and not only in co-located programs. *Integration* is thus defined as an approach that combines elements of both mental health and substance use treatment into a unified and comprehensive treatment program for patients with dual disorders.

Most experts readily agree that models of care that support people with a dual diagnosis need to be client-centred[18,24,30,31,33,34,51,53,66,70,77,99]. This agreement in principle is relatively easy, however in practice it produces challenges at all levels - from strategic, to operational planning, to delivery at the front line.

From the range of service and treatment models that have emerged over the last few decades, some version of an *integrated* (i.e. more cohesive) model of care appears to be felt most likely to offer the most success in effectively treating people with dual diagnosis disorders.

In practice it is notoriously difficult to co-ordinate inputs across many disparate services with their own cultures and policy frameworks. While integrated dual diagnosis services and other practices are widely advocated (and even purported to be 'evidence-based best-practice') they are rarely offered in routine treatment settings[18, 24, and 30,31,53,66,70,77,99]. The barriers to true integration of care delivery are legion.

Historically there are a range of problems in joint working between mental health and substance misuse experts. A truly integrated model of care deliver may often also require the involvement of a raft of other professionals from a range of providers in public & private healthcare; other government agencies (including the justice system, financial and social services) and a host of organisations and service providers in the third sector[30,31,33,34,51,53,66,70,77,99].

Integrated models, such as Integrated Dual Diagnosis Treatment (IDDT), are currently the model of choice in the US (with the use of DD enhanced treatment teams), however not all healthcare systems are structured in such a way as to be conducive to use of this model. Many other health systems deem models of care such as IDDT as unnecessary, impractical or too costly for their particular geographical and organisational context, instead relying on strong and robust linkages between services and other carers.

These DD capable services use strong service linkages to integrate care delivery (e.g. through the employment of liaison workers who are either joint appointments or employed by one service but work across services or by setting up specific teams to work with dual diagnosed clients from both services, providing advice, clinical input, consultancy, training and liaison between services) [30, 34,48,51,55,65,66,69,72,88,91,99].

Linked services must also take account of the severity of dual diagnosis disorders. If disorder(s) are relatively minor, then it is likely that they can be managed in primary care with input from either mental health or addiction services, similar to a serial model with effective liaison. However, as the needs of individuals become more complex and one or other specialist service is required, a parallel model would

be preferred. Those clients with the most severe disorders may also benefit from access to high intensity integrated models of care[30-34,48,51,55,65,66,69,72,88,91,99].

It is widely recognised that the profile of dual diagnosis clients and the context within they receive care are specific to a particular social context[4, 16-18,24,26,30, 33,38, 41,55,66,99]. So, although there are models of care devised and researched elsewhere, the unique setting of planned use must always be taken into consideration when developing local, regional and national dual diagnosis service plans.

Given the diversity of circumstances that characterise DD disorders and their treatment it would also be unwise to rely on any single service delivery model, as there will undoubtedly be situations where any one model of care would be either inappropriate or inefficient.

International care guidelines acknowledge the limitations of all care models and the need for flexibility when applying any model of care [4,17,24,29-34,56,60,66-69,72,74,95]. The appropriate model will be dependent on the needs of the person with the dual diagnosis and the context of their care.

It is also generally acknowledged that in all care systems there will be a small core group of people who have such complex needs associated with dual diagnosis that provision of care by a specialised team, unit or service is appropriate[17,24,29-34,56,60,66-69,72,74,95]. The nature of this core group has not yet been universally agreed.

C.4.5 What constitutes 'best practice'?

A lengthy discussion has taken place over several decades about how to define and demonstrate 'best practice' in the care of DD disorders. There is acknowledged to be an enormous variation in the spectrum of clients with DD disorders and in the health system contexts within which care is provided and in the processes and content of individual care programs[17,24,29-34,56,60,62,66-69,72,74].

More than two decades ago a series of demonstration projects using comprehensive integrated care programs (e.g. that incorporated assertive outreach, motivational interventions to help clients who did not perceive or acknowledge their substance abuse or mental illness problems and long-term rehabilitation) began to suggest better client outcomes, including substantial rates of stable remission of substance abuse, in persons with serious mental illness and a co-occurring substance use [7,16,21-23,37-40,48].

Controlled research studies of comprehensive dual diagnosis models of care in this client group began to appear in the mid-1990s. Recent reviews[21, 39] have identified over 45 studies with experimental or quasi-experimental designs that support the effectiveness of integrated dual diagnosis treatments for clients with severe mental illness and substance use disorders.

The type and array of dual diagnosis interventions in these programs vary. They have been reported to demonstrate a variety of positive outcomes in domains such as substance abuse, psychiatric symptoms, housing, hospitalization, arrests, functional status, and quality of life.

Despite methodological weaknesses in the majority of these studies, the following conclusions were made by the review authors[21, 39]:

- There is inconsistent evidence to support any individual psychotherapy intervention;

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- Peer-oriented group interventions directed by a professional leader, despite heterogeneity of clinical models, are consistently effective in helping clients to reduce substance use and to improve other outcomes;
- Contingency management also appears to be effective in reducing substance use and improving other outcomes, but has been less thoroughly studied and rarely used in routine programs;
- Long-term (one year or more) residential interventions, again despite heterogeneity of models, are effective in reducing substance use and improving other outcomes for clients who have failed to respond to outpatient interventions and for those who are homeless;
- Intensive case management, including assertive community treatment, consistently improves residential stability and community tenure, but does not consistently impact substance use; and
- Several promising interventions, including family psycho education, intensive outpatient programs, self-help programs, and jail diversion and release programs, have received minimal research attention but warrant further study.

There is certainly strong sector support, if not for intensive models of care like IDDT, then for the *principle* of better integrating mental health and substance abuse treatments. Most commentators in this area suggest that the needs of DD disorder clients will be better addressed by more integrated approaches to the provision of care than by less integrated approaches. This progressive accumulation of evidence supporting a range of integrated treatment models interventions in the DD population has convinced many observers that integrated treatment offers "best practice" care for patients and patients' families. Such 'high quality' integrated treatment programs are said to ensure coordination of substance abuse and mental health interventions, treat individual clients more effectively, improve client engagement, reduce substance abuse, improve mental health status, and reduce relapses for all age groups [42,54,61,67,81,90,93].

By contrast, some systematic reviews have reported fewer advantages to recommend integrated care models[18, 48, and 89]. The most widely referenced meta-analysis of care for DD disorders[20] found no compelling evidence to support any one psychosocial treatment over another to reduce substance use (or improve mental state) by people with DD disorders with serious mental illnesses. A recent review and analysis of the *integration* model literature concluded with a cautionary message, warning against mandating provision of an integrated model of care for all clients with DD disorders[90].

Most of the published work describing outcomes of models of care and services for individuals with dual diagnosis has been done in the US, although in the last decade Australia, the UK and NZ have also begun to develop and report upon service models and treatment programmes seeking to provide more clinically effective and efficient care in this area.

As much of the research into the effectiveness of integrated care models has been done in the USA; with many reports from a single treatment program, it cannot be taken for granted that this model is the most appropriate for other countries or that those results can necessarily be replicated by merely copying the described care programs[16,20,21,26,36-39,47,64]. As indicated in the above discussion, the literature highlights an urgent need for further research into the efficacy of various service models for the treatment and care of those with dual diagnosis[93]

Facilitators and challenges for implementation

Implementation of a specific evidence based practice for individuals with serious mental illness and AOD disorders, such as IDDT has been demonstrated to be feasible. There are however concerns that the successes reported by centres of excellence with use of such specialised integrated models of care

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in particular DD disorder client populations may not be able to be translated into broadly effective care programs for all DD disorder clients[10,20,43-45,63,68,82,92,100,101].

There is strong evidence that in other care settings these complex and highly specialised models of care are not actually implemented as intended; that is, truly are integrated, assertive and/ or sensitive to the vulnerabilities and capabilities of mentally ill patients[64,90]. In the well designed and funded national Evidence Based Practice implementation project in North America, which included study of the implementation of the IDDT program, found that only a minority (15%) of participating organizations were able to deliver the intended model of care with high fidelity[16, 17, 64].

This study found that while over half the sites were able to implement one of the five practice improvement programs with high fidelity to the model of practice, variation occurred across sites and by program, with IDDT the most difficult to implement[16, 17, 64].

The facilitators and barriers to implementation for IDDT program occurred at the clinician level (staff skills and turnover), at the organization and administration level (leadership and supervisor skills and commitment), at the level of the implementation roll-out (consultation, training, and feedback), and at the environmental context level (financing and the relationship with the mental health authority) [16, 17, 64]. This study confirmed research in other healthcare setting seeking the translation of evidence into practice suggesting the need for multilayered active implementation efforts[10]. However even with such intensive efforts at multiple levels most organizations did not achieve high-fidelity IDDT program implementation.

IDDT is a complex care model that contains multiple components and requires change at the provider, organization, and environment levels. For these reasons, this service may be more difficult to implement than single-component practices, such as cognitive therapy to treat major depression.
Researchers studying the implementation of the IDDT program found that difficulties in implementing IDDT at the agency level stemmed from[16, 17, and 64]:

- Staff attitudes about addiction at some sites, particularly a belief that abstinence must precede treatment.
- The complex clinical skill set that is required by assessment, motivational interviewing and stage based interventions.
- Staff difficulty understanding the model in concrete terms.
- Failure to appoint and empower appropriate team leaders.
- The lack of detailed care standards, such as are available for other practice improvement programs.
- Lack of funding specifically for IDDT implementation

The high prevalence of DD disorders in all service populations and service settings mean that this high priority population is very unlikely to ever be adequately served by implementation of a small number of highly specialized programs in any scarcely resourced healthcare system[90].

C.4.6 Comprehensive Continuous Integrated System of Care

Rather than relying exclusively on specialized care programs, client needs may be better met by the provision of a properly matched portfolio of services and interventions to individuals with DD disorders wherever they present[4,30-35,66,72, 83,99]. As a result, in recent years, there has been increasing recognition of the need for system level change to provide practical, locally relevant strategies to improve services for individuals with co-occurring disorders[17,18,24,30-35,48,51,53 65,66 ,72,91,94,99,101].

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One example of such an approach is the *Comprehensive, Continuous, Integrated System of Care* (CCISC) model for organizing services for individuals with concurrent psychiatric and substance disorders. Continuity of services refers to the coordination of care for individual client across different service systems. This model was designed to improve treatment capacity for these individuals in care systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies.

The CCISC model was designed to be implementation throughout an entire system of care, not just for implementation of individual programs or training initiatives. All programs were to become dual diagnosis capable (or enhanced) programs. Implementation of the model required systems improvement at the jurisdictional level, program level, clinical practice level, and clinician competency level to create comprehensive system change.

An important aspect of the implementation of structured interventions to improve care for DD disorder clients is the incorporation of better practices for the treatment of all types of DD disorders throughout the service system.

There is a recognition that DD disorders are not a single entity with a single "best practice" intervention, but rather that individuals with DD have a wide range of disorders and needs in combination, and that best practice treatment involves integrating the provision of best practice treatment for each disorder at the level of the client[30,33,35,65,69,71,72.74,76,77,80,94-96,99]. This encourages the system to develop as extensive a range of better practices for mental health and substance disorders as it can, and organize them so that improved practice for either type of disorder is provided by an appropriately trained team of professional.

This model can be used to develop a protocol for individualized treatment matching that in turn permits matching of particular cohorts of individuals to the comprehensive array of dual diagnosis capable services within the system.

The implementation of structured interventions to improve care for DD disorder clients involves complex multi-layered system improvement [25]. It requires an organized approach, incorporating principles of strategic planning and continuous quality improvement in an incremental process that involves interaction between all layers of the system (system, agency or program, clinical practice and policy, clinician competency and training) and all components of the system, regardless of the size or complexity of the system. Such an approach is possible in systems of any size (entire state, regions, counties, complex agencies, individual programs) and in any population.

The CCISC program developed a "Twelve Step Program of Implementation Guide" and a supporting CCISC Toolkit to provide a framework for evaluating and monitoring progress at the system level, the program level, and the clinician level. CCISC implementation was an ongoing quality improvement process that encouraged the development of a plan that includes attention to each of these areas in a comprehensive service array.

Other similar initiatives have published similar resources in terms of implementation guidance documents and/or toolkits[30,33,35,46, 49,65,69,71,72.74,76,77,80,94-96,99].

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C.5 Conclusion

Research in Australia and internationally highlights the considerable challenges in the identification and treatment of people with dual diagnosis. A review of the literature highlights a number of different service models. Traditional service models have provided treatment for dually diagnosed clients in adopted either a serial or parallel approach. More recent studies highlight the potential benefits of integrated models of care. There is a consensus that effective care for the majority of clients with DD disorders requires access to a variety of models of care and a range of skilled professional carers. These models must capable of being tailored to the needs of the client and must be congruent with the system within which care is delivered. Such 'fit for purpose' systems of care draw upon available guidance documents to inform the design and implementation of systems of care that will use the lessons of successful exemplar programs to enhance their ability of relevant service providers to deliver better clinical care for all DD disorder clients. Bearing this in mind it is likely that integrated services are better suited to providing flexible treatment arrangements for consumers than separated drug and mental health services.

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Appendix C: Dual Diagnosis Literature Scan

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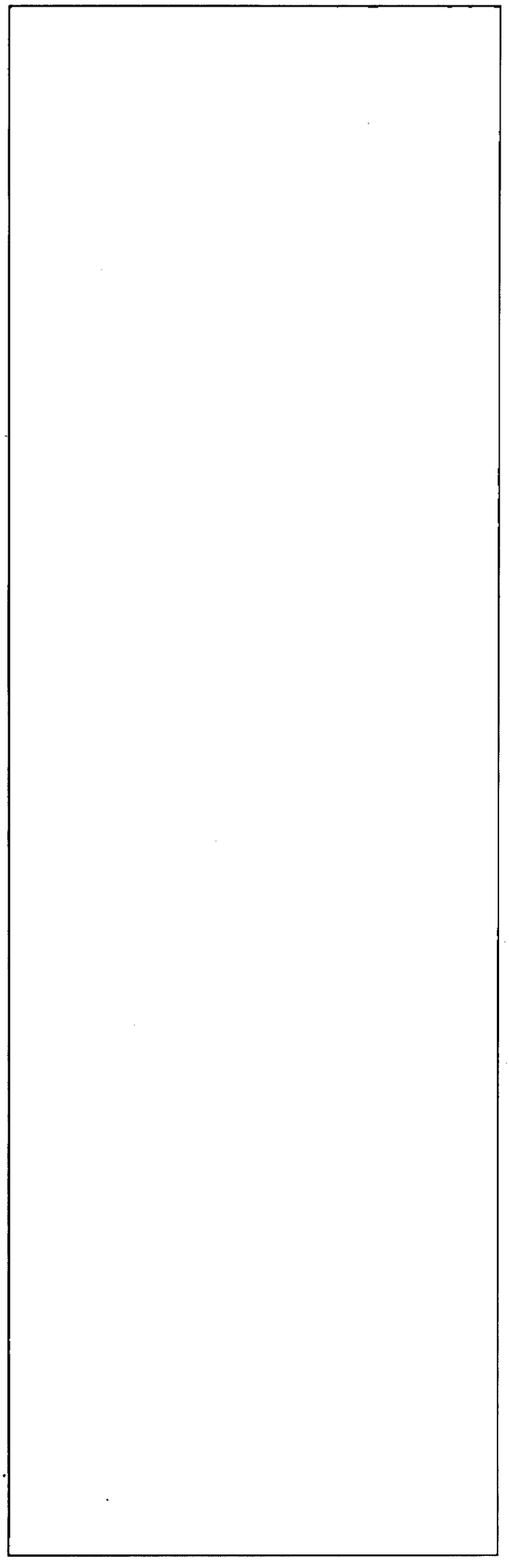

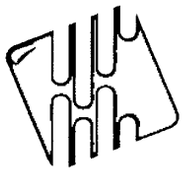

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Appendix D

Appendix D: Training

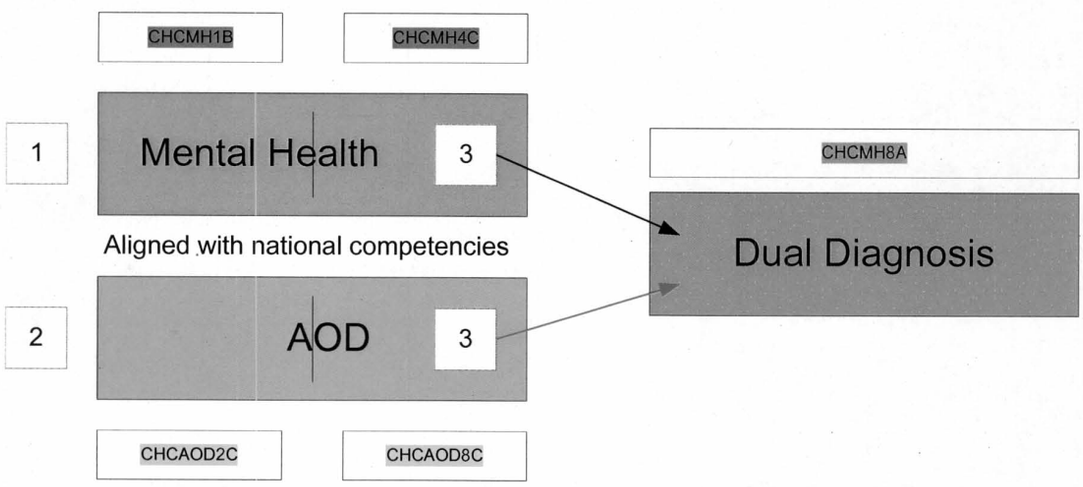
The following information has been adapted from "Dual Diagnosis. An on-line course for staff working with clients with both mental health and substance use problems. Learner's Guide and Prospective Student Information. 2010 Semester 1." Developed by the Statewide Dual Diagnosis Education and training Unit.

Accredited Courses

The ETU have partnered with educational institutions to develop and deliver dual diagnosis accredited courses.

Diploma Course

- Developed of a Dual Diagnosis Course in conjunction with GippsTAFE
    1. AOD workers study the mental health competencies CHCMH1B & 4C (approximately 6 weeks)
    2. Mental health workers study the AOD competencies CHCAOD2C 5 8C (approximately 6 weeks)
    3. All students complete the dual diagnosis competency CHCMH8A



Postgraduate

- Graduate Certificate/Diploma in Alcohol and Other Drug Studies – Offered by Turning Point Alcohol and Drug Centre

Appendix D: Training

Structure of the Course

The course comprises 5 competencies. These are:

AOD Stream:

CHCAOD2C – Orientation to Alcohol and Other Drugs Work (AOD) Work

CHCAOD8C – Assess the needs of people with AOD issues

Mental Health Stream:

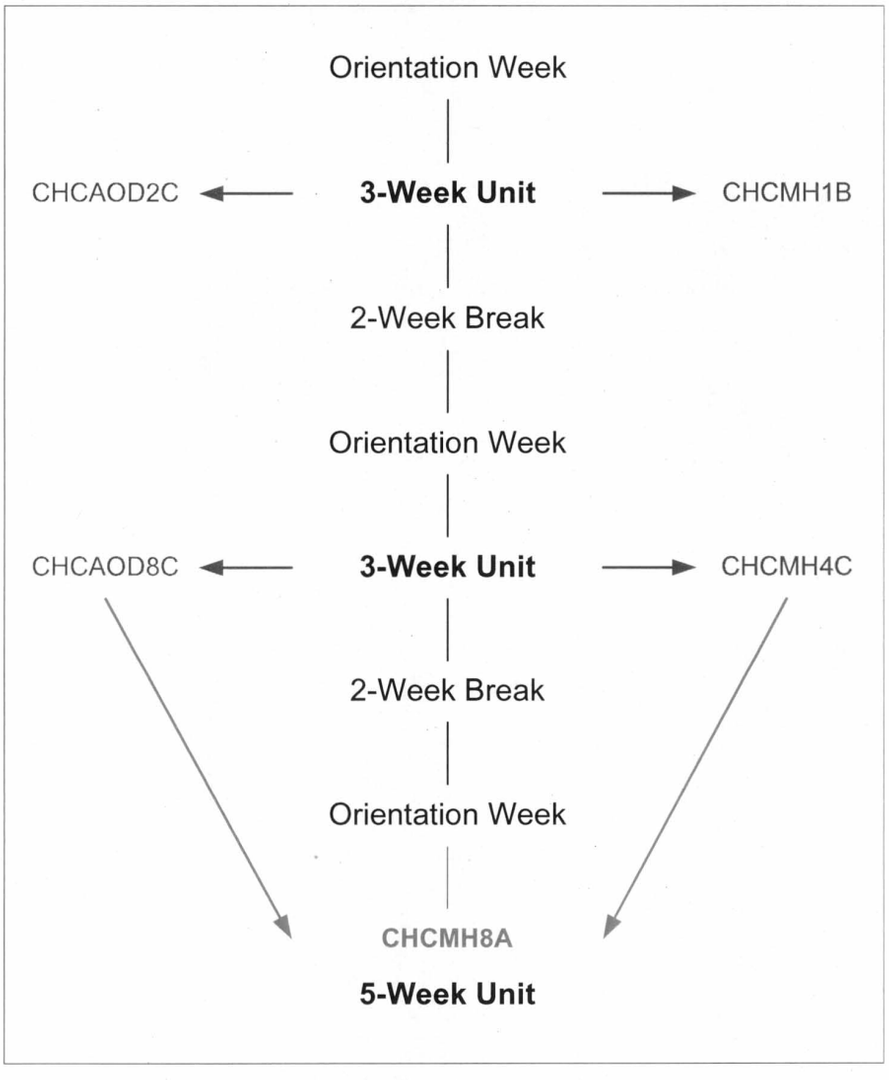
CHCMH1B – Orientation to Mental Health Work

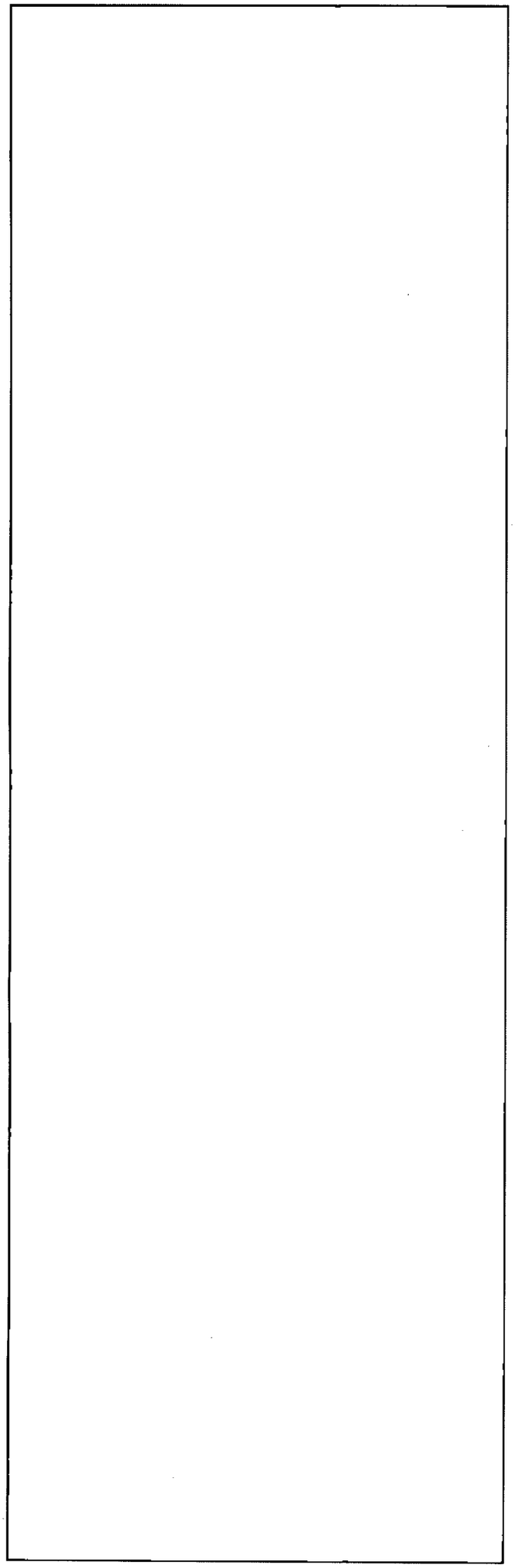
CHCMH4C – Provide Non-Clinical Interventions for People with Mental Health Problems

Dual Diagnosis Unit:

CHCMH8A – Provide interventions to meet the needs of consumers with Mental Health and AOD issues

The **AOD stream** and the **Mental Health stream** run concurrently, then all students join together for the **Dual Diagnosis unit** as follows





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Appendix E

Appendix E: Draft interim Learning and Development Strategy

Overall Objective

Key Directions Service Development Objectives (SDOs) reinforced and embedded among Victorian service providers by 2012.

Learning Objective One

100% of services in each sector (clinical mental health, Psychiatric Disability and Rehabilitation Support Services and Alcohol and Other Drug Services) have in place partnership agreements and protocols which support integrated assessment and treatment planning for people who experience dual diagnosis issues.

Method:

Hold facilitated face to face Workshops in each Department of Health clinical mental health region for senior service provider representatives and Department of Health regional representatives, prior to roll out of Learning Objectives two, three and four.

Facilitation to be conducted by Education and Training Unit (ETU) staff or informed by ETU / VDDI staff knowledge of specific regions.

Expected Outcomes of each Workshop:

- regional self assessment of progress towards Learning Objective One
- identification of strengths and opportunities to build on
- clarity about supports and resources for region to 2012
- agreement on action plans to address priority implementation issues and goals
- agreement on success measures and regional monitoring processes.

Possible Workshop activities could include:

- Pre-workshop organisational self assessment of progress toward meeting Learning Objective One.
- Presentation of information and select best practice rural and urban case studies drawn from the evaluation of the Victorian Dual Diagnosis Initiative (VDDI) Report.
- Clarification of ongoing support from Department of Health and VDDI, including roll out of Learning Objectives two, three and four, other workforce development activities as decided including on-line options such as moderated or facilitated Communities of Practice around screening and assessment tools.
- Provision of pro-forma organisational policies and procedures which incorporate SDO KPIs.
- Provision of pro-forma organisational policies and procedures covering integrated assessment, treatment and care.
- Provision of a pro-forma integrated dual diagnosis protocol, which allows definition of client care pathways within and between sectors.

Appendix E: Draft interim Learning and Development Strategy

Learning Objective Two

100% of existing client care staff in Psychiatric Disability and Rehabilitation Support Services (PDRSS) and Alcohol and Other Drug Services (AOD) workforce sectors have completed scope appropriate basic dual diagnosis training by 2012.

Method:

"Basic dual diagnosis training" is refers to a version of the Certificate IV level, five units of competency developed and trialled by the ETU whereby AOD staff focus on the mental health units of competency and the PDRSS staff focus on the AOD units of competency, so that each discipline completes with the equivalent of three units of competency. While these units of competency have been developed through the Vocational Education and Training (VET) system, the delivery of these three units does not necessitate participants undertaking work for assessment and does not lead to a qualification.

The mode of delivery may vary between face to face, blended and online, as may the training provider vary according to the need of the employer organisation. As a guide the courses provided by the Registered Training Providers which have partnered with the ETU, such as GippsTAFE, Odyssey House, Moreland Hall, Gordon TAFE, South West TAFE, Turning Point Alcohol and Drug Centre and VICSERV are recommended.

These courses generally require employers to allow participants two days off line to attend or undertake training, and learning is enhanced by interaction among participants from or within one or both sectors i.e.: group based delivery modes.

The evaluation of the Victorian Dual Diagnosis Initiative (VDDI) notes that "the great majority of workers across the three sectors have received training related to dual diagnosis" (page 43), or approximately 35% of PDRSS workers and 60% of AOD workers (page 35). As such training conducted to meet this Learning Objective should target the remainder of workers in each sector as well as allowing for turnover and the industry growth rate of 4.6 % per annum over the past five years[1].

Funds should be made available through Department of Health regions to support PDRSS and AOD employers to purchase scope appropriate basic dual diagnosis training for their client care staff by 2012. This funding should not be confused with the VET funding system, which is linked to the earning of qualifications.

Monitoring of progress on this Learning Objective would primarily be via employers keeping records of training attendance and employer receipt of participant feedback on training.

Employers could monitor contribution of this Learning Objective to the Overall Objective via observation of application of learning in the workplace plus staff engagement and compliance with organisational policies and procedures which incorporate the SDO KPIs.

[1] www.Skills Info.gov.au/Healthcare and Social Assistance.

Appendix E: Draft interim Learning and Development Strategy

Learning Objective Three

100% of existing client care staff in clinical mental health workforce sectors have completed scope appropriate basic dual diagnosis professional education by 2012.

Method:

The evaluation of the Victorian Dual Diagnosis Initiative (VDDI) notes, "there is a total of approximately 6,000 workers across the three sectors, of which around 4,500 are employed in clinical mental health" (page 1). While page 35 notes some 50% of these clinical mental health staff have completed dual diagnosis training, page 37 points out the very high turnover in this workforce, and thus the need for ongoing training of the existing workforce.

It is recommended here that this be addressed in the interim to 2012 through the mechanism of employing organisations' performance management cycles (25 clinical mental health organisations employing around 5,000 staff, page 53) and via the individual's clinical mental health professional development registration standard.

That is, while the ETU–driven Certificate IV level 3 relevant units of competency may be a suitable learning option for individual learners (whether learnt through face to face or through on-line learning modes), other dual diagnosis professional development relevant to the individual's practice setting and health professional background / continuing education points system is also appropriate.

Funds should be made available through the Department to these 25 mental health organisations to ensure clinical mental health workers access to scope appropriate basic dual diagnosis professional education by 2012.

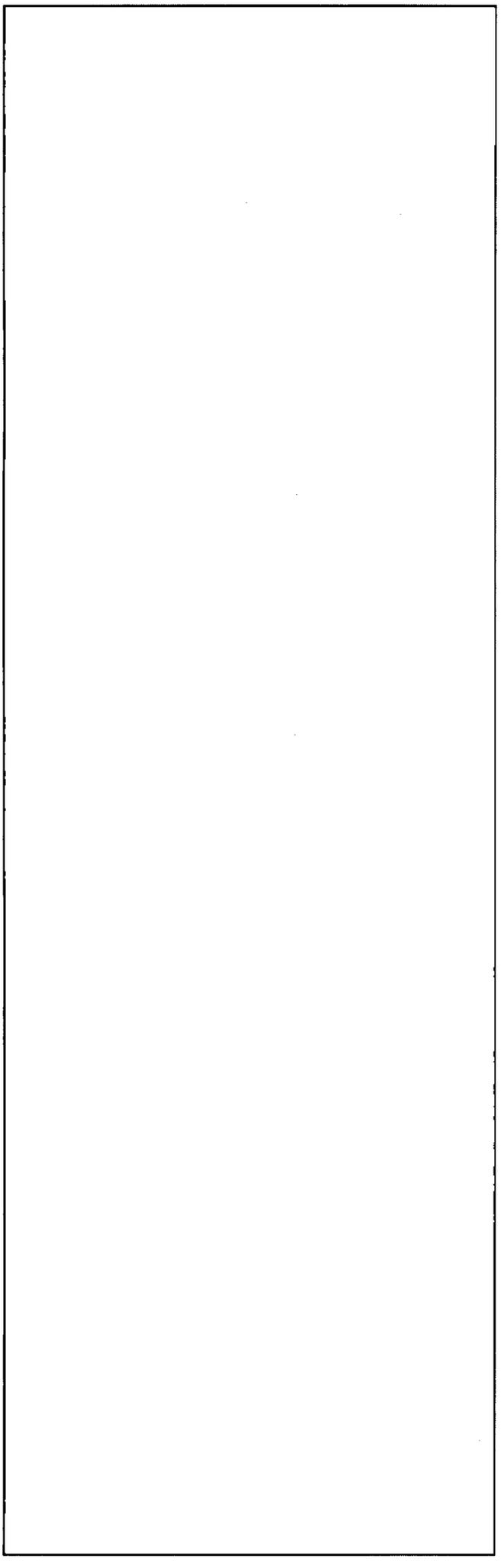
It is recommended that the ETU provide information about recommended dual diagnosis education providers by Victorian region and professional development dual diagnosis options including course content and mode of delivery for each of the clinical mental health worker disciplines via the Dual Diagnosis Support website; further that this information be provided as part of the resources provided to employers in Learning Objective One.

Monitoring of progress on this Learning Objective would primarily be via employer performance management / HR records.

Employers could monitor contribution of this Learning Objective to the Overall Objective via staff engagement and compliance with organisational policies and procedures which incorporate the SDO KPIs.

Appendix E: Draft interim Learning and Development Strategy

Learning Objective Four
The development of a short induction dual diagnosis workforce self paced training package (for example CD based and or on-line) for the two separate audiences of management staff and direct care staff; further, that this package be made freely available to employers to use as an induction tool in the three sectors of the dual diagnosis workforce by the time Learning Objective One is implemented.
Method: Content development of the manager's self paced training package to be informed by ETU and VDDI staff and include: ▪ Key Directions / SDOs or most recent Victorian dual diagnosis government policy ▪ pro-forma organisational policies and procedures which incorporate SDO KPIs. ▪ pro-forma organisational policies and procedures covering integrated assessment, treatment and care. ▪ a pro-forma integrated dual diagnosis protocol, which allows definition of client care pathways within and between sectors. Content development of the direct care staff self paced training package to be informed by ETU and VDDI staff and include: ▪ Key Directions / SDO or most recent Victorian dual diagnosis government policy ▪ Learning activities for the basic dual diagnosis units of competency ▪ Where to find and how to access courses provided by the Registered Training Providers which have partnered with the ETU ▪ List of dual diagnosis education providers by Victorian region and professional development dual diagnosis options including course content and mode of delivery for each of the clinical mental health worker disciplines. Choice of delivery mode and monitoring of take up of the self paced training package be informed by Department of Health and VDDI experience with the dual diagnosis workforce sector take-up of induction training packages.



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Appendix F

Appendix F: Data Collection and Tools

International Classification of Diseases – Tenth Revision (ICD – 10)

Mental and behavioural disorders
(F00-F99)

Mental and behavioural disorders due to psychoactive substance use
(F10-F19)

This block contains a wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed. The third character of the code identifies the substance involved, and the fourth character specifies the clinical state. The codes should be used, as required, for each substance specified, but it should be noted that not all fourth character codes are applicable to all substances. Identification of the psychoactive substance should be based on as many sources of information as possible. These include self-report data, analysis of blood and other body fluids, characteristic physical and psychological symptoms, clinical signs and behaviour, and other evidence such as a drug being in the patient's possession or reports from informed third parties. Many drug users take more than one type of psychoactive substance. The main diagnosis should be classified, whenever possible, according to the substance or class of substances that has caused or contributed most to the presenting clinical syndrome. Other diagnoses should be coded when other psychoactive substances have been taken in intoxicating amounts (common fourth character .0) or to the extent of causing harm (common fourth character .1), dependence (common fourth character .2) or other disorders (common fourth character .3-.9).
Only in cases in which patterns of psychoactive substance-taking are chaotic and indiscriminate, or in which the contributions of different psychoactive substances are inextricably mixed, should the diagnosis of disorders resulting from multiple drug use (F19.-) be used.

Excludes: abuse of non-dependence-producing substances (F55)

The following fourth-character subdivisions are for use with categories F10-F19:

.0 Acute intoxication

A condition that follows the administration of a psychoactive substance resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses. The disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. Complications may include trauma, inhalation of vomitus, delirium, coma, convulsions, and other medical complications. The nature of these complications depends on the pharmacological class of substance and mode of administration.

Acute drunkenness in alcoholism
"Bad trips" (drugs)
Drunkenness NOS
Pathological intoxication
Trance and possession disorders in psychoactive substance intoxication

Excludes: intoxication meaning poisoning (T36-T50)

.1 Harmful use

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

Appendix F: Data Collection and Tools

Psychoactive substance abuse

.2 Dependence syndrome

A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.
The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances.

Chronic alcoholism
Dipsomania
Drug addiction

.3 Withdrawal state

A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a psychoactive substance after persistent use of that substance. The onset and course of the withdrawal state are time-limited and are related to the type of psychoactive substance and dose being used immediately before cessation or reduction of use. The withdrawal state may be complicated by convulsions.

.4 Withdrawal state with delirium

A condition where the withdrawal state as defined in the common fourth character .3 is complicated by delirium as defined in F05.-. Convulsions may also occur. When organic factors are also considered to play a role in the etiology, the condition should be classified to F05.8.

Delirium tremens (alcohol-induced)

.5 Psychotic disorder

A cluster of psychotic phenomena that occur during or following psychoactive substance use but that are not explained on the basis of acute intoxication alone and do not form part of a withdrawal state. The disorder is characterized by hallucinations (typically auditory, but often in more than one sensory modality), perceptual distortions, delusions (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor), and an abnormal affect, which may range from intense fear to ecstasy. The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present.

Alcoholic:
· hallucinosis
· jealousy
· paranoia
· psychosis NOS

Excludes: alcohol- or other psychoactive substance-induced residual and late-onset psychotic disorder (F10-F19 with common fourth character .7)

.6 Amnesic syndrome

A syndrome associated with chronic prominent impairment of recent and remote memory. Immediate recall is usually preserved and recent memory is characteristically more disturbed than remote memory. Disturbances of time sense and ordering of events are usually evident, as are difficulties in learning new material. Confabulation may be marked but is not invariably present. Other cognitive functions are usually relatively well preserved and amnesic defects are out of proportion to other disturbances.

Appendix F: Data Collection and Tools

Amnestic disorder, alcohol- or drug-induced
Korsakov's psychosis or syndrome, alcohol- or other psychoactive substance-induced or unspecified

Excludes: nonalcoholic Korsakov's psychosis or syndrome (F04)

.7 Residual and late-onset psychotic disorder

A disorder in which alcohol- or psychoactive substance-induced changes of cognition, affect, personality, or behaviour persist beyond the period during which a direct psychoactive substance-related effect might reasonably be assumed to be operating. Onset of the disorder should be directly related to the use of the psychoactive substance. Cases in which initial onset of the state occurs later than episode(s) of such substance use should be coded here only where clear and strong evidence is available to attribute the state to the residual effect of the psychoactive substance. Flashbacks may be distinguished from psychotic state partly by their episodic nature, frequently of very short duration, and by their duplication of previous alcohol- or other psychoactive substance-related experiences.

Alcoholic dementia NOS
Chronic alcoholic brain syndrome
Dementia and other milder forms of persisting impairment of cognitive functions
Flashbacks
Late-onset psychoactive substance-induced psychotic disorder
Posthallucinogen perception disorder
Residual:
· affective disorder
· disorder of personality and behaviour

Excludes: alcohol- or psychoactive substance-induced:
· Korsakov's syndrome (F10-F19 with common fourth character .6)
· psychotic state (F10-F19 with common fourth character .5)

.8 Other mental and behavioural disorders

.9 Unspecified mental and behavioural disorder

F10 Mental and behavioural disorders due to use of alcohol
[See before F10 for subdivisions]

F11 Mental and behavioural disorders due to use of opioids
[See before F10 for subdivisions]

F12 Mental and behavioural disorders due to use of cannabinoids
[See before F10 for subdivisions]

F13 Mental and behavioural disorders due to use of sedatives or hypnotics
[See before F10 for subdivisions]

F14 Mental and behavioural disorders due to use of cocaine
[See before F10 for subdivisions]

F15 Mental and behavioural disorders due to use of other stimulants, including caffeine
[See before F10 for subdivisions]

F16 Mental and behavioural disorders due to use of hallucinogens
[See before F10 for subdivisions]

Appendix F: Data Collection and Tools

F17 **Mental and behavioural disorders due to use of tobacco**

[See before F10 for subdivisions]

F18 **Mental and behavioural disorders due to use of volatile solvents**

[See before F10 for subdivisions]

F19 **Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances**

[See before F10 for subdivisions]

This category should be used when two or more psychoactive substances are known to be involved, but it is impossible to assess which substance is contributing most to the disorders. It should also be used when the exact identity of some or even all the psychoactive substances being used is uncertain or unknown, since many multiple drug users themselves often do not know the details of what they are taking.

Includes: misuse of drugs NOS

Substance Use Interventions – ICD-10-AM

Intervention	Code (ICD-10-AM / ACHI)
Brief motivational Intervention/Counselling – Alcohol Use Disorder	Z71.4
Brief motivational Intervention/Counselling – Drug Use Disorder	Z71.5
Brief motivational Interventions/Counselling – Tobacco Use Disorder	Z71.6
Preventative counselling or education (substance use) i.e. harm reduction; education	96066-00
Alcohol Withdrawal Management	92003-00
Alcohol and Drug Withdrawal Management	92009-00
Drug Withdrawal Management	92006-00

Health of the Nation Outcome Scales (HONOS)

The HoNOS is a clinician-administered instrument comprising 12 items:
- Item 1: Overactive, aggressive, disruptive or agitated behaviour;
- Item 2: Non-accidental self-injury;
- Item 3: Problem drinking or drug taking;
- Item 4: Cognitive problems;
- Item 5: Physical illness or disability problems;
- Item 6: Problems associated with hallucinations and delusions;
- Item 7: Problems with depressed mood;
- Item 8: Other mental and behavioural problems;
- Item 9: Problems with relationships;

Appendix F: Data Collection and Tools

• Item 10: Problems with activities of daily living;
• Item 11: Problems with living conditions; and
• Item 12: Problems with occupation and activities.99

Collectively, the items cover the sorts of problems that may be experienced by people with a mental illness. The items 'roll up' into four subscales:
• Behaviour (Items 1-3);
• Impairment (Items 4-5);
• Symptoms (Items 6-8); and
• Social (Items 9-12).

Each item is rated on a five-point scale (0 = no problem; 1 = minor problem; 2 = mild problem; 3 = moderately severe problem; 4 = very severe problem), resulting in individual item scores, subscale scores and a total score. In assigning ratings, the clinician makes use of a glossary which details the meaning of each point on the item being rated[1].

Basis-32
The BASIS-32® is a consumer-rated instrument comprising 32 items:

• Item 1: Managing day-to-day life (e.g., getting places on time, handling money, making everyday decisions)
• Item 2: Household responsibilities (e.g., shopping, cooking, laundry, cleaning, other chores)
• Item 3: Work (e.g., completing tasks, performance level, finding/keeping a job)
• Item 4: School (e.g., academic performance, completing assignments, attendance)
• Item 5: Leisure time or recreational activities
• Item 6: Adjusting to major life stressor
• Item 7: Relationships with family
• Item 8: Getting along with people outside the family
• Item 9: Isolation or feelings of loneliness
• Item 10: Being able to feel close to others
• Item 11: Being realistic about yourself and others
• Item 12: Recognising and expressing emotions appropriately
• Item 13: Developing independence, autonomy
• Item 14: Goals or direction in life
• Item 15: Lack of self confidence, feeling bad about yourself
• Item 16: Apathy, lack of interest in things
• Item 17: Depression, hopelessness
• Item 18: Suicidal feeling or behaviour
• Item 19: Physical symptoms
• Item 20: Fear, anxiety or panic
• Item 21: Confusion, concentration, memory
• Item 22: Disturbing or unreal thoughts or beliefs
• Item 23: Hearing voices, seeing things
• Item 24: Manic, bizarre behaviour
• Item 25: Mood swings, unstable moods
• Item 26: Uncontrollable, compulsive behaviour

[1] Wing J, Curtis RH, Beevor A. Health of the Nation Outcome Scales (HoNOS). Glossary for HoNOS score sheet. British Journal of Psychiatry. May 1999;174:432-434 as cited in Pirkis J, Burgess P, Kirk P, Dodson Sand Coombs T. 2005. *Review of standardised measures used in the National Outcomes and Casemix Collection (NOCC). Version 1.1.* 2005: pg 14

Appendix F: Data Collection and Tools

- Item 27: Sexual activity or preoccupation
- Item 28: Drinking alcoholic beverages
- Item 29: Taking illegal drugs, misusing drugs
- Item 30: Controlling temper, outbursts of anger, violence
- Item 31: Impulsive, illegal or reckless behaviour
- Item 32: Feeling satisfaction with your life

Collectively, the items constituting the BASIS-32® comprise five subscales:

- Relation to self and others (Items 7, 8, 10, 11, 12, 14, 15);
- Depression and anxiety (Items 6, 9, 17, 18, 19, 20);
- Daily living and role functioning (Items 1, 2, 3, 4, 5, 13, 16, 21, 32);
- Impulsive and addictive behaviour (Items 25, 26, 28, 29, 30, 31); and
- Psychosis (Items 22, 23, 24, 27).224

Each item is rated using a five-point scale (0 = no difficulty; 1 = a little difficulty; 2 = moderate difficulty; 3 = quite a bit of difficulty; 4; extreme difficulty) which are used to calculate subscales and total scores by adding the ratings for each item and dividing by the number of non-omitted items. The exception to this rule is the computation of the Daily living and role functioning subscale, which is determined by taking the highest difficulty rating of items 2, 3 and 4 to create a single 'role functioning' rating, and averaging this value in with the remaining six items[2]

[2] Department of Human Services. Measuring Consumer Outcomes in Clinical Mental Health Services. A Training Manual for Services in Victoria (2nd edition): Victorian Government; 2003. As cited in ibid

Appendix F: Data Collection and Tools

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)
CAGE-AID[3]

1. Have you felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Score: __ /4
2/4 or greater = positive CAGE, further evaluation is indicated

[3] ***Wisconsin Medical Journal.*** **Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.**