

# **Better Outcomes: Towards a Victorian Complexity-Capable Service System**

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



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### ***About this Submission:***

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

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

### ***Disclaimer:***

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

### ***Suggested Reference:***

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## **RC Terms of Reference addressed in this submission**

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

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

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## 1.

### ABOUT CO-OCCURRING MENTAL HEALTH-SUBSTANCE USE CONCERNS

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#### Terminology

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

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

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

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

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

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

#### **Recommendation 1:**

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

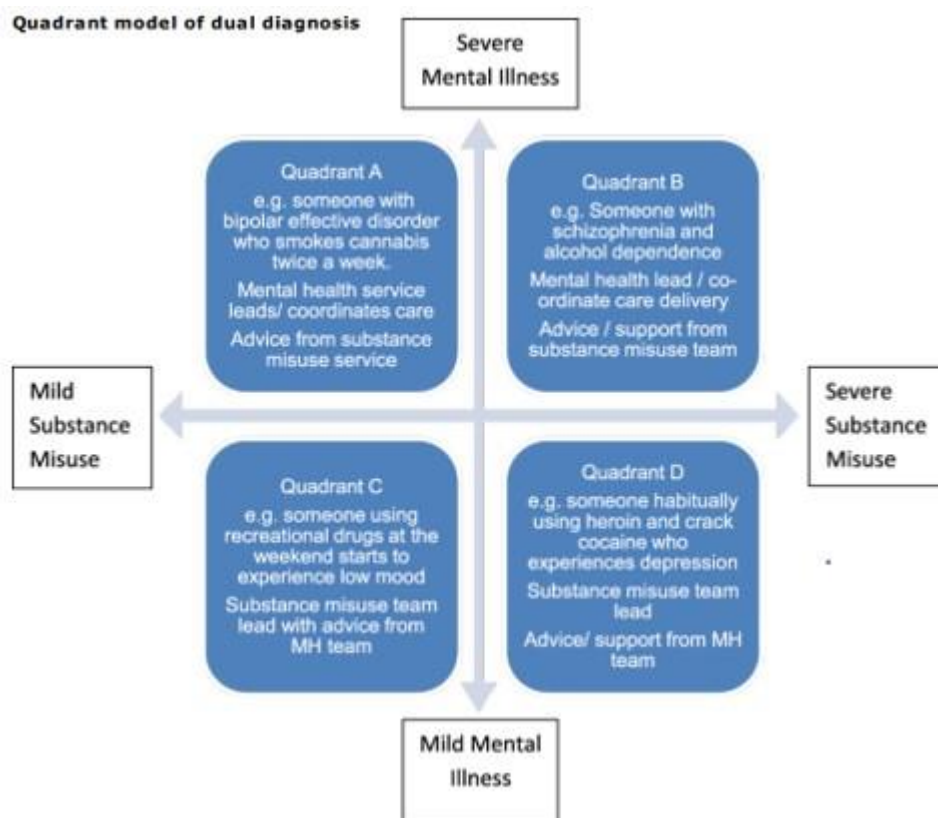
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## Cohorts

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

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

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



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

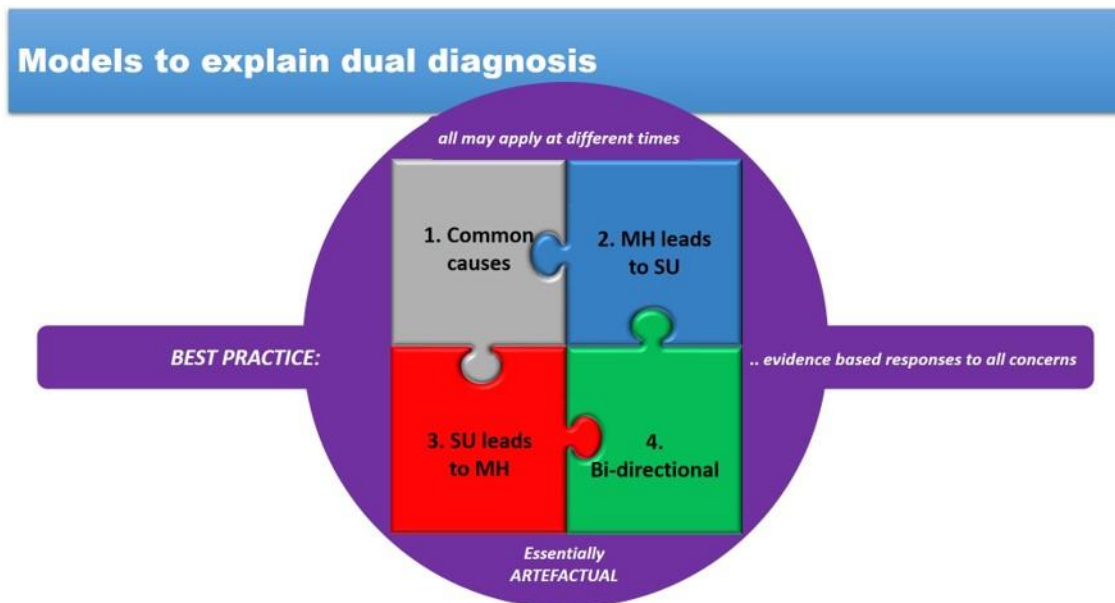
Some of the most visible cohorts of people with co-occurring mental health and substance use concerns are people experiencing co-occurring:

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



## Relationships between the concerns

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



1. **Common risk factors:** posits that common risk factors, such as trauma or poor cognitive functioning, may have influenced the person to develop both concerns.
2. **Mental health concern leads to substance use concern:** included in this model are relationships such as:
  - *Self-medication hypothesis* in which a person uses substances to alleviate the symptoms of a mental health concern e.g. a person developing an alcohol use problem as an outcome of using alcohol to relieve anxiety symptoms
  - *Dysphoria model* argues that life can sometimes have fewer pleasurable moments for people with mental health concerns making the person more susceptible to the immediate, predictable, rewards of substance use
  - *Super-sensitivity model* posits that some people with mental health concerns, whether through symptoms of the illness or the effects of the medications used to treat the illness, are exquisitely susceptible to the effects of substances
3. **Substance use leads to mental health concern:** sometimes a clear causal relationship can be observed between substance use and the subsequent development of a mental health disorder, for instance in amphetamine psychosis.
4. **Bi-directional model:** perhaps the most useful model that posits that each concern develops in relationship to the other – substance use influences mental health symptoms which in turn influence substance use and so on. Most commonly, when working with a person with co-occurring concerns, a clear, causal relationship of one concern leading to the other cannot be identified with confidence.

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

## Challenges

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

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

- **Access:** to effective treatment and support – there is strong evidence of poor access to treatment for either mental health and substance use concerns. Access is further compromised when a person has both disorders. A long-standing, often identified, issue occurs when a person assessed by mental health services receives feedback that before receiving any mental health service they first need to address their substance use- only then to be told by AOD services that first need to address their mental health concerns ....thus falling through the gaps receiving no treatment from either service.
- **Stigma and discrimination:** Individually mental health and substance use concerns are highly stigmatised healthcare needs. When a person experiences *both concerns*, they are likely to experience compounded stigma and discrimination with deleterious impacts on quality of life, access to, quality and effectiveness of treatment.
- **Unfriendly systems:** How to sufficiently compartmentalise their mental health and substance use concerns to address the concerns in two, often-dissimilar, systems in which the treating workers may have poor or no communication about the person's issues?
- **Harms and unwanted outcomes:** people with both concerns are more likely to experience a significant range of harms and unwanted outcomes than a person with only one of the concerns.

## Challenges - Significant Others

- **Parallel issues:** The challenges experienced by the significant others of people with co-occurring mental health and substance use concerns tend to parallel those of the person with the issues.
- **Courtesy stigma:** is the '*experience of stigma as a result of a relationship with, or proximity to, a stigmatised person*' (Adfam, 2012). Significant others may experience increased isolation and compromised access to supports as a result of courtesy stigma. Again, there is '*compounded stigma*' as a result of the person concerned having two of society's most stigmatised disorders.
- **Losses:** There is evidence that people caring for a person with both mental health and substance use concerns experience greater financial losses and anticipatory grief than people caring for someone with only one of the concerns.
- **Directions:** The significant others of people with co-occurring mental health and substance use concerns may experience dilemmas centred on questions of which concern has '*primacy*', what treatment would be helpful, where and how to access treatment and supports and dilemmas of responsibility v consequences
- **Information:** One of the greatest challenges can be where and how to get reliable information. This could be about the concerns that the person they care for is experiencing but also could be about how to navigate complex health and social services.

## Challenges – Clinicians and workers

- **Role-validity, knowledge, skills, confidence:** Mental health and substance treatment workers primary training is most often principally around single-disorders – hence they may lack role-validity, skills, knowledge and confidence when faced with responding to multiple other concerns.
- **Training standards:** To date there has seldom been agreed minimum standards and curriculum informing workplace training deployed to develop clinician's capacity to respond effectively to people with complex needs
- **Agency support:** Often workers, through workshop participation, become enthused about providing more integrated treatment only to learn that their auspice agency's tools, procedures, clinical leaders, culture and priorities do not support this practice development
- **Competing priorities:** Mental health and substance treatment workers work in time and resource-poor, crisis-focused (VAGO, 2019), pressured environments which perforce tend towards minimum, non-integrated, treatment provision. Which do not allow the time necessary for activities such as building and maintaining effective cross-sector relationships that augur towards cross sector understanding, collaboration and consultations and navigable treatment pathways.

## Challenges – Local Managers, Agencies, Planning & Funding bodies

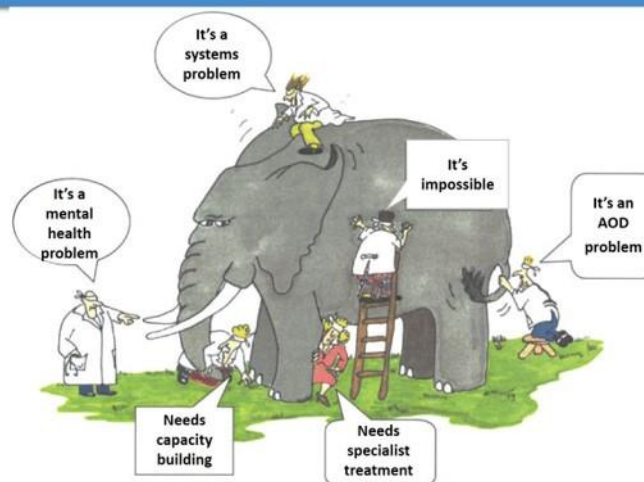
- **Resources:** Local Managers, Agencies, Planning & funding bodies are besieged by wicked problems around funding, resource allocation, systemic priorities, misaligned structural arrangements and layers of workforce challenges. Directions are heavily contested and there is an inadequate evidence base to guide decision making.  
Recent data (VAGO, 2019) (Perkins, 2019) has graphically demonstrated how under-resourced Victorian Mental Health services are to achieve against their tasks. In this context, struggling to provide effective mental health services per se, it is understandable that the services have made little recent headway in building their capacity and routine practice to provide integrated treatment to people presenting with dual diagnosis and other complex needs.
- **Systemic self-efficacy:** In trying to navigate and respond to this plethora of complex problems people with management and planning and funding responsibilities may have lost their belief that it is possible to deliver a system that is effective and efficient in responding to the needs of people with mental health concerns – loss of 'systemic self-efficacy' .
- **Competing reforms:** A clear, best practice, goal for services and systems attempting to prevent people with dual diagnosis and other complex needs from falling through the gaps is the development of a **No Wrong Door service system**. A host of central policy and planning documents in a variety of arenas identify the importance of agencies collaborating for best outcomes. These worthwhile goals contrast with many of the actual impacts of the last 5-years evolution of a commissioning, competitive-tendering, funding environment. Agencies which were once partners in developing local systemic dual diagnosis /complexity-capability may now view other local agencies as competitors and be averse to meaningful collaborations and local systems development initiatives.
- **Exclusion criteria:** Other best practice complexity responses such as active welcoming and flexible entry criteria are increasingly less possible due to central system design and funding mechanisms. In practice taut, limited, service entry criteria function as *exclusion* criteria and inhibit services and workers from flexibly, promptly responding to the diverse needs of the people with multiple and complex needs.

## Dual diagnosis - A wicked problem?

Wicked problems are problems that are *'difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize. It refers to an idea or problem that cannot be fixed, where there is no single solution to the problem. The use of the term "wicked" here has come to denote resistance to resolution, rather than evil'* (APSC, 2007). The Australian Public Service Commission identified nine characteristics of wicked problems – these are reproduced below in italics and discussed from a dual diagnosis perspective.

1. **Wicked problems are difficult to clearly define.** Co-occurring mental health and substance use concerns are not homogenous – there is great variability in the combinations and the severity of the concerns. Each person impacted by co-occurring mental health and substance use concerns will have unique experiences that shape their views of the nature of and possible solutions to the challenges involved.

### dual diagnosis.... a wicked problem ....



2. **Wicked problems have many interdependencies and are often multi-causal.** There are multiple, often competing, views about the causes, nature of and optimum responses to mental health concerns per se and similar contestability around the causes, nature of and responses to substance use concerns. These tensions and challenges are magnified when a person has both concerns and there is a plethora of consequent impacts on service delivery- for instance
  - an abstinence oriented AOD residential rehabilitation facility refusing to admit a person taking psychotropic medication
  - a person assessed by a MH service being advised to resolve their AOD use before they can be considered for MH treatment and then receiving mirror advice from an assessing AOD service – the MH service perceiving the AOD use as 'primary', the AOD service perceiving the MH symptoms as 'primary' and hence the person falling through the gaps, receiving no service from either agency
3. **Attempts to address wicked problems often lead to unforeseen consequences.** Dual diagnosis capacity building efforts focused on building relationships between AOD and mental health workers, in pursuit of more navigable treatment pathways, have sometimes observed an increase, rather than a decrease,

in cross-sector disputes and disappointments as the workers are thrown more together and the challenges to cross-sector collaboration become more apparent.

4. **Wicked problems are often not stable.** There is considerable variation in current trends in substance use and multiple, fluid influences impacting mental health and substance service delivery. Victoria's latest 'ice-epidemic' brought a new set of challenges to both mental health and AOD sectors. Victorian mental health and AOD sectors experienced a surge in systemic 'dual diagnosis capability' in the wake of the 2007 cross-sector, dual diagnosis policy - a surge gradually eroded by the multiple competing tensions and ongoing changes experienced in both systems.
5. **Wicked problems usually have no clear solution.** Because of the interplay of:
  - the complexity, variability and dynamic nature of co-occurring mental health and substance use concerns,
  - the divergent views about the nature of and solutions to the problems
  - the range of complex logistical, resource and other challenges inherent in mental health–substance use treatment deliverythe challenges around dual diagnosis service provision will never be 'solved' with any finality. Some strategies to address particular issues will be more effective than others. Efforts to achieve better outcomes for people with co-occurring mental health-substance use concerns will always need to be iterative – not least because of unrelenting systemic 'churn' and workforce throughput.
6. **Wicked problems are socially complex.** A learning from Victoria's efforts to date to address dual diagnosis issues has been that the most effective strategies that have influenced service delivery are those which have involved coordinated action by a range of stakeholders. The multi-stakeholder, multi-level, collaborative cross-sector service delivery changes that ensued from the 2007 cross-sector, dual diagnosis policy are an outstanding example.
7. **Wicked problems hardly ever sit conveniently within the responsibility of any one organisation.** At the most elementary level responsibility for addressing the challenges of dual diagnosis lie with all specialist mental health and AOD service delivery stakeholders. At the same time people with dual diagnosis and other complex needs are also highly prevalent in Primary Care / General Practice and tend to receive services from, and may be a challenge to, a host of other social and healthcare delivery organisations- housing, forensic, general healthcare, educational.
8. **Wicked problems involve changing behaviour.** This is particularly relevant to the challenges around influencing the complex behaviour of mental health and substance use counselling and support providers. A consistent finding (Moyers, 2015) is that the principle determinant of client outcomes is the relationship between client and counsellor and there are multiple complex factors impacting on service provider's capacities to develop the safe, collaborative relationships necessary for change to occur. Workplace culture is a particularly salient factor. There can be an inverse relationship between a clinician's qualifications and their receptivity to further developing their skills. Sustained, complementary diverse, coherent, evolving, strategies are necessary to influence complex behaviours such as individual clinician's healthcare service delivery.
9. **Some wicked problems are characterised by chronic policy failure.** Policy and funding bodies face an intimidating array of challenges in devising policies to address issues that transcend traditional service system boundaries. Victoria's 2007 cross-

sector, dual diagnosis policy<sup>7</sup> is a standout in the Australian landscape – few other Australian policies have had a significant, enduring impact on service delivery and client outcomes.

**Recommendation 2:**

That systems development initiatives crafted to address the issues around co-occurring mental health–substance use issues employ primarily collaborative and iterative strategies and are devised with a robust recognition of the complexity of the challenges.

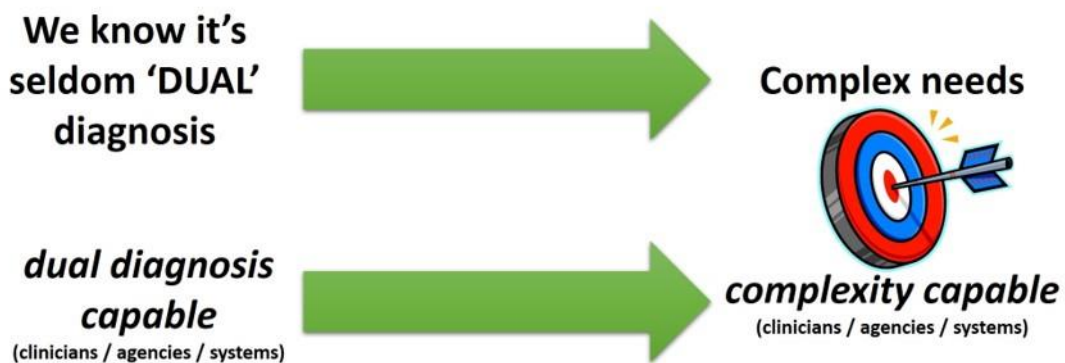
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## Dual Diagnosis Capability to Complexity Capability

People who present to services with co-occurring mental health-substance use concerns seldom have *only* mental health and substance use concerns. For good reasons they are at increased risk of also experiencing a range of other concerns and needs for service. This recognition has given rise to the phrase of people with '*dual diagnosis and other complex needs.*'

### Evolution: dual diagnosis capability to complexity capability



The United Kingdom's *All-Party Parliamentary Group on Complex Needs and Dual Diagnosis* (APPG-CNDD, 2013) defines people with complex needs as:

- 'A person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing.
- Such needs typically interact with and exacerbate one another leading to individuals experiencing several problems simultaneously.
- These needs are often severe and/or long standing, often proving difficult to ascertain, diagnose or treat.
- Individuals with complex needs are often at, or vulnerable to reaching crisis point and experience barriers to accessing services; usually requiring support from two or more services/agencies.
- Someone described as having complex needs will have (although not limited to) a co-morbidity of two or more of the following:
  - Mental health issues
  - Substance use issues
  - A dual diagnosis of mental health and substance use issues
  - A physical health condition
  - A learning disability
  - A history of offending behaviour
  - A physical disability
  - Employment problems
  - Homelessness or housing issues
  - Family or relationship difficulties
  - Domestic violence
  - Social isolation
  - Poverty
  - Trauma (physical, psychological or social)

- *These needs are often severe, longstanding, difficult to diagnose and therefore to treat. Ongoing inequalities continue to exist and are only likely to increase as people live longer with a wider range of needs.'*

Cline and Minkoff, architects of the **Comprehensive Continuous System of Care (CCISC)** model profiled in the final chapter of this submission, note that *'in real world behavioural health and health systems, individuals and families with multiple co-occurring needs are an expectation, not an exception. Individuals and families not only have substance use and mental health issues, they frequently have medical issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues. In addition, these individuals and families are culturally and linguistically diverse. In short, these are people and families who are characterized by "complexity", and they tend to have poorer outcomes and higher costs of care. (Cline, 2009)*

*However, instead of systems being designed to clearly welcome and prioritize these complex individuals and families with high risk and poor outcomes, individuals and families with complexity have historically been experienced as "misfits" at every level. This realization has become a major driver for comprehensive system change. For systems with scarce resources to successfully address the needs of the individuals and families with complex co-occurring issues who are the "expectation", it is not adequate to fund a few "special programs" to work around a fundamentally mis-designed system. We need to engage in a process of organizing everything we do, at every level, with every scarce resource we have, to be about all the complex needs of the people and families seeking help. (Cline, 2009)*

## Complexity Videos



VDDI-NEXUS have developed a series of short videos profiling recovery stories that highlight and personalise the complex range of issues and challenges also experienced by people with or caring for someone with substance use and mental health issues. These are real and lived individual experiences. Some of the stories contain sensitive and confronting material.

They can be accessed at [www.straightup.org.au/](http://www.straightup.org.au/)

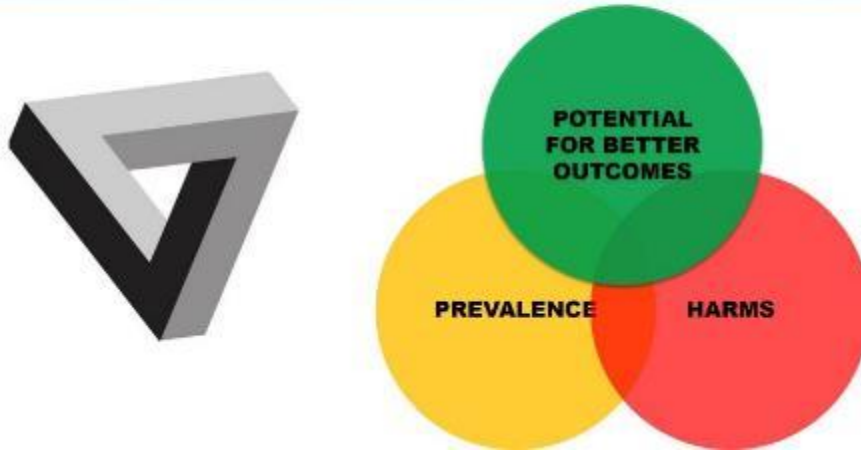
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2.

*Why people with dual diagnosis & other complex needs must be at the centre of mental health reform*

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why dual diagnosis matters .....



In order to be successful against its mandate it is critically important that the Royal Commission into Victoria's Mental Health System places people with dual diagnosis and other complex needs at the centre of their recommendations for mental health reform. There are three principal reasons for this priority (Croton, 2010):

- 1. Prevalence**
- 2. Harms**
- 3. Potential for better outcomes**

## **1. Prevalence – the expectation not the exception**

If a person experiences either a mental health or a substance use concern they are, for good reasons, at a greatly increased risk of experiencing both concerns together.

- I. People with co-occurring substance concerns are the ***expectation not the exception amongst people receiving treatment for mental health concerns.***
- II. People with co-occurring mental health concerns are *the expectation not the exception amongst people receiving treatment for substance use concerns.*
- III. People with co-occurring mental health-substance use concerns are ***highly prevalent in a range of service systems including the justice system***
- IV. People with co-occurring mental health-substance use concerns are ***highly prevalent amongst people accessing General Practice.***
- V. People with co-occurring mental health-substance use concerns are ***common in the general population***

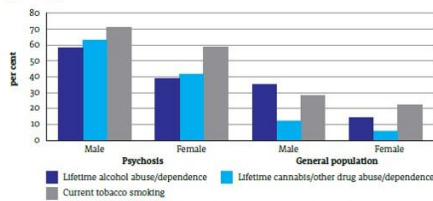
See Prevalence Snapshots on following page

# Dual Diagnosis Prevalence 'snapshots'

## People with psychosis

National Report Card on Mental Health (NMHC, 2013)

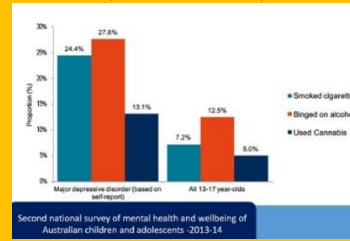
Figure 2: Drug use by people living with a psychotic illness compared with the general population



Sources: 2007 National Survey of Mental Health and Wellbeing and 2010 National Psychosis Survey

## Youth

National Survey MH Australian Children Adolescents 2013-14 (Lawrence D, 2015)



## Mental Health & AOD settings

(Deady, 2014)



## Emergency Departments

(ACEM, 2019)



Among people seeking help from EDs for mental health crises, **1/3<sup>rd</sup> have substance use recorded as a feature of their presentation**

## Prisoners

(Young, 2019)

**Prevalence of mental health disorders**

- Mental health disorders are substantially overrepresented among people in prison
  - Mental illness (MI)
    - Psychosis (3.6%); major depression (10-14%); personality disorders (43-65%)
    - 12-month prevalence in Australia – 80%
  - Substance use disorder (SUD)
    - Alcohol (10-51%); Drugs (2-69%)
    - Dual diagnosis of MI + SUD - 29% (12-month prevalence)
  - Intellectual disability – 9-11% screen positive
- All 3 to 11 times higher compared to the general population

## Coroner

(Coroners Court, 2017)

**Executive summary**

- This memorandum describes recent coronial research into the presence of intersecting diagnosed mental illness and drug dependence among suicide and overdose deceased, and offenders and deceased in intimate partner homicides.
- A detailed study of 838 Victorian overdose deaths occurring between 2011 and 2013, was undertaken in collaboration with researchers from Turning Point. The study found that 49.6% of deceased had both clinically documented drug dependence and a diagnosed mental illness (other than a mental illness relating to substance misuse).
- A pilot analysis of Victorian Suicide Register data for the period 2010-2011 established that 32.5% of all deceased were drug dependent proximal to their deaths. Among this drug-dependent cohort, 55.3% of deceased had clinically documented drug dependence in combination with a diagnosed mental illness (other than a mental illness relating to substance misuse).
- A pilot analysis of 64 intimate partner homicide incidents, using data drawn from the Victorian Homicide Register, showed that 46.2% of offenders had a history of substance misuse as well as a diagnosed mental illness at the time of the fatal incident, whereas 16.9% of the deceased had both a substance misuse history and diagnosed mental illness.

## Methamphetamine-Mental Health

(McKetin R, 2006)

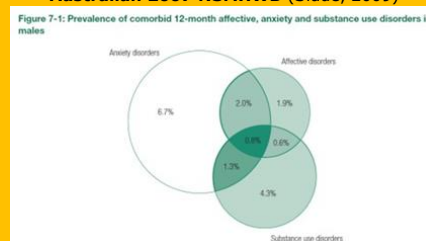
**The prevalence of psychotic symptoms among methamphetamine users**

Rebecca McKetin<sup>1</sup>, Jennifer McLaren<sup>1</sup>, Dan I. Lubman<sup>2</sup> & Leanne Hides<sup>2</sup>

**Prevalence of psychosis among methamphetamine users**  
**11 times > than general population**

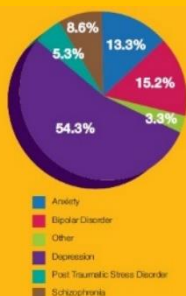
## General Population

Australian 2007 NSMHWB (Slade, 2009)



## AOD Residential Rehabilitation

(Odyssey House, 2015)



**2014-15: 46 % of clients** reported co-existing mental illness such as depression, anxiety, bipolar disorder, schizophrenia, PTSD or borderline personality disorder.

**2013-14: 57% of clients** had a dual diagnosis

## General Practice

(Hickie I, 2001)

**12% of GP attenders had comorbid mental health-substance use**

**Comorbidity of common mental disorders and alcohol or other substance misuse in Australian general practice.**

Hickie I, Andrews G, Stewart G, Heathcote J, South D, et al. Author information

**OBJECTIVE:** To determine in patients attending general practice: 1) the extent of comorbidity of mental disorders and alcohol or other substance misuse, and consequent disability, and 2) GP diagnosis and management of patients with comorbidity.

**DESIGN AND SETTING:** Cross-sectional national audit of general practice (throughout Australia) in 1995-1996.

**PARTICIPANTS:** 68 013 ambulatory care patients attending 388 GPs.

**KEY RESULTS:** A prevalence of common mental disorders (12 items from the 34-item GHQ-100) self-report questionnaire and associated identification system, prevalence of alcohol or other substance misuse (two self-report screening questions), 'episodic' misuse (a possible response to both questions) and 'stable' misuse (a possible response to one of the questions), disability (four items from the Brief Disability Questionnaire), and self-reported 'days out of work' and 'days in bed' in the last month, and rates of psychological diagnosis, medication use (other than GPs), and GP rating of patients' psychological risk.

**MAIN FINDINGS/CONCLUSIONS:** Comorbidity of mental disorders and alcohol or other substance misuse, disability, and comorbidity with GP diagnosis and management.

**KEYWORDS:** The screening questions revealed possible alcohol or other substance misuse in 11% of patients (511/4681), and possible misuse in an additional 3% of patients (208/4681). Comorbidity of mental disorders and substance misuse occurred in 17% (387/4681) of patients. Patients with comorbidity (compared with those with alcohol or other substance misuse alone) were more disabled (mean 'days out of work in the last month' 6.4 (SD) CI: 7.7-5.1) v 5.8 (SD) CI: 5.8-5.9), at greater psychological risk (as rated by GPs) v 22% v 7%, respectively, more frequently given psychological diagnosis by GPs v 12% v 5%, more frequently treated for psychological comorbidity by GPs v 4% v 1%, and more frequently referred to mental health specialists by GPs v 3% v 2%.

**CONCLUSIONS:** Comorbidity of mental disorders and alcohol or other substance misuse is common in patients attending general practice, and results in considerable disability. Four patients require an adequate attention diagnosis and management from GPs, GP identifying one of these four types of substance disorder in a patient should consider whether the other type is also present.

**Recommendation 3:**

That, given

- the prevalence of people with mental health concerns presenting to Victorian AOD services
- the numbers of people with mental concerns receiving services from Victorian AOD services

that the Royal Commission extends its purview and recommendations to include reforms in the AOD system towards more effective response to people with co-occurring mental health-substance use concerns.

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**Recommendation 4:**

That Australia's National Survey of Mental Health and Wellbeing be funded to occur at 5-yearly intervals.

*Page 22*



## 2. Harms associated with co-occurring mental health and substance use concerns



People with co-occurring mental health-substance use concerns, compared to people with only one of the concerns, are at a substantially greater risk of experiencing diverse harms and unwanted outcomes including:

- Increased treatment costs
- More frequent relapse
- More frequent hospitalisations
- Physical disorders
- Double stigma
- Blood-borne infections
- Compounded trauma & losses experienced by significant others
- Forensic involvement
- Housing difficulties / homelessness
- Poverty
- Suicide risk
- Unemployment and work instability
- Violence and exploitation

The harms and unwanted outcomes associated with co-occurring mental health-substance use disorders are reflected in:

- **Mainstream media**- recent, confronting, Victorian tragedies have involved people with ineffectively addressed co-occurring mental health-substance use concerns. Media reports of events involving people with co-occurring Amphetamine Use Disorders-Mental Health are daily fare. Much of the reporting of these issues contributes to stigma and impaired access to treatment (AOD Media Watch, 2019)
- **Coroners reports** (Coroners Court, 2017)
- **Emergency Department reports** (ACEM, 2019)
- **Forensic system reports** (Young J, 2018)

- **Housing and homelessness reports** (Flatau, 2013)
- **Physical Health reports**
- **General Practice reports**
- **Mental Health specific reports**
- **Substance treatment specific reports**

**Recommendation 5:**

That the Royal Commission recommend the funding of a Victorian study to identify principal harms and estimated costs, across healthcare and social services, associated with people experiencing co-occurring mental health-substance use concerns.

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### **3. Potentials for better outcomes**

In any one individual with co-occurring mental health and substance use concerns each concern influences the other in:

- their development,
- their severity,
- their response to treatment and
- their relapse circumstances.

Because each concern has such an influence on the other any response that only focuses on one of the concerns (the nominated 'target' of the treating worker or service) will tend to be less successful than a holistic response that identifies and works with the complexity of concerns that a person presents with. The corollary of this is that, if AOD-mental health clinicians, agencies and systems can build their capacity to recognise and respond effectively to co-occurring concerns they will be more successful in their treatment of 'target' concerns which will facilitate better outcomes for people affected by co-occurring mental health -substance use concerns.

### **Implications for the Royal Commission**

An implication of the:

- prevalence of people with co-occurring mental health and substance use concerns
- significant harms and poor outcomes associated with co-occurring mental health and substance use concerns and other complex needs

is that any mental health reform not designed around the expectation of dual diagnosis and complex needs will be less successful.

If the Royal Commission places people with co-occurring mental health and substance use concerns and other complex needs at the centre of their recommendations for systems reform they will be more effective in addressing the mental health needs of ALL Victorians.

#### **Recommendation 6:**

That the Royal Commission places people with co-occurring mental health and substance use concerns and other complex needs at the centre of their recommendations for systems reform

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### 3.

#### *Victoria's evolution thus far:*

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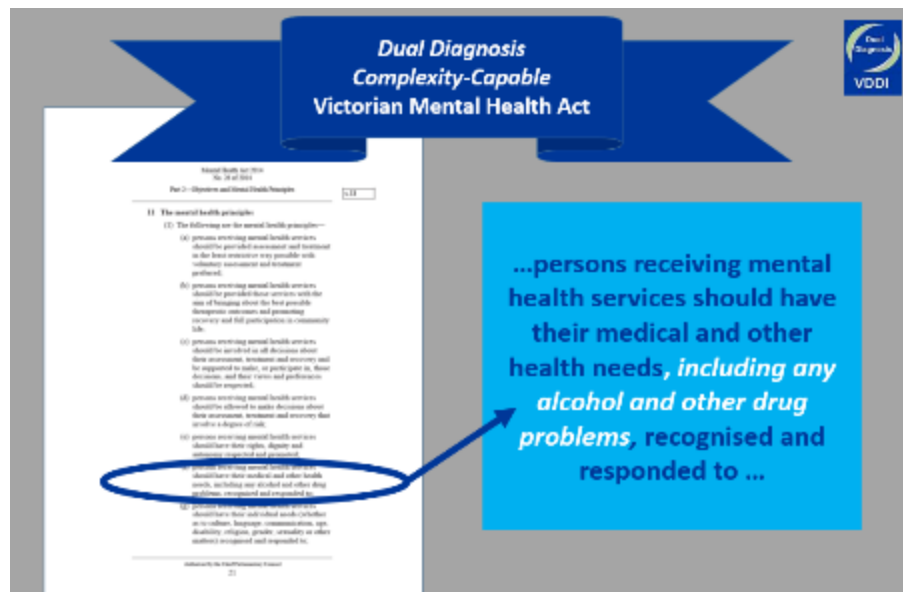
Of all Australian states Victoria has had the longest standing, most significant, investment in achieving better outcomes for people with co-occurring mental health-substance use concerns. Victoria has been in active in developing systemic 'dual diagnosis capability' since 1998. Discussed below are:

- Victoria's 2014 Mental Health Act
- Victorian Dual Diagnosis Policy
- The Victorian Dual Diagnosis Initiative
- Homeless Youth Dual Diagnosis Initiative
- Landmarks in Victoria's evolution towards systemic dual diagnosis capability
- Impacts of work to date.



## Victoria's 2014 Mental Health Act

Victoria's 2014 Mental Health Act is the only such act in Australia containing the principle that *...persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to*. While this is a systems-leading development the mental health workforce and mental health system experience a range of challenges in meeting the spirit and intent of this principle.



### Recommendation 7:

That the office of the Victorian Chief Psychiatrist be asked to write a Chief Psychiatrists Guideline around this Mental Health Act principle.

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### Recommendation 8:

That the Mental Health Branch in partnership with Drug Treatment creates a State Chief Addiction Psychiatrist position, whose role is to influence the dual diagnosis/complexity-capability of all Victorian psychiatrists and addiction medicine specialists employed in Victorian mental health-substance treatment services

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### Recommendation 9:

That the National Drug and Alcohol Research Centre be funded to develop *National Guidelines on the management of co-occurring mental health and alcohol and other drug and conditions in mental health treatment settings* that complement their 2016 *National Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*.

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## **Victorian Dual Diagnosis policy**

A watershed in Victoria's evolving responses was the 2007 cross-sector dual diagnosis policy ***Dual Diagnosis: Key Directions and Priorities for Service Development*** (DHS, 2007). The policy offered all stakeholders an evidence-informed vision of how the AOD and mental health treatment sectors will look, feel, behave and interact when providing effective responses to the various cohorts of people with dual diagnosis.

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

The policy's vision and strategies towards a No Wrong Door service system and its unambiguous statements that *'dual diagnosis is core business'* for mental health and AOD services furthered the policy's potential to influence the mental health and AOD sectors towards integrated service delivery.

The policy includes fine-grained, time-lined, Service Development Outcomes (KPI's) that service managers were obliged to report on. These include:

- Universal screening
- Tiered 'dual diagnosis capability' of workers
- Mental health and AOD services to establish partnerships and mechanisms to support integrated assessment and treatment
- Outcomes and service responsiveness for dual diagnosis clients to be monitored and regularly reviewed
- Consumer and carer involvement in the planning and evaluation of service responses.

In 2017 Borgermans and Devroey (Borgermans, 2017), reflecting on the pan-European EU Project INTEGRATE, observe that 'any policy on integrated care should be a tripartite of mission, vision and strategy towards the range of factors that influence the successful development of integrated care'. This submission argues that the 2007 Victorian dual diagnosis policy abundantly meets those criteria and is a landmark Australian example of central policy influencing the development of integrated care. The Victorian policy, of comparable Australian state-level policies, is the most robust and influential in its vision of and strategies towards integrated service delivery.

The Victorian dual diagnosis policy was successful for a number of years in positively influencing practice across three sectors. The evidence informed vision that it offered provided a clear central focus around which all Victorian stakeholders – AOD and mental health managers, workers, clinicians and VDDI workers were able to unite and coordinate their efforts around. Chapter 5 discusses the potential benefits of and an approach to renewing the policy for the current Victorian environment.

## The Victorian Dual Diagnosis Initiative (VDDI)

Created in 2002 the **Victorian Dual Diagnosis Initiative (VDDI)** is a cross-sector (Alcohol and Drug, Mental Health Community Support and Clinical Mental Health) initiative funded by the Victorian Department of Health, to assist mental health and drug and alcohol clinicians, agencies and sectors to develop their capacity to recognise and respond effectively to people with co-occurring mental health and substance use concerns.

The VDDI's structure includes four metropolitan agencies with links to VDDI workers embedded in each rural region. The VDDI is coordinated by the **VDDI Leadership Group (VDDILG)** and the **VDDI Rural Forum (VDDIRF)**. Metropolitan lead agencies are funded for a range of positions including psychiatrist and specialist youth workers and to provide supports to rural VDDI workers and their regions.



In December 2016 Victorian DHHS-Mental Health Branch (DHHS, 2016) defined the VDDI's role as:

Dual Diagnosis services aim to improve treatment outcomes for individuals who have co-existing mental health and substance use issues.

Services include:

- education and training for mental health, drug and alcohol and MHCSS staff,
- support to organisations to develop dual diagnosis capabilities, and
- clinical consultations in collaboration with primary case managers.

In December 2018 Victorian DHHS-Drug Treatment (DHHS, 2018) further defined the VDDI's role as:

#### **Purpose**

The VDDI supports the development of better treatment practices and collaborative relationships between AOD treatment and mental health services. The key activities of the VDDI are:

- the development of local networks
- training, consultation and modelling of good practice through direct clinical intervention and shared care arrangements.

#### **Target group**

Mental health and AOD treatment workers who require support to respond to clients with concurrent AOD and mental health issues, and people who are experiencing issues related to concurrent AOD and mental health issues.

#### **Key service requirements**

The initiative includes the following functions.

- Develop co-operative working relationships between mental health and AOD treatment services within the relevant area service catchment. This should particularly address areas of access, assessment and the development of effective treatment planning.
- Provide training and consultation to all community mental health and AOD treatment services within the catchment with a strong focus on building capacity within the services to respond more effectively to people with a dual diagnosis.
- Provide direct service to clients with a serious mental illness and substance use problems with a focus on developing and modelling good practice. This may be by providing a limited direct service and intensive support/consultation to case managers on specific cases.

The view of the author -a biased VDDI worker ☺ - is that the VDDI has proven to be a worthwhile investment in building systemic dual diagnosis capability. This view is supported by the 2004 (Roberts B. B., 2004) and 2011 (Australian Healthcare Associates, 2011) evaluations, discussed below.

The VDDI has a productive, innovative and resilient workforce notable for the passion and commitment of its workers. An interesting 'by-product' of the VDDI is the numbers of workers who, after working in the VDDI, have gone on to other roles in which they have continued to influence local and systemic dual diagnosis capability.

One of the VDDI's strengths has been its diffused, localised structures which have allowed the VDDI to develop in response to local needs and priorities. While that structure has significant advantages it has, in some respects, been a challenge that has



impacted on the direction of the initiative. Some regions have diverted their VDDI funding to other strategies and priorities.

While there have been some successes (VDDI-Nexus, 2012) the lead agencies have experienced geographical and logistical challenges in acquitting their responsibilities to support rural regions. The **VDDI-Rural Forum**, which with the support of VDDI-Nexus meets 3-monthly in Melbourne, has been an outstanding success in supporting the capacity-building work of isolated rural workers (DHHS, 2015). The VDDI-RF has been a template model for other healthcare initiatives attempting to support the work of isolated rural speciality workers.

The VDDI structure included a dedicated **VDDI-Education and Training Unit** in the period 2005-2015. The VDDI-ETU had significant achievements in coordinating and supporting VDDI work, in curriculum design and development, in influencing undergraduate course content and, with co-located VDDI-Nexus, in addressing dual diagnosis in particular populations. (VDDI-ETU, 2012) (VDDI-ETU, 2012b) (VDDI-Nexus, 2015)

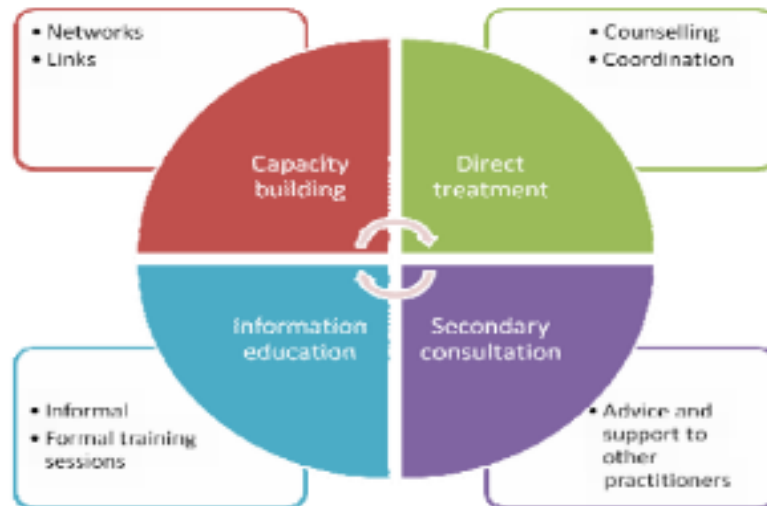
**Recommendation 10:**

1. That the VDDI be reviewed state-wide against its role descriptions
2. That the VDDI continue to receive ongoing funding
3. That consideration be given to broadening the VDDI's mandate to achieving better outcomes for people with '*dual diagnosis and other complex needs*'
4. That consideration be given to what strategies (role description / structure / accountability points) could further contribute to the VDDI's effectiveness?
5. That consideration be given to refunding a **VDDI Education and Training Unit** with a remit to influence the complexity-capability of AOD-MH workforce professional development, dedicated curriculum development and the content of a range of undergraduate healthcare courses
6. That funding be allocated to support the 3-monthly meetings of the **VDDI-Rural Forum**

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## **Homeless Youth Dual Diagnosis Initiative (HYDDI)**

HYDDI, funded through the National Partnership Agreement on Homelessness in partnership with Victorian DHS, is a dual diagnosis service response placed within the youth homelessness service sector of each DHS region - approximately 8 workers across the state. The role of a HYDDI clinician is to identify symptoms of mental illness and substance use issues, maximise recovery and assist to establish service linkages for young homeless people who are in receipt of homelessness assistance.



### **HYDDI Role Components /Functions**

HYDDI eligibility requirements are:

- an impacting substance use and mental health issue (no formal diagnosis required)
- a primary youth housing case manager
- an age of 16 to 25 years.

Regions with HYDDI workers have been positive about their impacts however the initiative has been impacted by annual funding uncertainties that have contributed to worker throughput and difficulties in filling positions.

#### **Recommendation 11:**

1. That there be an evaluation of the impacts of HYDDI initiative to date
2. That the HYDDI role description be updated
3. That HYDDI be extended to other Victorian regions
4. That strategies be devised to address annual funding tensions

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## Landmarks in Victoria's evolution towards systemic dual diagnosis capability

1886	<ul style="list-style-type: none"> <li>• <b>Victorian Royal Commission on Asylums for the Insane &amp; Inebriate</b>- The Zox Commission - <a href="#">Report here</a></li> </ul>
1998	<ul style="list-style-type: none"> <li>• McDermott and Pyett's <b>Not Welcome Anywhere</b> report</li> <li>• <b>SUMHNet: Substance Use Mental Health Network</b> formed. A state-wide coalition of health care providers, consumers and carers with an interest in dual diagnosis. SUMHNet was auspiced by VICSERV and met regularly till 2002.</li> <li>• <b>SUMITT: Substance Use Mental Illness Treatment Team</b> pilot service. A partnership of two central policy and planning bodies - the (then) Victorian Mental Health Branch and the Drugs Policy Branch - created the SUMITT pilot in the western regions of Melbourne and rural Victoria. Direct service and capacity building functions</li> <li>• <b>Eastern Hume Dual Diagnosis</b> cross-sector project commenced in NE Victoria</li> <li>• <b>Conference: Problematic Drug and Alcohol Use and Mental Illness</b> auspiced by Connexions at Melbourne University</li> </ul>
2001	<ul style="list-style-type: none"> <li>• <b>VDDI rural forum</b> formed (active &amp; ongoing)</li> </ul>
2002:	<ul style="list-style-type: none"> <li>• <b>Victorian Dual Diagnosis Initiative (VDDI):</b> Commenced. Current</li> <li>• <b>5 metro VDDI specialist youth dual diagnosis workers</b> positions instituted</li> </ul>
2003	<ul style="list-style-type: none"> <li>• 21 <b>Mobile Support &amp; Treatment Teams</b> dual diagnosis positions created</li> <li>• <b>Victorian Travelling Fellowship</b> – VDDI fellow undertook 6-week fellowship investigating integrated treatment responses in UK, USA and NZ with subsequent report</li> <li>• <b>Statewide Dual Diagnosis Initiative Evaluation</b></li> </ul>
2004	<ul style="list-style-type: none"> <li>• Creation of <b>Dual Diagnosis Australia &amp; New Zealand</b> – <a href="http://www.dualdiagnosis.org.au">www.dualdiagnosis.org.au</a> website</li> <li>• <b>Rotations project:</b> Funded mental health or AOD workers to undertake a 3-month rotation in the 'opposite' sector as core of a 12-month staff development and education process. Evaluation available.</li> </ul>
2005	<ul style="list-style-type: none"> <li>• <b>State-wide Dual Diagnosis Education &amp; Training Unit:</b> The VDDI E&amp;T Unit developed nationally recognised diploma level dual diagnosis competencies</li> </ul>
2006	<ul style="list-style-type: none"> <li>• <b>Strengthening psychiatrist support project:</b> Extra specialist MH-SU psychiatrist time for the four lead agencies</li> </ul>

	<ul style="list-style-type: none"> <li>• At State Government cabinet level, a dedicated <i>Ministerial position for Mental Health and Drugs</i> was created.</li> <li>• At the central policy and planning level, the former <i>Mental Health Branch</i> and the <i>Drugs Policy Branch</i> merged into the <i>Division of Mental Health and Drugs</i></li> <li>• <b>Policy:</b> Launch of the state-wide, cross-sector 'Dual Diagnosis: Key directions &amp; priorities for service development' policy <sup>7</sup>.</li> <li>• <b>VDDI Aboriginal Dual Diagnosis Project</b> Phase 1</li> </ul>
<b>2007</b>	<ul style="list-style-type: none"> <li>• Drs Minkoff &amp; Cline – CCISC - 1-day forum</li> <li>• <a href="#">Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol &amp; Other Drug and Mental Health Services</a></li> <li>• Daylesford VDDI conference</li> <li>• <b>ISI commences:</b> 27 Victorian NGO AOD agencies funded under ISI</li> <li>• 6 Victorian General Practice Divisions received 'Can Do' Grants Program Comorbidity Projects</li> </ul>
<b>2008</b>	<ul style="list-style-type: none"> <li>• VDDI Screening and Assessment Training for AOD workers trained &gt;500 AOD clinicians from &gt; 80 agencies across Victoria.</li> <li>• Gippsland VDDI conference</li> <li>• Suite of <b>Checklists of Dual Diagnosis Capability</b> – Agency &amp; Clinicians levels published</li> <li>• Creation of <a href="#">Dual Diagnosis Support Victoria</a> –web2 social networking site(currently c. 2,800 members)</li> </ul>
<b>2009</b>	<ul style="list-style-type: none"> <li>• Beechworth ISI / VDDI conference</li> <li>• <b>BUDDYS</b> – <i>Building Up Dual Diagnosis Youth Service</i> – VDDI/ ISI partnership addressing the issues around dual diagnosis in younger people and their families</li> <li>• <b>Evaluation:</b> of the Victorian Dual Diagnosis Platform</li> </ul>
<b>2010</b>	<ul style="list-style-type: none"> <li>• <b>HYDDI – Homeless Youth Dual Diagnosis Initiative</b> positions commenced around Victoria</li> <li>• Lorne VDDI/ISI conference</li> <li>• VDDI capability project</li> </ul>
<b>2011</b>	<ul style="list-style-type: none"> <li>• Werribee ISI/VDDI conference – Drs Minkoff &amp; Cline keynotes</li> <li>• <b>BUDDHAS</b> – <i>Building Up Dual Diagnosis Holistic Aged Services</i></li> </ul>
<b>2012</b>	<ul style="list-style-type: none"> <li>• Withdrawal Guidelines in Mental Health settings</li> </ul>
<b>2013</b>	

- Aboriginal Dual Diagnosis Supervision Suite of Resources
- 2014**
  - Victorian Mental Health Act (complexity content)
  - VDDI ETU sunset
- 2015**
  - Older Persons Dual Diagnosis manual
  - Youth Dual Diagnosis Manual
- 2016**
  - VDDI Conference
  - Reasons for Use Package
- 2017**
  - NEXUS videos
  - Before During After Harm Reduction Tool (BDA)
- 2018**
  - Dual Diagnosis Residential Rehabilitations
- 2019**
  - VDDI form – Peering into the future

## *Impacts of work to date*

There have been two relevant Victorian evaluations:

- **2004 - Statewide Dual Diagnosis Initiative Evaluation** conducted by Turning Point (Roberts B. B., 2004)
- **2011 - Evaluation of the Victorian Dual Diagnosis Initiative** (Australian Healthcare Associates, 2011)

Both evaluations are available [by request](#)

Also relevant is a subsequent 2014 thesis: **Dual diagnosis discourse and narratives in the State of Victoria 1985-2012** (Roberts B. , 2014)



### **Broader implications**

Finding common ground across the specialist MH and AOD sectors and combatting the marginalisation of people with a dual diagnosis has been an ongoing challenge as social stigma and the social and structural determinants of ill-health have endured. Progress has been slow. This case study concludes, however, with a note of hope that the learning from ongoing dual diagnosis discourse will help to resolve wider systemic questions as well as those specific to dual diagnosis. An overarching finding from my research is that a focus on dual diagnosis has been a (limited) step towards a larger goal, namely a better quality, more effective response to complex, multiple needs, moving beyond dual diagnosis, as one clinician put it, to 'health'. Dual diagnosis discourse includes key contemporary issues in health care delivery:

individualised and comprehensive care, workforce planning and development, sustainability and quality assurance. In particular my work recommends that better interprofessional and intersectoral practices are critical factors in the wider public health vision of person-centred care. This thesis also clearly highlights that success in these realms entails cultural change: longstanding beliefs, practices and hierarchies may be threatened; organisations and professions may not survive in their current form. The initiatives undertaken in Victoria to improve dual diagnosis capability have demonstrated the effectiveness of champions and catalysts working at the service level to provide education, training, mentoring and supervision, supported by top-down policy direction. The reported unevenness of success, on the other hand, underlines the inadequacy of funding in relation to the magnitude of the task, and the need for funding models to stimulate linkages and shared care.

Finally, the overall intention of this thesis was to provide a detailed analysis of the development of dual diagnosis discourse in the context of a particular time and place, its implications for service providers within those sectors, for policy makers in government and potentially its meaning for consumers and for other sectors. By studying, in context, the operation of a medical construct, I have highlighted two things. First, that challenging the single-diagnosis approach is a step towards and can give impetus to health and social care that sees and respects the whole person. Secondly, the path towards such a perspective continues to be limited by stigma and cultural barriers. Together these findings contribute a fresh perspective to dual diagnosis discourse. The thesis contributes to the body of qualitative research on the history and course of efforts to develop appropriate treatment and care for people experiencing difficulties with their mental health and their use of alcohol and other drugs. In doing so, the thesis also illuminates the development and implications of a medical construct over time in a particular context, adding to arguments for quality improvement, interdisciplinary, intersectoral workforce development in an integrated, adequately funded health and social support system.

**Excerpt: Dual diagnosis discourse and narratives in the State of Victoria 1985-2012.**  
(Roberts B. , 2014)

There have been significant broad gains in the AOD and mental health service system's capacity to recognise when people have co-occurring mental health-substance use concerns. Most mental health and AOD workers now have a nuanced understanding of the impacts and interplays of co-occurring mental health-substance use concerns.

There have been outstanding examples of workers and service systems being innovative, creative and effective in delivering integrated treatment. Those examples tend to be the exception rather than routine practice, especially in highly-pressured, under-funded, Clinical Mental Health environments (VAGO, 2019). Clinical Mental Health services tend to have advanced skills and practice in particular aspects of integrated treatment (for instance responding to iatrogenic withdrawal in inpatient units) but there are ongoing tensions, in many sites, in regard to responding to people with dual diagnosis as core business, integrated assessment, cross-sector treatment pathways and the routine provision of integrated, 1-stop-shop treatment.

Substance treatment workers have been active in developing their practice to be able to respond effectively to people with co-occurring high-prevalence disorders, trauma and personality issues. Tensions in the AOD sector are principally around timely access and responding to people with long-term needs, acute suicidality and risk.

The 2007 Victorian dual diagnosis policy had significant impact upon service delivery for several years, but its influence has now waned with the impacts of reforms, workforce changes and workloads in both mental health and AOD service systems. There were significant broad developments towards an actual No Wrong Door service system in the wake of the 2017 policy. These developments were eroded by the evolution of a commissioning, competitive tendering, for-profit, environment.

The advent of the NDIS has meant a significant loss of the MHCSS sectors capacity to rapidly, flexibly respond to people with risk associated with Serious Mental Illness-Substance Use.

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## 4.

### *Challenges:*

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Responding to the issues around dual diagnosis and other complex needs is a complex (wicked) problem with a plethora of challenges. Discussed in this section are some of our most pressing, current challenges:

- Dual Cumulative Stigma
- Access to services
- National Disability Insurance Scheme
- Systemic responsibility
- Reforms- Potential Pitfalls
- Systemic self-efficacy

#### *Dual Cumulative Stigma*

The impacts of mental health disorder stigma are well known and there has been some progress in addressing mental health stigma and discrimination. Less generally recognised and barely addressed is the stigma experienced by people with substance use disorders. Experiencing a substance use disorder remains heavily conflated with and impacted by myths around moral weakness. There is now a body of literature that identifies some of the ways in which the stigma associated with substance use disorders impacts negatively on outcomes including:

- **Accessing treatment:** people are reluctant to disclose stigmatised disorders and hence have compromised access to treatment. (Cumming, 2016) This issue is compounded in rural regions where there are fewer providers, less choice in provider and greater risk of a person being visible with substance use-mental health concerns.
- **Stigma from health care providers:** people with substance use concerns may be excluded from or receive less than optimal treatment because of health care provider's perception that they are less deserving, that they have inflicted the health care need on themselves (NCETA, 2006) . A 2013 review (van Boekel, 2013) of 28 studies of health professionals' attitudes and behaviours to people with substance use disorders found:
  - negative attitudes to service users.
  - less engaged and have diminished empathy
  - patients feel disempowered and tend to have poorer treatment outcomes
  - professionals lack education, training and support to enable them to work effectively with this group of health treatment consumers
- **Stigma from health care planners:** similar to provider's stigma, people with substance use concerns may not have needed services funded or available to them because of planning/funding bodies perception that they are less deserving- *'there are no votes in drug and alcohol'*.
- **Self-stigma:** people experiencing substance use concerns tend to have the same beliefs as the broader community and hence tend to internalise social stigma, have very negative self-esteem and this is often a significant barrier to effective treatment

- **Social exclusion** as a result of stigma is a barrier to re-integration

Australia's National Drug Strategy 2010-2015 (MCDA, 2011) aspired to '*develop a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards drug dependence, help seeking and the related problems of the individual*'. There appears to have been no progress against this strategy. In fact, many of the responses to the issues around methamphetamine appear to have exacerbated stigma.

The families of people with substance use concerns experience 'courtesy stigma' often with parallel experiences and feelings to the person with the substance use disorder, feelings of failure and guilt and inhibitions re accessing supports.

**Dual stigma:** People with co-occurring mental health and substance use concerns experience compounded dual stigma consequent on having two, heavily stigmatised concerns. This double-stigma has compounded effects in regard to access to, quality and effectiveness of treatment and support and recovery from mental health-substance use concerns. Families and significant others, of people with co-occurring mental health-substance use concerns experience parallel, compounded, dual 'courtesy dual stigma' which impact negatively on their lives and their capacities to support the person with the concerns.

There is now a substantial evidence base to guide systems wishing to address the stigma associated with substance use concerns (Global Commission on Drug Policy, 2017) (National Academies of Sciences, 2016) . There is potential, in addressing substance use stigma, to improve outcomes for people with co-occurring mental health and substance use concerns.

**Recommendation 12:**

1. That a range of strategies be funded to address
  - the stigma associate with substance use disorders per se
  - the impacts of dual stigma
2. That these strategies include strategies targeting the beliefs and attitudes of a range of relevant healthcare providers
3. That policy and resources be devoted to addressing how welcoming mental health and AOD services are – including physical layout, induction priorities and requirements and clinician and in developing worker competencies in creating a welcoming, collaborative, safe engagement with people

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## Access



The seminal **Not Welcome Anywhere** report (McDermott, 1993) was the first Victorian report to highlight that people with co-occurring mental health–substance use concerns (serious mental illness cohort) frequently fall through the gaps in our service systems, tending to

- a) access many services
- b) with usually the only service they receive being referral onto another service.

Since then the dual diagnosis literature has frequently identified the concern that a person with dual diagnosis, on presenting to a mental health service, will be advised to resolve their substance use before they can be considered for mental health treatment and then receive mirror advice from an assessing AOD service – the person falling through the gaps, receiving no service from either agency. Variations of this scenario still occur in Victoria in 2019.

The goal of a No Wrong Door service system developed from recognition that people with mental health-substance use concerns frequently fall through the gaps. A No Wrong Door service system is one in which *'when clients appear at a facility that is not qualified to provide some type of needed service, those clients should carefully be guided to appropriate, cooperating facilities, with follow-up by staff to ensure that clients receive proper care* (SAMHSA, 2005).

No wrong door refers to *'formal recognition by a service system that individuals with co-occurring disorders may enter a range of community service sites; that they are a high priority for engagement in treatment; and that proactive efforts are necessary to welcome them into treatment and prevent them from falling through the cracks'* (SAMHSA, 2005). While there was significant Victorian progress towards a No Wrong Door service system in the wake of the 2007 Victorian dual diagnosis policy most of these gains have now been eroded by the impacts of subsequent system reforms.

A current trend across behavioural health care, perhaps in response to limited resources, increasing demand and increasingly complex presentations is for services and systems to proclaim increasingly narrow, limited, service entry criteria with complex pathways to service. Essentially, we will only provide services to you if you meet our criteria; the



person and their needs has to fit the system rather than the systems flexibly responding to the kaleidoscopic variety of possible presenting needs. These models, while they may have surface appeal to funding bodies, are neither effective nor efficient and they influence sectors, agencies and workers to be increasingly rigid, increasingly unwelcoming and increasingly defensive around scarce resources.

This model is typically built around a central infrastructure to determine client eligibility- an infrastructure that is costly, often divorced from local contexts and possibilities, that add to systemic complexity and that creates difficult to navigate, pathways to services. The most dispossessed people, the people in most urgent need of services are generally the people least equipped to navigate these pathways to service. Too often these will be the people with co-occurring mental health-substance use and other complex needs.

**Recommendation 13:**

That Victoria again consider the goal of a No Wrong Door service system and develops a coherent web of strategies and incentives to achieve against that goal.

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**Recommendation 14:**

That there is consideration given to the adoption of Single Session Therapy models in some components of the Victorian mental health and substance treatment systems.

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## National Disability Insurance Scheme (NDIS)



There is now a body of literature (Smith-Merry, 2018) critiquing the effectiveness of the NDIS for people with mental health disability. To date few of these critiques have considered the challenges experienced by people with mental health disability co-occurring with substance use concerns. This is concerning given what we know about the prevalence of and harms associated with co-occurring substance use issues amongst people experiencing mental health disability.

Most of the well-documented concerns around NDIS with people with mental health disability per se are compounded when the person involved ALSO has a substance use issue. It is anecdotal evidence only but there are consistent reports of mental health workers who, in working with a person towards an NDIS application, coach the person to avoid disclosing their issues with substances to the assessing NDIS worker. Practice wisdom now is that having a co-occurring substance use issue will act as an exclusion criterion for an NDIS application. Again, this is difficult to reconcile with the known prevalence of substance use issues in people with mental health disability.

Concerns with the NDIS, from a mental health-substance use and other complex needs perspective, include:

1. **Costs and inefficiencies:** the NDIS model is predicated on a central assessing agency that determines eligibility and develops plans. There are considerable infrastructure and bureaucracy costs inherent in this model – funds that could otherwise be spent in direct service provision. Bureaucracies grow and swallow resources- we risk duplicating inefficient USA healthcare models where a sizeable proportion of each healthcare dollar is swallowed in processes and negotiations around service eligibility- especially so when that person has complex co-occurring needs that transcend traditional service system boundaries.
2. **Misaligned eligibility criteria:** people applying to the NDIS are required to prove enduring disability – this is at odds with the strengths-based, recovery focus and hopes of both mental health and AOD service provision.

3. **Access:** Note reports of mental health workers coaching clients applying to the NDIS to avoid disclosing substance use issues. There is established poor uptake of the NDIS and reluctance of eligible people with mental health disability to apply (Malbon, 2019). It is likely that eligible people with co-occurring substance use issues are even more reluctant to apply. People with severe co-occurring mental health-substance use concerns need easily-accessible, welcoming, timely, responsive services – the NDIS, which requires participants to have the skills, stability, persistence and capabilities to successfully navigate daunting, slow, cumbersome entry processes is the antithesis of this.
4. **Reliability and utility of NDIS assessments:** There have been many concerns expressed about how well equipped NDIS assessors are to assess mental health concerns and to develop a useful plan. It must be asked, given known comorbidity prevalence data, how well equipped and oriented are the NDIS assessors to non-judgementally assess and develop useful planning around co-occurring, stigmatised, substance use issues?
5. **Flexibility and responsiveness:** the NDIS model is built on an assessment at a static point in time in order to generate a plan for the next 12-months. People with mental health disability experience fluctuation in their circumstances and needs over the course of a year- amplified if they have a co-occurring substance use concern. It is difficult to see how even a very skilled, qualified assessor, can develop a plan that remains useful for a year for a person with complex, fluctuating needs.
6. **Inequity:** A recent paper (Malbon, 2019) reviewed the direct evidence that different groups benefit disproportionately from the NDIS. Their review revealed that vulnerable groups are less likely to receive supports than other NDIS participants with similar needs – quoting Mavromaras et al (Mavromaras K, 2018) :

*“Those more vulnerable to poorer outcomes included participants with intellectual disability and/or complex needs; from CALD communities; those experiencing mental health, substance use, or forensic issues; and older carers who were socially isolated and had their own health issues. These vulnerable groups were considered to receive less funded supports in their NDIS plans than others with similar support needs and to struggle with NDIS processes.”*

Presumably people with a number of these vulnerabilities, such as co-occurring mental health-substance use needs, are likely to be at even greater risk of poorer outcomes. They are less likely to apply to the NDIS; if they do apply, they are less likely to be successful and, if successful, are likely to receive less supports.

7. **‘Market’ failures:** the benefit of the NDIS scheme is that participants have choice and control (Malbon, 2019) over the services they receive and are able to make changes if they receive inadequate services. Rural participants often have little or no choice in providers or no available providers at all. Malbon et al note a further, related concern that some providers, wary of the costs involved, are choosing to decline to provide services to people with the most complex needs. Warr et al (Warr D, 2017) quoted in Malbon:

*“People talk about us having choice and control but ... They’ve got individual workers saying, ‘No, I don’t like that client, that client’s got behavioural problems, I’m not working with them’. So they’ve got individual workers that are now picking and choosing their clients. So you’ve got clients with the most complex needs ... they can’t find support workers ...”*

## 8. **Loss of MHCSS services to people with the most complex needs**

Before the advent of NDIS Victoria boasted a world-class Mental Health Community Support System (MHCSS) that was able to rapidly, flexibly initiate often life-saving, services to substantially disenfranchised, disempowered people with complex mental health-substance use problems. MHCSS workers were particularly skilled in and committed to engaging with people who had lost other supports, who may have been averse to engaging with clinical mental health services and who were at imminent risk of adverse outcomes. Often the MHCSS worker's patient involvement would lead to the person eventually being willing to engage with other services.

Since NDIS initiation MHCSS capacity to flexibly initiate services has been lost- people with the most complex needs are unlikely to instigate an NDIS application and, if they did and they were successful, the process would be too slow to be useful. This loss has been exacerbated by:

- *'organisations with expertise in psychosocial disability are collapsing, merging and selecting not to engage with the NDIS due to an inability to provide effective services within the NDIA costing structure'*
- *'Organisations are losing staff with expertise in psychosocial disability because the level of funding provided by the NDIA for instances of care does not match the cost of employing trained staff or providing training and supervision to new staff'* (Smith-Merry, 2018)

In recognition of this issue, in September 2018 the Victorian Government allocated \$70 million to Victoria's community mental health sector (Victorian Govt., 2018) so that 'people with a mental illness don't fall through the cracks'. This is a welcome initiative however a condition of entry into this service model is that the person is already case managed by Clinical Mental Health services. This condition may exclude some people with particularly complex needs.

Can recognition of how inequitable and inefficient the vessel is be enough to turn the NDIS-mental health ship around? In April 2017, Professor Patrick McGorry, Exec Director of Orygen, Professor of Youth Mental Health at The University of Melbourne, Director of the Board of the National Youth Mental Health Foundation (headspace), and Chair of the Royal Commission's Advisory Group called for mental health to be removed from the NDIS (AMA, 2017) identifying the mismatch of the NDIS disability model with the realities of mental illness.

This submission argues that all current concerns about the NDIS for people with mental health disability are *amplified* when one considers the co-occurring substance use and other complex needs that are the *expectation not the exception* in people with mental health disability. We urge the Royal Commission to include in its recommendations that mental health disability be removed from the NDIS.

**Recommendation 15:**

That the Royal Commission investigate:

- The capacities and qualifications of NDIS assessors to non-judgementally assess and develop useful plans for people with co-occurring mental health disability-substance use issues
- Numbers of people with a co-occurring mental health disability- substance use issue who have made successful applications to the NDIS
- Nature and size of the funding received by people with co-occurring mental health disability-substance use issue who have made successful applications to the NDIS compared to the nature and size of the funding received by people with mental health disability alone.
- Whether the presence of a co-occurring substance use issue has served as an effective exclusion criterion for people with mental health disability applying to the NDIS

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**Recommendation 16:**

That Victorian DHHS relax entry criteria into the new MHCSS model so that MHCSS services can flexibly initiate services with people with severe mental health concerns who do not wish to engage with clinical mental health services.

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**Recommendation 17:**

That the Royal Commission include in its recommendations that mental health disability be removed from the NDIS

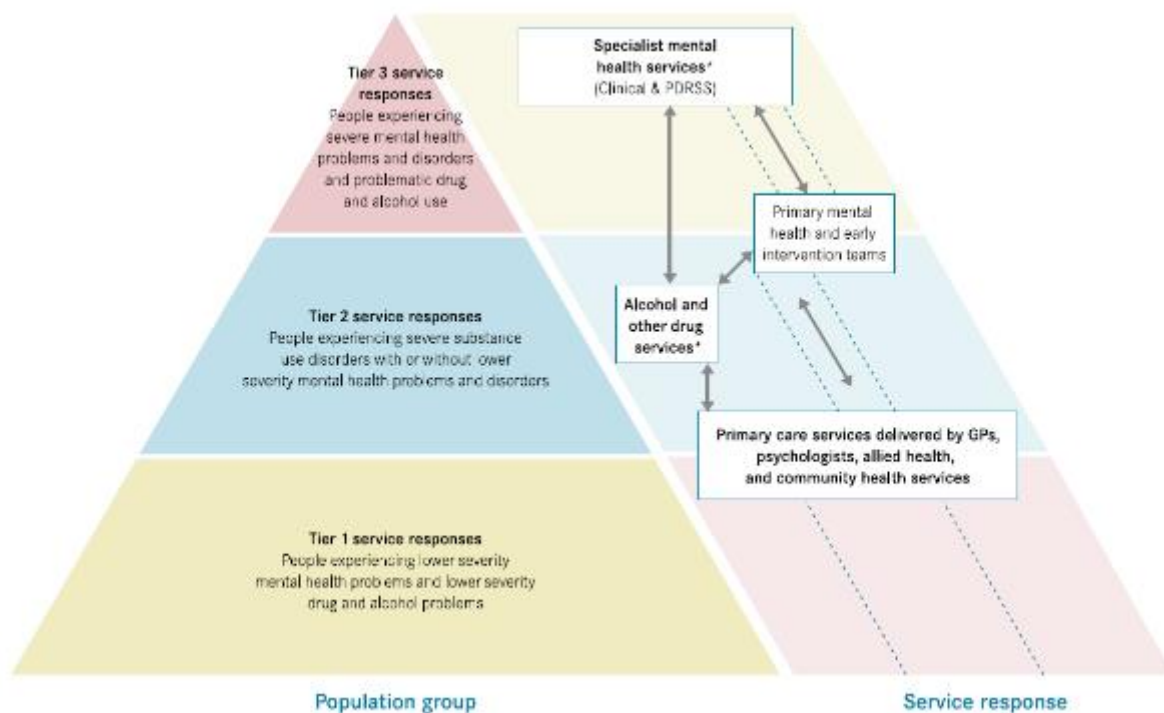
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## Systemic responsibility

At a national level, over the past 15 years, the Commonwealth has tended to conceptualise co-occurring mental health-substance use needs as primarily the responsibility of the specialist AOD sector. Most Commonwealth 'comorbidity' initiatives have been targeted at the AOD sector per se. While initiatives such as the Improved Services Initiative (National Improved Services Initiative Forum, 2010) and the National Comorbidity Guidelines (Marel, 2016) have been extremely valuable the Commonwealth's lack of action in also recognising and addressing comorbidity in other sectors is a missed opportunity.

The reality is that people with co-occurring mental health-substance use issues are highly prevalent in each of AOD, mental health and primary care - albeit different predominant cohorts in each sector. In Australia mental health services are approximately five times the size of AOD services. One implication of this, leaving aside questions of effectiveness, is that mental health services treat more people with substance use issues than does the AOD sector. At the same time General Practice services treat more people for either mental health or substance use issues than do either specialist mental health or specialist AOD services- 12.4% of all GP encounters in 2015-16 were mental health-related (AIHW, 2019).

Victoria has a strong record of conceptualising the issues around people with co-occurring mental health-substance use needs as cross-sector issues, of recognising that people with co-occurring mental health-substance use needs are prevalent in each of specialist mental health, specialist AOD and in primary care settings. This recognition led to the cross-sector approach of the 2007 Victorian dual diagnosis policy (DHS, 2007) and that policy's inclusion of this three-level schema for responding to dual diagnosis.



**Three level schema for responding to dual diagnosis (DHS, 2007)**

It is critical that future Victorian strategies towards better outcomes for people with co-occurring mental health-substance use continue to be designed around a strong recognition of the prevalence of people with mental health-substance use and other complex needs in each of specialist mental health, substance treatment and Primary Care sectors.

**Recommendation 18:**

That future Victorian strategies to address the needs of people with co-occurring mental health-substance use issues are designed around a robust recognition of the diversity of cohorts and the diversity of their treatment needs and preferences.

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## Reforms- Potential Pitfalls

All reforms have potential for harm or unintended consequences. Dual diagnosis is best conceived of as a wicked problem that can be addressed but will not be solved by simplistic solutions. Discussed in this section are five potential pitfalls in designing strategies towards improved outcomes for people with co-occurring mental health-substance use issues

1. Subsuming AOD services into Mental Health
2. Co-location as a panacea
3. Conflation of integrated treatment with integrated services
4. Dual diagnosis specific initiatives
5. Stand-alone workforce strategies

### 1. Subsuming AOD services into Mental Health

Subsuming AOD services into the mental health system has not infrequently been mooted as a solution to the challenges around providing integrated treatment. While this solution has some surface appeal it does not adequately recognise the different predominant cohorts in mental health and AOD services or that, for good reasons, AOD and mental health services operate from different treatment philosophies.

The different cohorts in each sector have different treatment needs and preferences – were we to subsume AOD under mental health the most likely outcome is that the people who now engage with AOD services would fall through the gaps and receive no treatment.

Notwithstanding the above caution there is certainly a strong case for, on an enduring basis, merging mental health and AOD at a policy and planning, DHHS level.

#### **Recommendation 19:**

- That Victorian healthcare planners continue to develop a range of well-connected treatment options around the treatment needs and preferences of the different cohorts of people with co-occurring mental health-substance use concerns.

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#### **Recommendation 20:**

- That Victorian AOD services are not subsumed under mental health services

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#### **Recommendation 21:**

- That mental health and AOD are enduringly braided together at a central policy and planning, DHHS level.

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## 2. Co-location as a panacea

Co-location of mental health and AOD services has been frequently proposed as a strategy to build working relationships and navigable treatment pathways between the sectors. Our experience is that, while it *may* help, it is by no means a panacea. It is possible for AOD and mental health services to have strained relationships whilst all working under one roof. A more sophisticated, iterative web of strategies is necessary to develop and to maintain navigable treatment pathways and cross-sector understanding and collaboration.

## 3. Conflation of integrated treatment with integrated programs, integrated services and integrated systems

Not infrequently there is unhelpful conflation in the dual diagnosis literature between integrated treatment, integrated programs, integrated services and integrated systems. This conflation, at times, has impacted on the clarity and direction of change initiatives.

**Integrated Treatment** - the Victorian dual diagnosis policy's (DHS, 2007) definition of integrated treatment is useful here:

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

Relevant to this definition's second, multi-sector, option for achieving integrated treatment is the Centre for Substance Abuse Treatment advice (CSAT, 2007) that the threshold for 'integration' relative to 'collaboration' is shared responsibility for the development and implementation of a treatment plan.

**Integrated Programs** 'are implemented within an entire provider agency or institution to enable clinicians to provide integrated treatment' (CSAT, 2006). An example could be a community mental health agency whose staff includes a portfolio holder with AOD expertise who provides consultation and support to her/his colleague in delivering integrated treatment with an individual client.

**Services Integration** refers to 'any process by which mental health and substance use services are appropriately integrated or combined at either the level of direct contact with the individual client with co-occurring disorders or between providers or programs serving these individuals. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients.' (CSAT, 2007)

**Systems Integration** describes the 'process by which individual systems or collaborating systems organize themselves to implement services integration to clients with co-occurring disorders and their families.' (CSAT, 2007)

#### 4. Dual diagnosis specific initiatives

Systems working towards better outcomes for people with mental health-substance use can be tempted to create special, dual diagnosis-specific treatment programs. There may be benefits in this approach for the relatively small numbers of people who will receive services from these specialist programs and potential best practice learnings. At the same time good practice does not spread osmotically; a range of strategies are necessary for the learnings from demonstration projects to influence a whole system's service delivery.

Other concerns with the creation of special, dual diagnosis-specific, treatment programs include that:

- They fail to recognise the prevalence of people with mental health-substance use in mental health and substance treatment settings. Specialist services can only respond to a fraction of the numbers of people with co-occurring mental health-substance use concerns.
- They add to system complexity and navigation challenges. Rather than develop a third treatment system it makes more sense to develop the capacities of our current mental health and AOD systems to respond effectively to people with co-occurring mental health-substance use concerns. Assuming we had the resources, will and time to develop a third treatment system, that was effective with all the various cohorts of people with dual diagnosis, what would our existing mental health and AOD systems do when they had lost most of their current clients?
- They send a message to the mental health and AOD workforces that, rather than being core business for both workforces, responding to people with co-occurring mental health-substance use concerns is only the domain of specialists.
- They tend to focus a system's conceptualisation of co-occurring disorders on only one cohort – generally the Seriously Mentally Ill-Severe Substance Use cohort – with a diminution of the systems recognition of the need to develop a variety of treatment options to meet the differing treatment needs of the different cohorts
- Potentially stigmatising – people receiving treatment from specialist dual diagnosis services may experience compounded dual stigma

#### **Recommendation 22:**

That central policy and planning bodies be cautious about developing dual diagnosis-specific treatment options

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## 5. 'Stand-alone' workforce strategies

A common response to an identified or emerging service gap is to commission training for the workforce/s involved. If this is a stand-alone strategy the impacts on service delivery are almost inevitably disappointing. It is more effective, before training is initiated, to consider:

- What is the current workforce morale level? What is the predominant workplace culture? Is the workforce feeling sufficiently secure, confident and supported to be able to contemplate and embrace changed practice? Are the demands of the workplace at a sufficiently manageable level to allow workers the space and safety to develop their practice?
- Is there a central agreed vision, and strategies to achieve that vision, that the workforce can align its efforts around? Does the workforce feel involved in the development of that vision or do they feel that it is being imposed from above without their input or expertise?
- How well understood and supported is the desired change by all levels of clinical and opinion leaders?
- What strategies can be deployed to build recognition of the need for, understanding of and enthusiasm for the desired change?
- How well aligned are existing procedures (e.g. Clinical Review / Clinical Supervision) and tools (e.g. screening and assessment documentation) with the desired change? What can be done to better align them with the desired changes well in advance of training?

Training per se tends to evaporate unless supported by a range of complementary strategies.

- What pre-training 'supplements' can be designed in to maximise the learnings from the training? These may include activities such as pre-reading, quizzes, competency assessments that can be implemented before the training.
- What post-training 'supplements' can be designed in to work in and continue to develop the learnings from the training? These may include aligned mentoring, Clinical Supervision, journal clubs, brief refreshers, portfolio holders, interest groups.

## **Systemic self-efficacy**

People with practice development responsibilities- whether at agency, service or whole of system levels- face invidious challenges. Many of the competing problems and priorities they contend with are wicked in nature. The stakes are high and definitions of the challenges, priorities and solutions are contested territory. Changes can be slow, difficult to effect and the methods and success indicators may be disputed. Practice developments may not be sustained. In this context people with development responsibilities can begin to lose 'systemic self-efficacy' – their sense that it is possible to successfully, usefully, influence complex healthcare provider behaviours and client outcomes.

Change *is* possible, healthcare systems *are* often effective with people with complex needs and there are outstanding instances of systems that have evolved to assist workers to facilitate this. It is critical that people with change agent responsibilities celebrate existing achievements whilst contributing to the further development of an ambitious vision of a complexity-capable service system that helps all people interacting with it lead their unique vision of a happier life.

### **Recommendation 23:**

That a range of mechanisms and incentives be devised to 'celebrate' and promote successes in developing complexity-capability – at clinician, agency and systems levels.

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## 5.

### *Ways forward*

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Victoria has a strong record of action towards a dual diagnosis capable service system and continues to develop and deploy strategies towards that end. The recent Victorian Mental Health Services Annual Report 2017–18 (DHHS, 2018) proposed, as Action area 4, '*Improving effectiveness of responses to clients with co-existing AOD and mental health issues*'. This final chapter explores some of the possible strategies towards that goal.

**Action area 4**  
Improving effectiveness of responses to clients with co-existing AOD and mental health issues

- ▶ Support for mental health services to more effectively manage consumers' co-existing AOD problems
- ▶ Support for AOD services to respond to their clients' mental health needs
- ▶ Enhanced dual diagnosis services

**Excerpt: Victorian Mental Health Services Annual Report 2017–18** (DHHS, 2018)

## **Policy renewal**

As discussed throughout this submission the cross-sector 2007 Victorian dual diagnosis policy (DHS, 2007) was extraordinarily successful for a number of years in influencing practice across three sectors. While some of the changes it led to have now been eroded the policy continues to exert an influence today with its coherent, fine-grained, aspirational vision of how the three sectors will look, behave and interact when providing effective treatment to the various cohorts of people with dual diagnosis.

There is much to be gained in updating and promoting the policy for the current environment. Elements which should be considered and built on from the 2007 policy include:

- Cornerstone elements of best practice including:
  - Vision of a No Wrong Door service system
  - Core business mandate
  - Concept of developing worker 'dual diagnosis capability'
  - Routine Screening
  - Integrated assessment and treatment planning
  - Operationally useful definition of Integrated Treatment
  - Attention to cross sector treatment pathways and partnerships
  - Involvement of people with Lived Experience in training and systems development
  - Developed around recognition of the different cohorts of people with dual diagnosis
  - Routine data collection and reporting
- Time-lined KPIs with reporting requirements
- Cross-sector focus

An update of the policy has potential to harness existing learnings from Victoria's journey thus far and broaden the goal to that of a Complexity Capable Service System.

### **Recommendation 24:**

- That the 2007 cross-sector dual diagnosis policy is revised and renewed.
- That a codesign process informs this review.
- That the focus of the renewed policy is better outcomes for people with co-occurring mental health and substance use and other complex needs.

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## **Comprehensive Continuous System of Care (CCISC) model**

Drs Ken Minkoff and Christie Cline's **Comprehensive Continuous System of Care (CCISC)** model has been and is influential in the USA, Canada and Australia. Drs Minkoff and Cline have visited and worked in Victoria on multiple occasions and their work and model has had a substantial influence on Victorian developments to date. CCISC offers a coherent, step-wise, vision-driven, continuous quality improvement approach to develop a complexity capable service system. The following table profiles the CCISC model.



### **An Evidence-based Approach for Transforming Behavioural Health Systems by Building a Systemic, Customer-oriented, Quality Management Culture and Process**

From: <http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc/>

The **Comprehensive Continuous Integrated System of Care (CCISC)** model has been developed over the last 15 years by ZiaPartners. It is an evidence-based model (Minkoff & Cline, 2004, 2005) that has been identified by SAMHSA as a “best practice” for system design, and has been used in dozens of local, regional, state or provincial systems of care internationally, including over 35 states in the U.S., 5 Canadian provinces, and several states in Australia. CCISC is designed to create a framework for systems to engage in this type of vision-driven transformation. It is built on the framework of the IOM Quality Chasm series, which has recommended the need for a customer-oriented quality improvement approach to inform all of health and behavioural health care.

#### **Key Elements (CCISC)**

1. The system must be built to fulfil the biggest possible vision of meeting the needs and hopes of its customers: both the individuals and families who are seeking help, and the system partners (e.g., criminal justice, child welfare, juvenile justice, homeless services, public health, etc.) that share the responsibility to respond. The emphasis always begins with those individuals and families who the system is currently not well designed to serve (people with co-occurring issues, people with cultural diversity, people in complex crisis, etc.)
2. The whole system must be organized into a horizontal and vertical continuous quality improvement partnership, in which all programs are responsible for their own data-driven quality improvement activities targeting the common vision that all programs become person/family-centered, recovery/resiliency-oriented, trauma-informed, complexity capable (that is, organized to routinely integrate services for individuals and families with multiple complex issues and conditions), and culturally/linguistically competent. In addition, all the major processes and subsystems (e.g., crisis response) must be reworked within this quality improvement partnership to be better matched to what people need.
3. The whole process is designed to implement a wide array of best practices and interventions into all the core processes of the system at an adequate level of detail to ensure fidelity and achieve associated outcomes. This is not about simply “funding special programs,” but rather about defining what works, and making sure, within the systemic continuous quality improvement (CQI) practice improvement/workforce development framework, that what works is routinely provided in all settings.
4. The whole process is data driven. Each CQI component, whether at the program level, the subsystem level, or the overall system level, is driven by commitment to measurable progress toward quantifiable objectives.

5. The whole process is built within existing resources. All systems need more resources, but it is critical to challenge ourselves to use the resources we have as wisely as possible before acquiring more. In most behavioural health systems, as noted by the IOM, poor system design produces inefficient and ineffective results, and then more resources are invested to work around the poorly designed system. The goal of CCISC is to create processes to move beyond that over time.
6. The whole process is built with the assumption that every piece of practice and process improvement needs to be anchored firmly into the supporting operational administrative structure and fiscal/regulatory compliance framework. This includes not only clinical instructions, but also resource and billing instructions, quality and data instructions, paperwork and documentation requirements, and so on. The fiscal/regulatory compliance framework can be the biggest supporter of quality-driven change, if the same rigidity that may hold ineffective processes in place is “rewired” to hold improved clinical processes in place that are consistent with the overall values and mission of the systems. Many systems think that this cannot occur, and therefore stop trying. CCISC challenges systems to discover the ways that financial integrity and value-driven practice can be anchored into place simultaneously.

The whole CCISC process begins with a big vision of change and puts in place a series of change processes that proceed in an incremental, stepwise fashion over time. However, because the design of the process is to create organized accountability for change at every level of the system concurrently, thereby increasing the total activation and personal responsibility for improvement by both customers and staff (both front-line and managers), even though each part of the system may only take small steps, the whole system starts to make fundamental changes in its approach to doing business. Although a transformation process is by design “continuous improvement” and will involve significant changes over several years, the shift to implementation of a quality-driven framework process can occur in a relatively short time frame (e.g., 6-12 months).

This model is based on the following eight clinical consensus best practice principles (Minkoff and Cline, 2004, 2005) which espouse an integrated recovery philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system.

### Principles

***Principle 1. Co-occurring issues and conditions are an expectation, not an exception.***

This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues.

***Principle 2. The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship.***

Within this partnership, integrated longitudinal strength-based assessment, intervention, support, and continuity of care promote step-by-step community-based learning for each issue or condition.

***Principle 3. All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring-capable services for different populations.***

Assignment of responsibility for provision of such relationships can be determined using the four-quadrant national consensus model for system-level planning, based on high and low severity of the psychiatric and substance disorder.

***Principle 4. When co-occurring issues and conditions are present, each issue or condition is considered to be primary.***

The best-practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately-matched intervention at the same time.



***Principle 5. Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue.***

Mental illness and substance dependence (as well as other conditions, such as medical disorders, trauma, and homelessness) are examples of chronic biopsychosocial conditions that can be understood using a condition and recovery model. Each condition has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. For each condition or issue, interventions and outcomes must be matched to stage of change and phase of recovery.

***Principle 6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue.***

For each co-occurring condition or issue, treatment involves getting an accurate set of recommendations for that issue, and then learning the skills (self-management skills and skills for accessing professional, peer, or family support) in order to follow those recommendations successfully over time. In order to promote learning, the right balance of care or support with contingencies and expectations must be in place for each condition, and contingencies must be applied with recognition that reward is much more effective in promoting learning than negative consequences.

***Principle 7. Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual-diagnosis program or intervention for everyone.***

For each individual or family, integrated treatment interventions and outcomes must be individualized according to their hopeful goals; their specific diagnoses, conditions, or issues; and the phase of recovery, stage of change, strengths, skills, and available contingencies for each condition.

***Principle 8. CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring-capable.***

Each program has a different job, and programs partner to help each other succeed with their own complex populations. The goal is that each individual or family is routinely welcomed into empathic, hopeful, integrated relationships, in which each co-occurring issue or condition is identified, and engaged in a continuing process of adequately supported, adequately rewarded, strength-based, stage-matched, skill-based, community-based learning for each condition, in order to help the individual or family make progress toward achieving their recovery goals.

**Co-occurring Capability Resources**

Resources for agencies/programs, clinicians, and system implementation teams developing co-occurring capability or competency can be found [here](#). The steps are based on the principles above, and can be initiated by anyone to organize progress within the scope of mission, job category, and resources.

**Recommendation 25:**

That the Royal Commission video-conference with Drs Minkoff and Cline to consider approaches to further develop Victorian mental health and substance treatment services in alignment with the Comprehensive Continuous Integrated System of Care (CCISC) model

## ***New service models***

It seems clear that one of the many challenges faced by the Royal Commission, particularly in strategising how best to meet the needs of the 'missing middle', is whether to place their emphasis on the development of new service models or on reform of the existing models. It is an exciting and daunting challenge.

One of the potential new service models, promoted by Professor McGorry, is profiled in the table below.



Every Australian community will have its own stigma-free, mental health collaborative care hub, with an expert multidisciplinary team of GPs, psychiatrists, allied health professionals, addiction specialists, and 24-hour mobile home intensive care unit. Developmentally appropriate versions, vertically integrated with primary care for children, young people, older adults and the elderly would be crucial. Every Federal Electorate would over time be home to at least one of these hubs. Headspace, with its one-stop-shop design, is a small-scale prototype and an example of the first step in such a reform. This solution is readily affordable, with each of these hubs costing around \$15m and even less in rural and regional Australia

(The Feed, 2018)

One of the many strengths of this model is that it has been developed with a robust appreciation of the prevalence, harms and potential for better outcomes associated with experiencing co-occurring mental health-substance use and other complex needs.

### **Recommendation 26:**

That any new service models recommended by the Royal Commission have at their core the goal of being Complexity Capable – especially in their capability to respond effectively to the different cohorts of people experiencing or impacted by co-occurring mental health-substance use concerns.

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## *Build on current Victorian strengths and developments*

### **Victorian Dual Diagnosis Initiative**

See earlier VDDI profile

#### **Recommendation 27:**

1. That the VDDI be reviewed state-wide against its role descriptions
2. That the VDDI continue to receive ongoing funding
3. That consideration be given to broadening the VDDI's mandate to achieving better outcomes for people with '*dual diagnosis and other complex needs*'
4. That consideration be given to what strategies (role description / structure / accountability points) could further contribute to the VDDI's effectiveness?
5. That consideration be given to refunding a **VDDI Education and Training Unit** with a remit to address AOD-MH workforce professional development, curriculum development and to influence the content of a range of undergraduate healthcare courses
6. That funding be allocated to support the 3-monthly meetings of the **VDDI-Rural Forum**

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#### **Website / clearing house**

In 2004, as the Hume-Border VDDI worker, the author created the [www.dualdiagnosis.org.au](http://www.dualdiagnosis.org.au) website as a clearing house resource for all people with an interest in co-occurring mental health-substance use concerns. The site has been a considerable success, at times receiving 8000 individual visits a month and having a range of undergraduate healthcare courses directing their students to resources on the site.

This success has occurred despite challenges around the time available to administer and develop the site and annual funding tensions in keeping the site on the web. There are a host of resources waiting to be uploaded to the site and potential to further contribute to systemic complexity-capability in developing more site-resources tailored to the specific needs of the different people who use the site.

#### **Recommendation 28:**

That funding be allocated to support the further development of the [www.dualdiagnosis.org.au](http://www.dualdiagnosis.org.au) website.

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## Lived Experience workforces

There is exciting potential, as Victoria begins to benefit from its new Lived Experience workforces, to avoid recreating the silos (and sub-silos) of Victoria's existing mental health and substance treatment systems and agencies. In this regard we would particularly like to direct the Royal Commission's attention to these developments' innovations:

1. **Eastern Metropolitan Region Dual Diagnosis Consumer and Carer Advisory Council (DDCCAC)** Established in 2010 DDCCAC is Victoria's pre-eminent example of a region's cross-sector, consumer and carer, lived experience, co-design and service delivery towards improved service responses to people with a dual diagnosis. (DDCCAC, 2014) (DDCCAC, 2019)
  
2. **Self Help Addiction Resource Centre (SHARC)** –SHARC are a visionary organisation that have been actively developing and implementing self-help and peer-support approaches to AOD recovery for over 30 years. SHARC have established peer workforce partnerships across a number of domains including justice, mental health, harm reduction and gambling. SHARC have been deploying strategies to help the lived experience workforces avoid replicating the siloed approaches of our current mental health and AOD treatment systems. Recent activity included providing scholarships for Mental Health Lived Experience workers to participate in SHARC's 5-day AOD Peer Worker Training
  
3. **Lived Experience Workforce Strategies** Launched this month, each of the three strategies-
  - a) Consumer Mental Health Workforce (LEWSSG, 2019)
  - b) Family Carer Mental Health Workforce (LEWSSG-b, 2019)
  - c) Alcohol and Other Drug Peer Workforce (LEWSSG-c, 2019)contain an overt recognition that many consumers and carers have experiences of seeking support from both mental health and AOD services; that lived experience workers may have experienced both mental health and substance use issues or supported a family member or friend who has experiences of both. All three Strategies recognise the *'unique opportunity for a more inter-sectorial and collaborative approach to supporting mental health and/or AOD consumers and their family/carers, regardless of which sector they interact with.'*

### **Recommendation 29:**

That the Royal Commission, in its findings and its recommendations, recognises, celebrates and builds on these Lived Experience workforce initiatives

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## Capacity building innovations

A recent Victorian development has seen the introduction of dedicated AOD-specific workers in several mental health sites (Croton G., 2019). This development aligns with the Victorian definition of integrated treatment and there are good early indications that these initiatives have had a range of notable benefits including more integrated treatment of client's co-occurring substance use issues.

Figure 2. Recent Eastern Health service innovations – alignment with 2007 Victorian dual diagnosis policy

Recent Eastern Health Service Innovations Targeting people receiving services from Clinical Mental Health Services.	
Alignment with 2007 Victorian dual diagnosis policy aims	<p><b>1. 6 peer-led dual diagnosis groups</b></p> <ul style="list-style-type: none"> <li>• Inpatient &amp; community settings</li> <li>• Recovery principles – person centred, strength based, integrated support</li> <li>• Explore resilience factors, examine personal values, evoke own conclusions re goals and needs</li> </ul>
	<p><b>2. Dedicated AOD workers in inpatient mental health units</b></p> <ul style="list-style-type: none"> <li>• Partnership with Anglicare</li> <li>• Delivering AOD screening, assessment and treatment within a mental health inpatient unit</li> <li>• Seamless pathways to dedicated AOD treatment</li> </ul>
	<p><b>3. Specialist dual diagnosis clinicians working across mental health case management teams</b></p> <ul style="list-style-type: none"> <li>• Workers required to have mental health and advanced AOD skills and qualifications</li> <li>• Shared care model</li> </ul>

**Excerpt: Victoria's strategies towards integrated service delivery for people with mental health-substance use concerns.** (Croton G., 2019)

Rather than the mental health staff involved perceiving that responding to substance use is only the specialist worker's responsibility it appears the mental health workers have demonstrated increased role-validity and interest in developing their capacities to respond to client's co-occurring substance use issues.

### Recommendation 30:

1. That an evaluation of the impacts of the co-located AOD worker models be conducted including their impacts on organisational dual diagnosis capability.
2. That parallel strategies of funding a psychiatrist or mental health nurse practitioner into AOD services be trialled and evaluated in both rural and metropolitan sites
3. That these models be funded state-wide

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## Capability tools

There is great potential to contribute to systemic capability in system leaders promoting the use of dual diagnosis capability tools. These tools can contribute in a variety of ways including

- building wide-spread, fine-grained understanding of what dual diagnosis capability is
- aligning service providers agencies and other stakeholders around a common vision of dual diagnosis capability
- celebrating existing successes in achieving dual diagnosis capability
- building enthusiasm for and a plan towards the next steps in developing dual diagnosis capability

There are a number of tools available to audit dual diagnosis capability. There are tools available to audit agency capability and to audit worker capability. Minkoff and Cline’s Comprehensive continuous Integrated System of Care model has, by far, the most extensive sophisticated complementary array of tools towards implementing the CCISC model.

One of the distinctions between the available tools is whether they employ a self-auditing or an external auditor methodology. The self-audit tools tend to have the most focus on evoking, from the wisdom of the people completing the self-audit, their plan for the next steps in developing their own or their agency’s dual diagnosis capability. The table below summarises some of the good things and less good things of self-audit v. external auditor methodologies

	External auditor	Self-Assessment
Good things:	When administered by objective raters who have received appropriate training, this process provides reliable ratings tied to concrete steps to improve services for individuals and families with co-occurring disorders.	Conducting the self-assessment, usually involving as many members of the team as possible in a conversation is in itself a significant dual diagnosis capacity building activity. The team discussions, group reflections, information sharing and learnings around agency progress towards dual diagnosis capability constitute a principle benefit of using this tool.
Less good things:	May have little impact on service provision or worker’s understanding of and enthusiasm for developing dual diagnosis capability.	Tendency for people completing self-assessment to score higher than would an external rater -particularly on the first occasion of completing the tool

**Good things & less good things of self-audit v. external auditor methodologies.**

Appendix One compares some of the principal tools available for agency level audits.

### Recommendation 31:

1. That DHHS promote and incentivise the use of dual diagnosis capability tools in all Victorian mental health and substance treatment services – both at agency and worker levels
2. That Victorian mental health and substance treatment agencies be tasked to provide annual reports on the strategies they are currently deploying to develop their complexity-capability.

## **Recording prevalence**

*What gets measured gets done.* An effective strategy to influence systemic dual diagnosis capability is to require all mental health and substance treatment services to develop their capacity to be able to, at the touch of a keyboard, report on

- The percentage of current clients have co-occurring substance use-mental health concerns
- The percentage of current clients don't have co-occurring substance use-mental health concerns?
- The percentage of current clients for which it is unknown whether they have co-occurring substance use-mental health concerns

This strategy has implications for the service's recognition of clients who have co-occurring substance use-mental health concerns. Increasing a service's recognition has implications for the worker's role-validity and capabilities and for the agency's intake processes, intake tools, review mechanisms and discharge planning.

### **Recommendation 32:**

1. That DHHS require all Victorian mental health and substance treatment agencies to develop their capacity to provide fine-grained reports on the current prevalence of people with co-occurring substance use-mental health concerns within their agency.
2. That agencies are required to report on this at intervals and their reports are used in service planning
3. That, over time, this reporting requirement is deepened to include some reporting on the principle cohorts of people with co-occurring substance use-mental health concerns within their agency.

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### **Recommendation 33:**

1. That Victorian Mental Health Services Outcomes Framework include reporting on substance use-mental health prevalence data in both mental health and substance treatment services

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## **Concluding words**

It is critical that people with dual diagnosis and other complex needs are at the centre of the Royal Commission's recommendations for system reform because of:

- Prevalence: people with mental health-substance use and other complex needs are the *expectation not the exception* in Victorian mental health and substance treatment services
- Harms: there are a litany of significant harms and unwanted outcomes strongly associated with having mental health-substance use and other complex needs
- Potential for better outcomes: if the Royal Commission can influence the development of a complexity-capable Victorian service system it will have made a huge contribution to the mental health and wellbeing of all Victorians

The strategies discussed in this submission are by no means an exhaustive list – there are many more possible approaches to achieving better outcomes for people with mental health-substance use and other complex needs. It is both possible and critically important that Victoria develops a complexity capable service system

To do so requires the systematic, iterative deployment of an array of complementary strategies to achieve a vision of how our treatment services will look, feel and behave when we are providing effective responses to the various cohorts of people experiencing or affected by mental health-substance use concerns and other complex needs.



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## *Recommendations*

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**Recommendation 1:**

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

*Page 6*

**Recommendation 2:**

That systems development initiatives crafted to address the issues around co-occurring mental health–substance use issues employ primarily collaborative and iterative strategies and are devised with a robust recognition of the complexity of the challenges.

*Page 16*

**Recommendation 3:**

That, given

- the prevalence of people with mental health concerns presenting to Victorian AOD services
- the numbers of people with mental concerns receiving services from Victorian AOD services

that the Royal Commission extends its purview and recommendations to include reforms in the AOD system towards more effective response to people with co-occurring mental health-substance use concerns.

*Page 22*

**Recommendation 4:**

That Australia's National Survey of Mental Health and Wellbeing be funded to occur at 5-yearly intervals.

*Page 22*

**Recommendation 5:**

That the Royal Commission recommend the funding of a Victorian study to identify principal harms and estimated costs, across healthcare and social services, associated with people experiencing co-occurring mental health-substance use concerns.

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**Recommendation 6:**

That the Royal Commission places people with co-occurring mental health and substance use concerns and other complex needs at the centre of their recommendations for systems reform

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**Recommendation 7:**

That the office of the Victorian Chief Psychiatrist be asked to write a Chief Psychiatrists Guideline around this Mental Health Act principle.

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**Recommendation 8:**

That the Mental Health Branch in partnership with Drug Treatment creates a State Chief Addiction Psychiatrist position, whose role is to influence the dual diagnosis/complexity-capability of all Victorian psychiatrists and addiction medicine specialists employed in Victorian mental health-substance treatment services

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**Recommendation 9:**

That the National Drug and Alcohol Research Centre be funded to develop *National Guidelines on the management of co-occurring mental health and alcohol and other drug and conditions in mental health treatment settings* that complement their 2016 *National Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*.

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**Recommendation 10:**

7. That the VDDI be reviewed state-wide against its role descriptions
8. That the VDDI continue to receive ongoing funding
9. That consideration be given to broadening the VDDI's mandate to achieving better outcomes for people with '*dual diagnosis and other complex needs*'
10. That consideration be given to what strategies (role description / structure / accountability points) could further contribute to the VDDI's effectiveness?
11. That consideration be given to refunding a **VDDI Education and Training Unit** with a remit to influence the complexity-capability of AOD-MH workforce professional development, dedicated curriculum development and the content of a range of undergraduate healthcare courses
12. That funding be allocated to support the 3-monthly meetings of the **VDDI-Rural Forum**

Page 31

**Recommendation 11:**

5. That there be an evaluation of the impacts of HYDDI initiative to date
6. That the HYDDI role description be updated
7. That HYDDI be extended to other Victorian regions
8. That strategies be devised to address annual funding tensions

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**Recommendation 12:**

4. That a range of strategies be funded to address
  - the stigma associate with substance use disorders per se
  - the impacts of dual stigma
5. That these strategies include strategies targeting the beliefs and attitudes of a range of relevant healthcare providers
6. That policy and resources be devoted to addressing how welcoming mental health and AOD services are – including physical layout, induction priorities and requirements and clinician and in developing worker competencies in creating a welcoming, collaborative, safe engagement with people

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**Recommendation 13:**

That Victoria again consider the goal of a No Wrong Door service system and develops a coherent web of strategies and incentives to achieve against that goal.

Page 41

**Recommendation 14:**

That there is consideration given to the adoption of Single Session Therapy models in some components of the Victorian mental health and substance treatment systems.

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**Recommendation 15:**

That the Royal Commission investigate:

- The capacities and qualifications of NDIS assessors to non-judgementally assess and develop useful plans for people with co-occurring mental health disability-substance use issues
- Numbers of people with a co-occurring mental health disability- substance use issue who have made successful applications to the NDIS
- Nature and size of the funding received by people with co-occurring mental health disability-substance use issue who have made successful applications to the NDIS compared to the nature and size of the funding received by people with mental health disability alone.
- Whether the presence of a co-occurring substance use issue has served as an effective exclusion criterion for people with mental health disability applying to the NDIS

*Page 45*

**Recommendation 16:**

That Victorian DHHS relax entry criteria into the new MHCSS model so that MHCSS services can flexibly initiate services with people with severe mental health concerns who do not wish to engage with clinical mental health services.

*Page 45*

**Recommendation 17:**

That the Royal Commission include in its recommendations that mental health disability be removed from the NDIS

*Page 45*

**Recommendation 18:**

That future Victorian strategies to address the needs of people with co-occurring mental health-substance use issues are designed around a robust recognition of the diversity of cohorts and the diversity of their treatment needs and preferences.

*Page 47*

**Recommendation 19:**

- That Victorian healthcare planners continue to develop a range of well-connected treatment options around the treatment needs and preferences of the different cohorts of people with co-occurring mental health-substance use concerns.

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**Recommendation 20:**

- That Victorian AOD services are not subsumed under mental health services

*Page 48*

**Recommendation 21:**

- That mental health and AOD are enduringly braided together at a central policy and planning, DHHS level.

*Page 48*

**Recommendation 22:**

That central policy and planning bodies be cautious about developing dual diagnosis-specific treatment options

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**Recommendation 23:**

That a range of mechanisms and incentives be devised to 'celebrate' and promote successes in developing complexity-capability – at clinician, agency and systems levels.

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**Recommendation 24:**

- That the 2007 cross-sector dual diagnosis policy is revised and renewed.
- That a codesign process informs this review.
- That the focus of the renewed policy is better outcomes for people with co-occurring mental health and substance use and other complex needs.

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**Recommendation 25:**

That the Royal Commission video-conference with Drs Minkoff and Cline to consider approaches to further develop Victorian mental health and substance treatment services in alignment with the Comprehensive Continuous Integrated System of Care (CCISC) model

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**Recommendation 26:**

That any new service models recommended by the Royal Commission have at their core the goal of being Complexity Capable – especially in their capability to respond effectively to the different cohorts of people experiencing or impacted by co-occurring mental health-substance use concerns.

Page 58

**Recommendation 27:**

7. That the VDDI be reviewed state-wide against its role descriptions
8. That the VDDI continue to receive ongoing funding
9. That consideration be given to broadening the VDDI's mandate to achieving better outcomes for people with '*dual diagnosis and other complex needs*'
10. That consideration be given to what strategies (role description / structure / accountability points) could further contribute to the VDDI's effectiveness?
11. That consideration be given to refunding a **VDDI Education and Training Unit** with a remit to address AOD-MH workforce professional development, curriculum development and to influence the content of a range of undergraduate healthcare courses
12. That funding be allocated to support the 3-monthly meetings of the **VDDI-Rural Forum**

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**Recommendation 28:**

That funding be allocated to support the further development of the [www.dualdiagnosis.org.au](http://www.dualdiagnosis.org.au) website.

Page 59

**Recommendation 29:**

That the Royal Commission, in its findings and its recommendations, recognises, celebrates and builds on these Lived Experience workforce initiatives

Page 60

**Recommendation 30:**

4. That an evaluation of the impacts of the co-located AOD worker models be conducted including their impacts on organisational dual diagnosis capability.
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**Recommendation 33:**

2. That Victorian Mental Health Services Outcomes Framework include reporting on substance use-mental health prevalence data in both mental health and substance treatment services

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## Appendix One *Menu of options: Dual diagnosis capability tools*

### 1. Agency Level Tools

<p style="text-align: center;"><b>Options <sup>1</sup> :</b> <i>Click icon to hyperlink:</i></p>	<p style="text-align: center;"><b>DDCAT / DDCMHT</b> <a href="#">LINK</a>   <a href="#">LINK</a></p> 	<p style="text-align: center;"><b>COMPASS-EZ™</b> <a href="#">LINK</a></p> 	<p style="text-align: center;"><b>Checklist Dual Diagnosis Capability</b> <a href="#">LINK</a></p> 	<p style="text-align: center;"><b>Co-Existing Problems (CEP) Service checklist</b> <a href="#">LINK</a></p> 
<p style="text-align: center;"><b>About:</b></p>	<p>2 companion instruments:</p> <p><b>1. Dual Diagnosis Capability in Addiction Treatment Index (DDCAT)</b> benchmark instrument for measuring <b>addiction treatment program services</b> for persons with co-occurring mental health and substance use disorders</p> <p><b>2. Dual Diagnosis Capability in Mental Health Treatment (DDCMHT)</b> benchmark instrument for assessing <b>mental health treatment program</b> capacity for persons with co-occurring mental health and substance use disorders</p> <p>- <a href="#">Multiple capability studies</a> have utilised the DDCAT Ratings based upon observation, conversations with program personnel and clients, and record reviews. Background documentation includes guidelines around the process of conducting a typical site visit, from scheduling to exit interview.</p>	<p>‘Designed to help behavioural health services organise a baseline self-assessment of recovery oriented complexity (co-occurring) capability. This permits each program to develop and take ownership of a quality improvement process for making progress.’</p> <p>‘Using this tool all programs in a behavioural health system can work in partnership using a shared process to make progress toward the collective vision of recovery oriented complexity (co-occurring) capability across the whole system’</p> <p>Complemented by sophisticated array of tools to help services develop towards a <a href="#">Comprehensive Continuous Integrated System of Care</a> (CCISC) model <a href="#">More</a></p>	<p>Developed around the 2007, cross-sector, <a href="#">Victorian Dual Diagnosis Policy</a>.</p> <p>The agency/service level tool is a part of a suite of tools that MH or AOD workers OR agencies can use to:</p> <ol style="list-style-type: none"> <li>1. Reflect on and self-assess their existing level of dual diagnosis capability</li> <li>2. Identify training needs in relation to dual diagnosis capability</li> <li>3. Develop a time-lined plan of actions to further develop their levels of dual diagnosis capability</li> </ol> <p>The tools have been used widely including in collaborative, multi-agency, multi-sector, system development processes - <a href="#">Report here</a></p>	<p>A brief tool for mental health and addiction/AOD services to use for self-assessment, reflection and planning to develop service level co-existing problems (CEP) responsiveness and capability. Based on the Australian Checklists</p> <p>Co-existing problems refers to co-occurring complex mental health, <b>gambling</b> and substance use disorders.</p> <p><a href="#">Matua Raki</a> &amp; <a href="#">Te Pou</a> have developed <a href="#">a range of resources</a> to assist NZ mental health and AOD workforces to respond effectively to people with co-occurring mental health and substance use problems.</p>

Methodology <sup>2</sup> :	External auditor	Agency self-assessment	Agency self-assessment	Agency self-assessment
<b>Designed for:</b>	DDCAT – AOD services DDCMHT – MH services	Behavioural Health Programs (including MH & AOD). Other Compass versions specific to Intellectual Disability Programs and Prevention & Early Intervention Programs	Mental Health (both Clinical and MHCSS) and AOD services	Mental health and addiction/AOD services
<b>Validated:</b>	<a href="#">Yes</a>	No	No	No
<b>Fee:</b>	No	Yes ( <a href="#">Inquire here</a> )	No	No
<b>Companion Tools:</b>	No Agency level only	Yes <a href="#">Extensive array of aligned CCISC 'Zia-tools'</a> – arranged at: - Systems - Agency - Primary Care / Behavioural health integration - Staff Competency and - Practice levels	Yes 2009 -2013 clinician-level capability tools specific to each of: - <a href="#">AOD</a> - <a href="#">Clinical Mental Health</a> - <a href="#">MH Community Support Services</a>  In 2018 DHHS commissioned an integrated (MH-AOD) clinician level tool as an aid to new, dual diagnosis-specific, resi rehabs – <a href="#">available here</a>	No Agency level only
<b>Domains:</b>	<ol style="list-style-type: none"> <li>1. Program Structure</li> <li>2. Program Milieu</li> <li>3. Assessment</li> <li>4. Treatment</li> <li>5. Continuity of Care</li> <li>6. Staffing</li> <li>7. Training</li> </ol>	<ol style="list-style-type: none"> <li>1. Program Philosophy</li> <li>2. Program Policies</li> <li>3. Quality Improvement and Data Access</li> <li>4. Access</li> <li>5. Screening and Identification</li> <li>6. Recovery-oriented Integrated Assessment</li> <li>7. Integrated Person-centered Planning</li> <li>8. Integrated Treatment/ Recovery Programming</li> <li>9. Integrated Treatment/ Recovery Relationships</li> <li>10. Integrated Treatment/ Recovery Program Policies</li> <li>11. Psychopharmacology</li> <li>12. Integrated Discharge/ Transition Planning</li> <li>13. Program Collab'n &amp; Partnership</li> </ol>	<ol style="list-style-type: none"> <li>1. Agency policy &amp; documentation</li> <li>2. Detection &amp; Assessment</li> <li>3. Integrated treatment</li> <li>4. Working with the broader service system</li> <li>5. Quality assurance</li> </ol>	<ol style="list-style-type: none"> <li>1. Service Objectives</li> <li>2. Service Workforce Development Objectives</li> </ol>

		14. General Staff Competencies and Training 15. Specific Staff Competencies <a href="#">More</a>		
<b>Fine-grain:</b>	35 items (33 in Australian adaptation)	69 items	45 items	19 items
<b>Outcomes:</b>	<p><b>For DDCAT</b> rating (ASAM taxonomy) of whether the service is:</p> <ul style="list-style-type: none"> <li>- Addiction Only Services (AOS),</li> <li>- Dual Diagnosis Capable (DDC) or</li> <li>- Dual Diagnosis Enhanced (DDE).</li> </ul> <p><b>For DDCMHT</b> rating of whether the service is:</p> <ul style="list-style-type: none"> <li>- Mental Health Only Service (MHOS)</li> <li>- Dual Diagnosis Capable (DDC) or</li> <li>- Dual Diagnosis Enhanced (DDE).</li> </ul>	<p>Develop an action plan based on the learning experience with the COMPASS-EZ™</p> <p>Beginning of an organised quality improvement process towards a <a href="#">Comprehensive Continuous Integrated System of Care</a> (CCISC) model</p>	<ul style="list-style-type: none"> <li>- Development of a time-lined plan of strategies to further develop dual diagnosis capability</li> <li>- Increased understanding of what being dual diagnosis capable involves</li> <li>-Recognition and ‘celebration’ of existing achievements in developing capability</li> <li>- Increased self–efficacy about further developing capability</li> </ul>	<p>The checklist can be used to develop an action plan that identifies work to develop service level CEP responsiveness and capability (including any workforce development needs).</p>
<b>Country of origin:</b>	<p><b>USA</b></p> <p><i>In 2008 an Australian adaptation, (Improved Services Initiative) omitted those items which didn’t align with the Australian service system environment</i></p>	<b>USA</b>	<b>Australia</b>	<b>New Zealand</b>
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<b>Created:</b>	- DDCAT in development since 2003	2009-2016	2009	2012