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Appendix A

Appendix A: Methodology

A. METHODOLOGY

A.1 Framework for the evaluation

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

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

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

A.2 Project plan

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

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

Appendix A: Methodology

A.2.1 Phase 1: Project Initiation

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

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

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

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

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

A.2.2 Phase 2: Stakeholder Consultations

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

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

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

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

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Table A-1: Methods of consultation

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

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

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

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

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

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

The sample was selected to reflect the following characteristics:

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

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

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

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

A.2.3 Phase 3: Analysis and interpretation

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

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



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Appendix B

Appendix B: Telephone Interview and Survey Comparison

B. TELEPHONE INTERVIEW AND SURVEY COMPARISON

B.1 Methodology

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

B.1.1 Areas of inquiry

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

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

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

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

B.1.2 Comparison of results

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

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

Appendix B: Telephone Interview and Survey Comparison

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

B.1.3 Findings

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

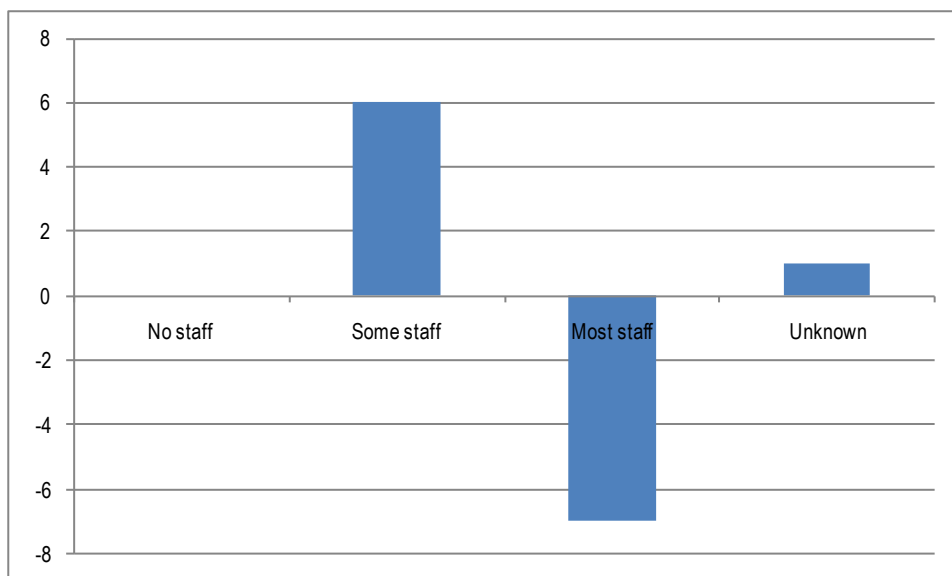
- Staff training
- Dual diagnosis specific screening of clients
- Dual diagnosis specific assessment of clients
- Development of integrated treatment plans for clients
- Development of dual diagnosis specific policies and procedures
- Involvement of consumers and carers in review mechanisms

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

Staff training

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

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

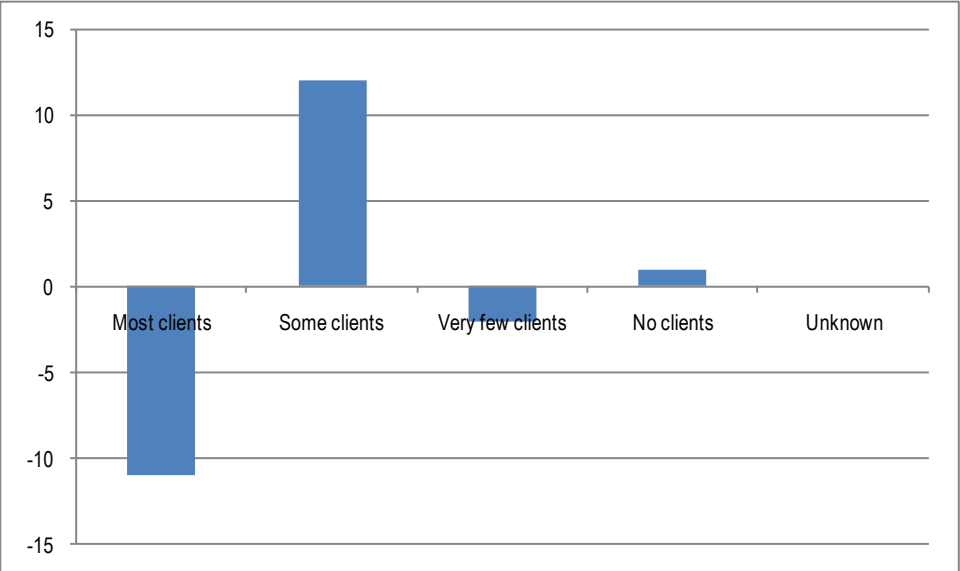


Appendix B: Telephone Interview and Survey Comparison

Dual diagnosis specific screening of clients

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

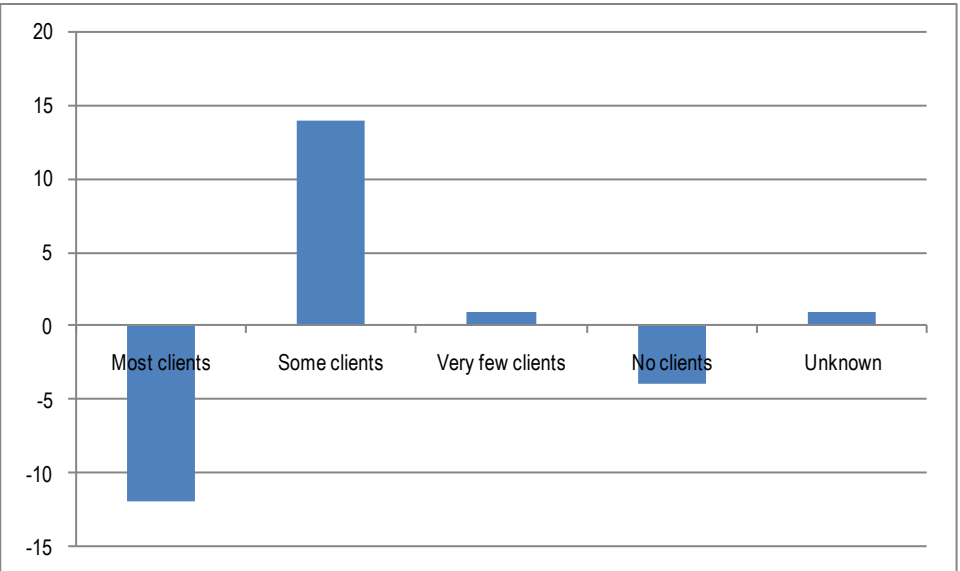
Figure B-2: Extent of DD screening - variation



Dual diagnosis specific assessment of clients

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

Figure B-3: Extent of DD assessment - variation

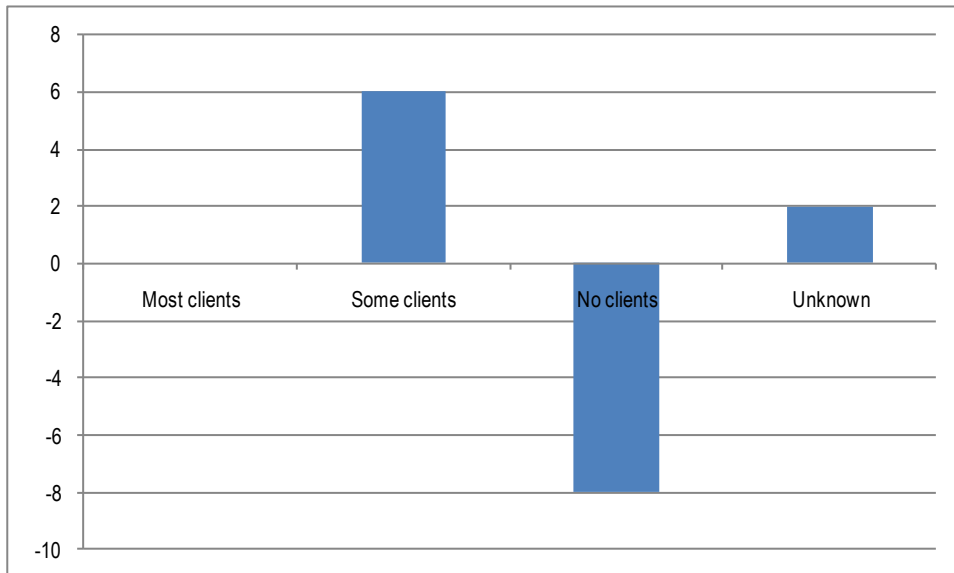


Appendix B: Telephone Interview and Survey Comparison

Development of integrated treatment plans for clients

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

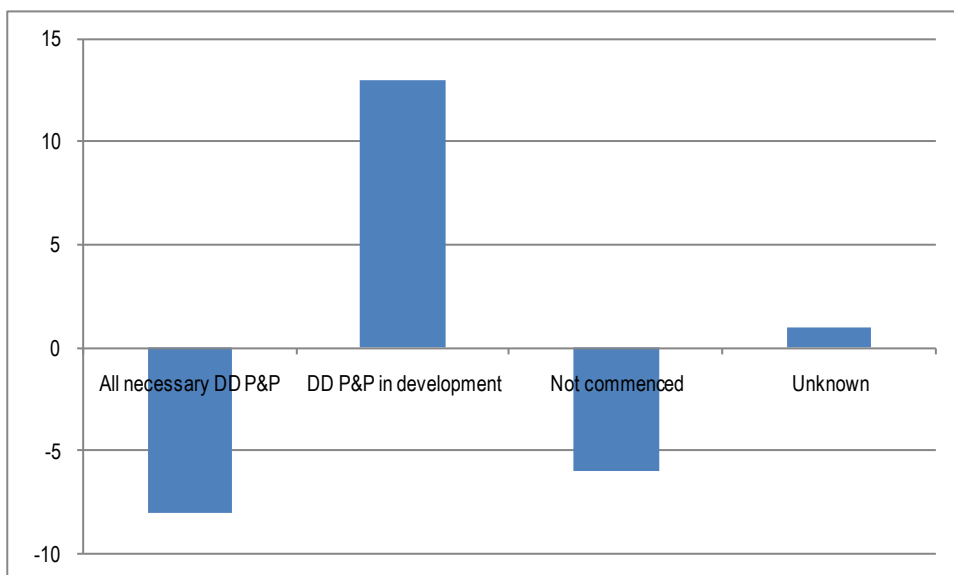
Figure B-4: Extent of use of integrated treatment plans - variation



Development of dual diagnosis specific policies and procedures

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

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

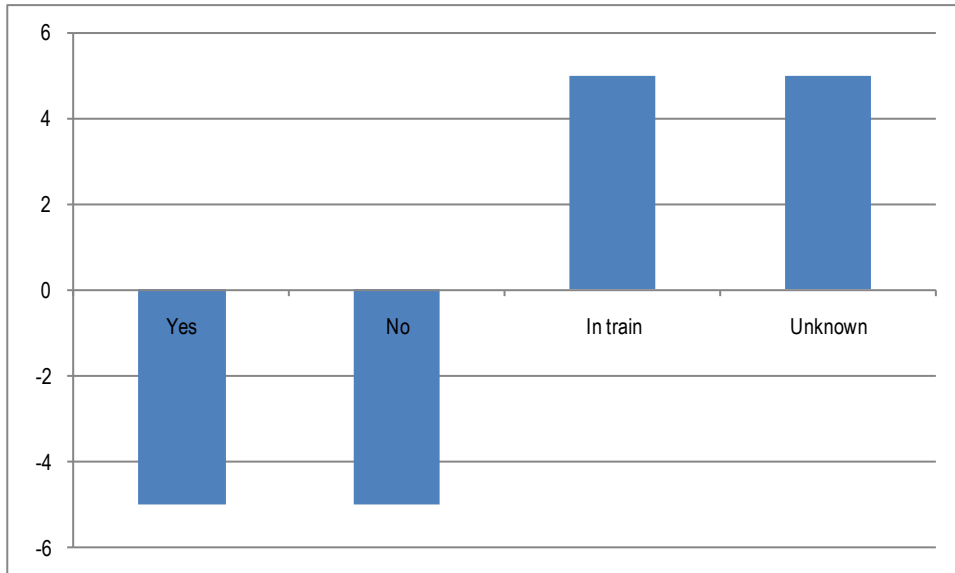


Appendix B: Telephone Interview and Survey Comparison

Involvement of consumers and carers in review mechanisms

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

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





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Appendix C

Appendix C: Dual Diagnosis Literature Scan

C. DUAL DIAGNOSIS LITERATURE SCAN

C.1 Introduction

Dual diagnosis (DD) disorder clients are very common in both mental health (MH) and alcohol & other drug (AOD) services. Dual diagnoses are made in at least one third of MH service users, in about one half of AOD service users and in up to two thirds of some prison populations. Complex interdependencies occur between clients' MH and AOD disorders, although the causal linkage(s) between these disorders remains incompletely understood³⁷.

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

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

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

The extensive DD disorder literature reviewed¹⁻¹⁰⁴ lacks a cohesive or comprehensive framework with which to address the majority of the key issues for those with DD disorders [prevention, awareness, screening, assessment, treatment, and ongoing support]. Methodological challenges have resulted in little rigorous or generalisable research evidence being generated as yet on which to confidently make genuinely evidence-based decisions regarding the care of clients with DD disorder. These methodological challenges with DD disorder research include:-

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

Appendix C: Dual Diagnosis Literature Scan

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

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

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

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

C.2 Context

C.2.1 Definition

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

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

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

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

C.2.2 Prevalence

Many individuals in western societies have both psychiatric and substance disorders^{1, 8, 23, 30, 31, 72, 104}. Dual diagnosis disorders have been found in between one third and one half of clients of MH and AOD services and in up to two thirds of some prison populations in Australia³¹⁻³⁴. They are a very common population, not only in addiction and mental health service systems, but also in the juvenile & criminal justice systems, welfare systems and amongst homeless persons.

Appendix C: Dual Diagnosis Literature Scan

C.2.3 Aetiology

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

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

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

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

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

C.2.4 Barriers to accessing appropriate care

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

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

Community surveys suggest that many persons with DD disorders currently receive no treatment whatsoever for either condition. A survey by UCLA and RAND® found that 72 percent of people with co-occurring disorders did not receive any mental health or substance abuse treatment over the previous year^{17, 103}. Fewer than 25 percent of individuals with co-occurring disorders received appropriate mental health services, and only 9 percent received supplemental substance abuse services¹⁰³.

Many health care organizations still fail to approach concurrent psychiatric disorders and addiction as disorders requiring concurrent treatment^{21, 31, 32, and 91}. Some estimates suggest that fewer than half of clients with recognised DD disorders do not receive concurrent treatment for both disorders¹⁰³. Where concurrent treatment is offered, those services are often not offered in an integrated manner, with health

Appendix C: Dual Diagnosis Literature Scan

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

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

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

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

A recent Australian survey of mental health service providers found that perceived barriers to better treatment of DD disorder clients included:- low client motivation to reduce substance use; poor carer communication; poor coordination between treatment services and a lack of appropriate specific services for dual diagnosis clients²¹.

Almost all survey respondents identified a need a need for further professional training for themselves in the area of dual diagnosis. The authors of this study drew the following sobering conclusion²¹:-

“Dual diagnosis is common and the reality is that this vulnerable clientele will continue to challenge service providers and treatment approaches into the foreseeable future.

Issues include the organization and delivery of treatment services, education and training, resource allocation, collaboration between treatment agencies and clinically relevant research evaluating the effectiveness of practice.

It is thus surprising that with so much investment in this area the majority of stakeholders are still dissatisfied with access to and the level of care for dual diagnosis clients”.

C.2.5 Treatment approaches:

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

Psychosocial interventions

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

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

Pharmacological interventions

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

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

C.2.6 Significant recent initiatives:

In addition to the program of work undertaken within the Victorian Dual Diagnosis Initiative³⁴ there have been several other significant recent activities in Australasia and elsewhere regarding DD disorders:

- The Australian Government have funded a major initiative (2003-2009) to improve the care of persons with DD disorders⁷⁰. This 'National Comorbidity Initiative' offered a range of interventions to improve service co-ordination and treatment outcomes for people with coexisting mental health and substance use disorders. The initiative focused on the following priority areas⁷⁰:
 - Raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models;
 - Providing support to general practitioners and other health workers to improve treatment outcomes for comorbid clients;
 - Facilitating resources and information for consumers; and
 - Improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively.
- *Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician*²³. As part of its National Drug strategy the Australian government have recently released this comprehensive guide to the assessment and care of DD disorder clients in the primary care setting. It incorporates an extensive bibliography.
- *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*⁶⁵. The National Drug and Alcohol research centre has recently released comprehensive guidance on the management of DD disorders. This resource has a comprehensive summary of current state-of-the-art approaches to care and includes an extensive bibliography.

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- The Australian Institute for Primary Care released the *Final Report on their evaluation of comorbidity treatment models in 2009*²⁴. This report offers a detailed insight on contemporary knowledge and attitudes towards models of care for DD disorder clients based upon a literature review and service provider inputs.
- Also in 2009 Beyond Blue published a research report “*Looking beyond dual diagnosis: Young people speak out*” that provides valuable insights from clients with DD disorders on current systems of care in Australia⁹¹.
- The New Zealand Health Ministry has recently issued policy guidance on the assessment and management of DD clients^{66, 99}. They note that despite many years of discussion and many strategic statements urging mental health and addiction services to respond equally to mental health and addiction issues in a co-ordinated and complementary manner, surveys of the respective services have shown a variety of approaches to these issues with poor communication and coordination between the two services, with the result that clients continue to fall between the gaps.
- *Integrated* service provision is supported, based on the reality that DD disorder clients are core business for both mental health and addiction services. In general, better outcomes are felt likely to be achieved when care is well co-ordinated and complementary, where access barriers are minimised, and when agencies, services and staff understand each others’ roles and work together closely. These NZ reports include an extensive bibliography and a comprehensive list of contemporary resources for those engaged in DD health service planning and delivery.
- Concerned with this gap between research and practice The Centre for Substance Abuse Treatment in the USA has instituted two major programs to bridge the gap⁹⁴⁻⁹⁶. The Addiction Technology Transfer Centres are charged with the dissemination of evidence based practices to the field in forms that are tailored to different disciplines or settings. The Practice Improvement Collaborative network was developed to address the adoption of evidence-based practices in the field: They have identified key lessons regarding the transfer of best practice care into everyday, usual care.
- The NHS have released ‘Developing a Capable Dual Diagnosis Strategy: A Good Practice Guide’ that provides a valuable tool designed to assist local healthcare providers in implementing effective care for their local DD disorder clients³³. This builds on previous guidance documents³⁰ that have sought to offer implementation guidance for Community-Based Substance Abuse Treatment Agencies.
- Last year the UK Department of Health released a guide for the management of dual diagnosis for prisons¹. This document provided good practice guidance to commissioners and practitioners on for the management of dual diagnosis within a prison setting. As such it is a good example of the frequent need to tailor the approach to DD disorder clients for the very specific context within which they are to receive their care.

C.3 Assessment

Given the prevalence of DD disorders, it can quite easily be argued that assessment for the presence of dual diagnosis should be a feature of any systematic assessment of people entering either addiction or mental health services so that appropriate treatment can be recommended. ^{1,4,12,18,24,28,30,33,34,35,38,51,52,56,57,66,70,72,74,75,83,84,93,99,104}

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C.4 Models of Care

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

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

Other categorisations of models of care have been used. These include:

By the extent to which care is seamless from the point of view of the client^{33, 60},

- Consultative
- Collaborative
- Coordinated
- Integrated

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

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- 1-4 Levels (or tiers) of care

By the population treated

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

By the nature of the care teams^{30-34, 58,66, 99}

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

C.4.1 Single model of care

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

C.4.2 Sequential model of care

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

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

C.4.3 Parallel model of care

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

Parallel models of care intend to provide care for both mental health and substances uses disorders at the same time, but care is typically offered in different settings and by different providers.

There is usually some level of communication, collaboration or coordination of care between providers. These relationships between providers determine if parallel care is categorised as consultative, collaborative or coordinated care.

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

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

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

C.4.4 Integrated model of care

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

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

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

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

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

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

Some regard the widespread reference to "integrated" treatment models as problematic, given that the word *integrated* is used by various parties to describe very different models of care⁶³.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C.4.5 What constitutes 'best practice'?

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

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

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

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

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

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

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

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

By contrast, some systematic reviews have reported fewer advantages to recommend integrated care models^{18, 48, and 89}. The most widely referenced meta-analysis of care for DD disorders²⁰ found no compelling evidence to support any one psychosocial treatment over another to reduce substance use (or improve mental state) by people with DD disorders with serious mental illnesses. A recent review and analysis of the *integration* model literature concluded with a cautionary message, warning against mandating provision of an integrated model of care for all clients with DD disorders⁹⁰.

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

As much of the research into the effectiveness of integrated care models has been done in the USA; with many reports from a single treatment program, it cannot be taken for granted that this model is the most appropriate for other countries or that those results can necessarily be replicated by merely copying the described care programs^{16,20,21,26,36-39,47,64}. As indicated in the above discussion, the literature highlights an urgent need for further research into the efficacy of various service models for the treatment and care of those with dual diagnosis⁹³

Facilitators and challenges for implementation

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

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

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

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

The facilitators and barriers to implementation for IDDT program occurred at the clinician level (staff skills and turnover), at the organization and administration level (leadership and supervisor skills and commitment), at the level of the implementation roll-out (consultation, training, and feedback), and at the environmental context level (financing and the relationship with the mental health authority)^{16, 17, 64}. This study confirmed research in other healthcare setting seeking the translation of evidence into practice suggesting the need for multilayered active implementation efforts¹⁰. However even with such intensive efforts at multiple levels most organizations did not achieve high-fidelity IDDT program implementation.

IDDT is a complex care model that contains multiple components and requires change at the provider, organization, and environment levels. For these reasons, this service may be more difficult to implement than single-component practices, such as cognitive therapy to treat major depression.

Researchers studying the implementation of the IDDT program found that difficulties in implementing IDDT at the agency level stemmed from^{16, 17, and 64}:

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

The high prevalence of DD disorders in all service populations and service settings mean that this high priority population is very unlikely to ever be adequately served by implementation of a small number of highly specialized programs in any scarcely resourced healthcare system⁹⁰.

C.4.6 Comprehensive Continuous Integrated System of Care

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

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

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

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

There is a recognition that DD disorders are not a single entity with a single “best practice” intervention, but rather that individuals with DD have a wide range of disorders and needs in combination, and that best practice treatment involves integrating the provision of best practice treatment for each disorder at the level of the client^{30,33,35,65,69,71,72,74,76,77,80,94-96,99}. This encourages the system to develop as extensive a range of better practices for mental health and substance disorders as it can, and organize them so that improved practice for either type of disorder is provided by an appropriately trained team of professional.

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

The implementation of structured interventions to improve care for DD disorder clients involves complex multi-layered system improvement²⁵. It requires an organized approach, incorporating principles of strategic planning and continuous quality improvement in an incremental process that involves interaction between all layers of the system (system, agency or program, clinical practice and policy, clinician competency and training) and all components of the system, regardless of the size or complexity of the system. Such an approach is possible in systems of any size (entire state, regions, counties, complex agencies, individual programs) and in any population.

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

Other similar initiatives have published similar resources in terms of implementation guidance documents and/or toolkits^{30,33,35,46, 49,65,69,71,72,74,76,77,80,94-96,99}.

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C.5 Conclusion

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

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Appendix D

Appendix D: Training

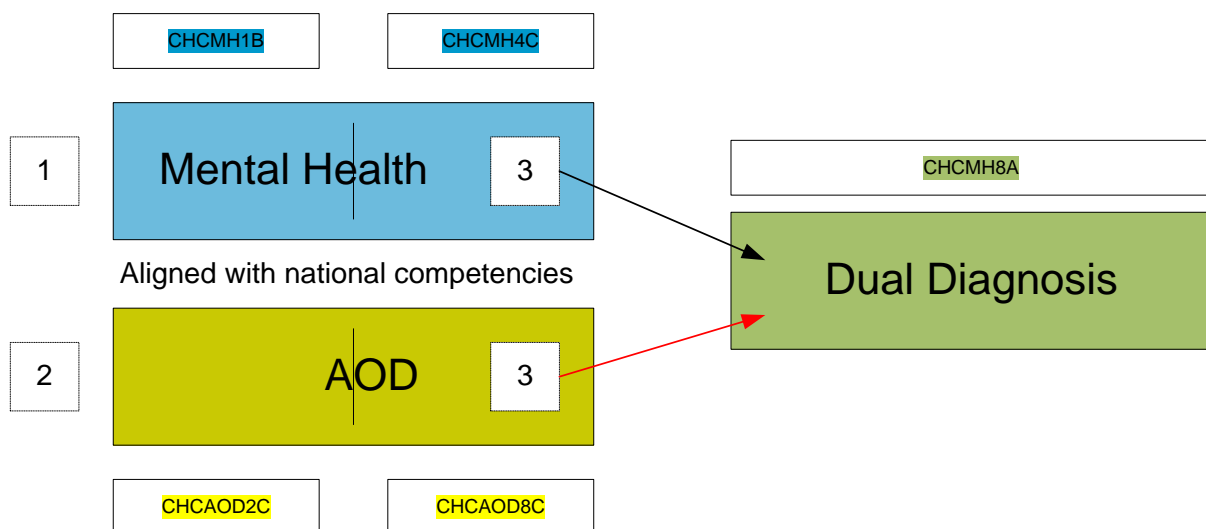
The following information has been adapted from “Dual Diagnosis. An on-line course for staff working with clients with both mental health and substance use problems. Learner’s Guide and Prospective Student Information. 2010 Semester 1.” Developed by the Statewide Dual Diagnosis Education and training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

Accredited Courses

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

Diploma Course

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



Postgraduate

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

Appendix D: Training

Structure of the Course

The course comprises 5 competencies. These are:

AOD Stream:

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

CHCAOD8C – Assess the needs of people with AOD issues

Mental Health Stream:

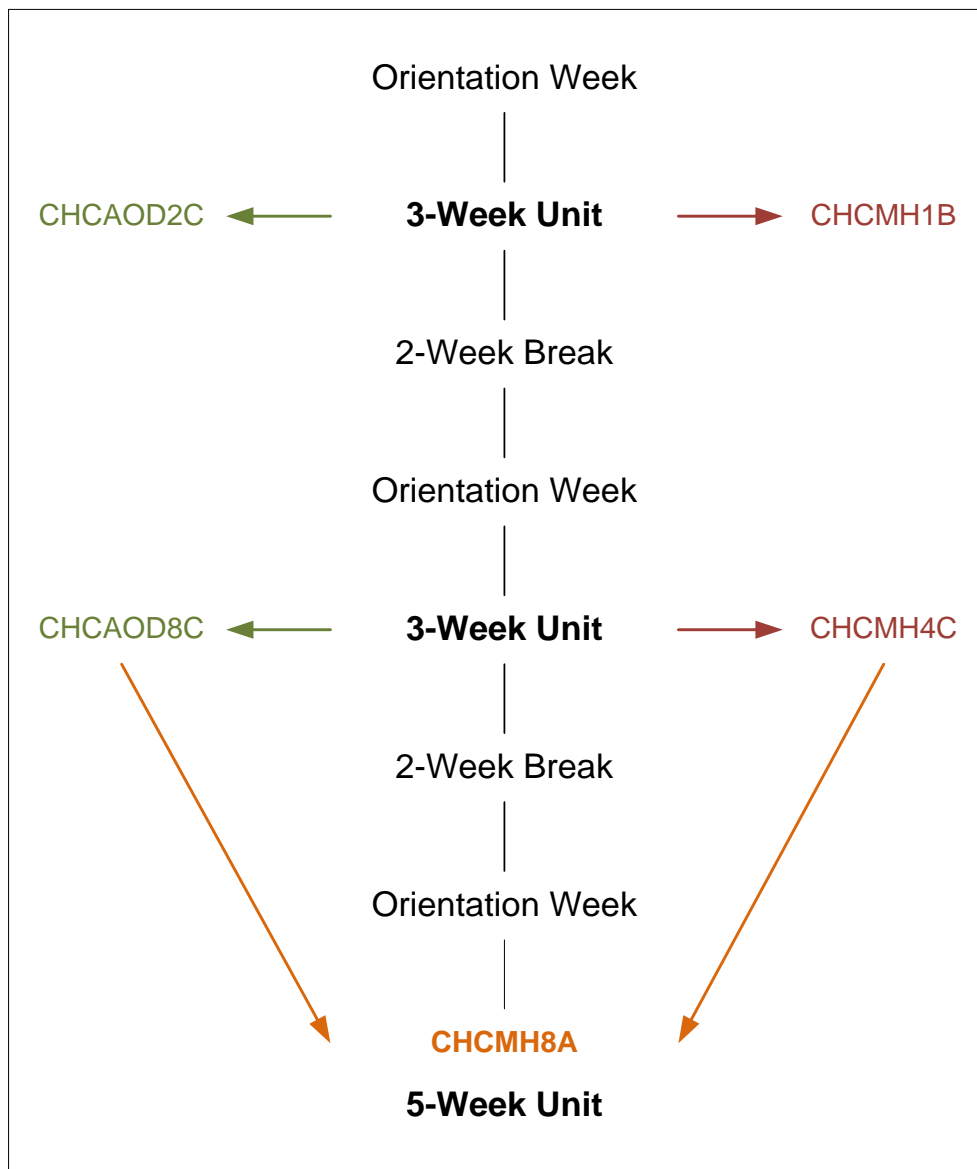
CHCMH1B – Orientation to Mental Health Work

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

Dual Diagnosis Unit:

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

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





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Appendix E

Appendix E: Draft interim Learning and Development Strategy

Overall Objective

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

Learning Objective One

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

Method:

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

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

Expected Outcomes of each Workshop:

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

Possible Workshop activities could include:

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

Appendix E: Draft interim Learning and Development Strategy

Learning Objective Two

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

Method:

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

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

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

The evaluation of the Victorian Dual Diagnosis Initiative (VDDI) notes that “the great majority of workers across the three sectors have received training related to dual diagnosis” (page 43), or approximately 35% of PDRSS workers and 60% of AOD workers (page 35). As such training conducted to meet this Learning Objective should target the remainder of workers in each sector as well as allowing for turnover and the industry growth rate of 4.6 % per annum over the past five years¹.

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

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

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

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

Appendix E: Draft interim Learning and Development Strategy

Learning Objective Three

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

Method:

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

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

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

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

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

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

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

Learning Objective Four

The development of a short induction dual diagnosis workforce self paced training package (for example CD based and or on-line) for the two separate audiences of management staff and direct care staff; further, that this package be made freely available to employers to use as an induction tool in the three sectors of the dual diagnosis workforce by the time Learning Objective One is implemented.

Method:

Content development of the manager's self paced training package to be informed by ETU and VDDI staff and include:

- Key Directions / SDOs or most recent Victorian dual diagnosis government policy
- pro-forma organisational policies and procedures which incorporate SDO KPIs.
- pro-forma organisational policies and procedures covering integrated assessment, treatment and care.
- a pro-forma integrated dual diagnosis protocol, which allows definition of client care pathways within and between sectors.

Content development of the direct care staff self paced training package to be informed by ETU and VDDI staff and include:

- Key Directions / SDO or most recent Victorian dual diagnosis government policy
- Learning activities for the basic dual diagnosis units of competency
- Where to find and how to access courses provided by the Registered Training Providers which have partnered with the ETU
- List of dual diagnosis education providers by Victorian region and professional development dual diagnosis options including course content and mode of delivery for each of the clinical mental health worker disciplines.

Choice of delivery mode and monitoring of take up of the self paced training package be informed by Department of Health and VDDI experience with the dual diagnosis workforce sector take-up of induction training packages.



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Appendix F

Appendix F: Data Collection and Tools

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

Mental and behavioural disorders (F00-F99)

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

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

Only in cases in which patterns of psychoactive substance-taking are chaotic and indiscriminate, or in which the contributions of different psychoactive substances are inextricably mixed, should the diagnosis of disorders resulting from multiple drug use (F19.-) be used.

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

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

.0 Acute intoxication

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

Acute drunkenness in alcoholism

"Bad trips" (drugs)

Drunkenness NOS

Pathological intoxication

Trance and possession disorders in psychoactive substance intoxication

Excludes: intoxication meaning poisoning ([T36-T50](#))

.1 Harmful use

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

Appendix F: Data Collection and Tools

Psychoactive substance abuse

.2 **Dependence syndrome**

A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances.

Chronic alcoholism

Dipsomania

Drug addiction

.3 **Withdrawal state**

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

.4 **Withdrawal state with delirium**

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

Delirium tremens (alcohol-induced)

.5 **Psychotic disorder**

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

Alcoholic:

- hallucinosis
- jealousy
- paranoia
- psychosis NOS

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

.6 **Amnesic syndrome**

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

Appendix F: Data Collection and Tools

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

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

.7 Residual and late-onset psychotic disorder

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

Alcoholic dementia NOS

Chronic alcoholic brain syndrome

Dementia and other milder forms of persisting impairment of cognitive functions

Flashbacks

Late-onset psychoactive substance-induced psychotic disorder

Posthallucinogen perception disorder

Residual:

- affective disorder
- disorder of personality and behaviour

Excludes: alcohol- or psychoactive substance-induced:

- Korsakov's syndrome ([F10-F19](#) with common fourth character .6)
- psychotic state ([F10-F19](#) with common fourth character .5)

.8 Other mental and behavioural disorders

.9 Unspecified mental and behavioural disorder

F10 Mental and behavioural disorders due to use of alcohol

[\[See before F10 for subdivisions \]](#)

F11 Mental and behavioural disorders due to use of opioids

[\[See before F10 for subdivisions \]](#)

F12 Mental and behavioural disorders due to use of cannabinoids

[\[See before F10 for subdivisions \]](#)

F13 Mental and behavioural disorders due to use of sedatives or hypnotics

[\[See before F10 for subdivisions \]](#)

F14 Mental and behavioural disorders due to use of cocaine

[\[See before F10 for subdivisions \]](#)

F15 Mental and behavioural disorders due to use of other stimulants, including caffeine

[\[See before F10 for subdivisions \]](#)

F16 Mental and behavioural disorders due to use of hallucinogens

[\[See before F10 for subdivisions \]](#)

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F17 Mental and behavioural disorders due to use of tobacco

[\[See before F10 for subdivisions\]](#)

F18 Mental and behavioural disorders due to use of volatile solvents

[\[See before F10 for subdivisions\]](#)

F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

[\[See before F10 for subdivisions\]](#)

This category should be used when two or more psychoactive substances are known to be involved, but it is impossible to assess which substance is contributing most to the disorders. It should also be used when the exact identity of some or even all the psychoactive substances being used is uncertain or unknown, since many multiple drug users themselves often do not know the details of what they are taking.

Includes: misuse of drugs NOS

Substance Use Interventions – ICD-10-AM

Intervention	Code (ICD-10-AM / ACHI)
Brief motivational Intervention/Counselling – Alcohol Use Disorder	Z71.4
Brief motivational Intervention/Counselling – Drug Use Disorder	Z71.5
Brief motivational Interventions/Counselling – Tobacco Use Disorder	Z71.6
Preventative counselling or education (substance use) i.e. harm reduction; education	96066-00
Alcohol Withdrawal Management	92003-00
Alcohol and Drug Withdrawal Management	92009-00
Drug Withdrawal Management	92006-00

Health of the Nation Outcome Scales (HONOS)

The HoNOS is a clinician-administered instrument comprising 12 items:

- Item 1: Overactive, aggressive, disruptive or agitated behaviour;
- Item 2: Non-accidental self-injury;
- Item 3: Problem drinking or drug taking;
- Item 4: Cognitive problems;
- Item 5: Physical illness or disability problems;
- Item 6: Problems associated with hallucinations and delusions;
- Item 7: Problems with depressed mood;
- Item 8: Other mental and behavioural problems;
- Item 9: Problems with relationships;

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- Item 10: Problems with activities of daily living;
- Item 11: Problems with living conditions; and
- Item 12: Problems with occupation and activities.⁹⁹

Collectively, the items cover the sorts of problems that may be experienced by people with a mental illness. The items 'roll up' into four subscales:

- Behaviour (Items 1-3);
- Impairment (Items 4-5);
- Symptoms (Items 6-8); and
- Social (Items 9-12).

Each item is rated on a five-point scale (0 = no problem; 1 = minor problem; 2 = mild problem; 3 = moderately severe problem; 4 = very severe problem), resulting in individual item scores, subscale scores and a total score. In assigning ratings, the clinician makes use of a glossary which details the meaning of each point on the item being rated¹.

Basis-32

The BASIS-32[®] is a consumer-rated instrument comprising 32 items:

- Item 1: Managing day-to-day life (e.g., getting places on time, handling money, making everyday decisions)
- Item 2: Household responsibilities (e.g., shopping, cooking, laundry, cleaning, other chores)
- Item 3: Work (e.g., completing tasks, performance level, finding/keeping a job)
- Item 4: School (e.g., academic performance, completing assignments, attendance)
- Item 5: Leisure time or recreational activities
- Item 6: Adjusting to major life stressor
- Item 7: Relationships with family
- Item 8: Getting along with people outside the family
- Item 9: Isolation or feelings of loneliness
- Item 10: Being able to feel close to others
- Item 11: Being realistic about yourself and others
- Item 12: Recognising and expressing emotions appropriately
- Item 13: Developing independence, autonomy
- Item 14: Goals or direction in life
- Item 15: Lack of self confidence, feeling bad about yourself
- Item 16: Apathy, lack of interest in things
- Item 17: Depression, hopelessness
- Item 18: Suicidal feeling or behaviour
- Item 19: Physical symptoms
- Item 20: Fear, anxiety or panic
- Item 21: Confusion, concentration, memory
- Item 22: Disturbing or unreal thoughts or beliefs
- Item 23: Hearing voices, seeing things
- Item 24: Manic, bizarre behaviour
- Item 25: Mood swings, unstable moods
- Item 26: Uncontrollable, compulsive behaviour

¹ Wing J, Curtis RH, Beevor A. Health of the Nation Outcome Scales (HoNOS). Glossary for HoNOS score sheet. British Journal of Psychiatry. May 1999;174:432-434 as cited in Pirkis J, Burgess P, Kirk P, Dodson Sand Coombs T. 2005. *Review of standardised measures used in the National Outcomes and Casemix Collection (NOCC). Version 1.1.* 2005: pg 14

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- Item 27: Sexual activity or preoccupation
 - Item 28: Drinking alcoholic beverages
 - Item 29: Taking illegal drugs, misusing drugs
 - Item 30: Controlling temper, outbursts of anger, violence
 - Item 31: Impulsive, illegal or reckless behaviour
 - Item 32: Feeling satisfaction with your life
- Collectively, the items constituting the BASIS-32® comprise five subscales:
- Relation to self and others (Items 7, 8, 10, 11, 12, 14, 15);
 - Depression and anxiety (Items 6, 9, 17, 18, 19, 20);
 - Daily living and role functioning (Items 1, 2, 3, 4, 5, 13, 16, 21, 32);
 - Impulsive and addictive behaviour (Items 25, 26, 28, 29, 30, 31); and
 - Psychosis (Items 22, 23, 24, 27).²²⁴

Each item is rated using a five-point scale (0 = no difficulty; 1 = a little difficulty; 2 = moderate difficulty; 3 = quite a bit of difficulty; 4; extreme difficulty) which are used to calculate subscales and total scores by adding the ratings for each item and dividing by the number of non-omitted items. The exception to this rule is the computation of the Daily living and role functioning subscale, which is determined by taking the highest difficulty rating of items 2, 3 and 4 to create a single 'role functioning' rating, and averaging this value in with the remaining six items²

² Department of Human Services. Measuring Consumer Outcomes in Clinical Mental Health Services. A Training Manual for Services in Victoria (2nd edition): Victorian Government; 2003. As cited in *ibid*

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The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID) CAGE-AID³

1. Have you felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Score: __ /4

2/4 or greater = positive CAGE, further evaluation is indicated

³ *Wisconsin Medical Journal*. Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.