Senate Enquiry into Mental Health, 2005

Submission on problems associated with DUAL DIAGNOSIS
Drug Action Information Exchange (DAIE)
Wollongong

Radda Jordan
02 42277298
Locked Bag 8821
South Coast Mail Centre 2521

The Drug Action Information Exchange (DAIE) is a meeting held quarterly and convened by Wollongong City Council. Members include:

- Wollongong City Lord Mayor
- NSW Police
- Illawarra Area Health Service, Drug and Alcohol Director
- Regional CDAT Chair
- Wollongong CDAT Chair
- Denison St Methadone Clinic manager (private)
- Bungora Methadone Clinic manager (Area Health Service)
- NSW Ambulance Service
- State and Federal Members of Parliament

The meeting is an information exchange forum for services involved with drug use and its effects in the Illawarra. The meeting offers a frank exchange of important information about the issues and problems each service is experiencing, and devises campaigns and strategies to combat these current problems.

The most pressing issue in the Illawarra, as far as the DAIE is concerned, centres on dual diagnosis. People suffering both mental illness and drug or alcohol dependence, once they become psychotic or experience severe psychotic symptoms, have great difficulty accessing adequate diagnosis and care. These patients have been refused treatment because medical personnel see their symptoms as a result of drug induced illness or indeed because they are affected by drugs and/or alcohol at the time of referral.

Police within the Illawarra are continually confronted with members of the public who are displaying severe symptoms of mental illness. Police acting within the guidelines of the Mental Health Act will transport the patient to a proclaimed hospital for assessment. On numerous occasions the resulting assessment diagnoses a drug induced psychosis. The end result is the patient being released and left with the Police to deal with. Police do not have the training or resources to deal with those patients. If left alone, they are a danger to themselves, if left with friends or relatives similarly those people are now in danger. Police do not have access to drugs which may be able to sedate the person and further do not have the facilities to hold them for any length of time. The persons are inevitably released out onto the street where they commit offences and then criminally charged. Due to their mental state and fear of further offences being committed these people end up spending unnecessary time in Police cells and in our prison systems.

Wollongong City Council is particularly concerned with people, in a confused or psychotic state, untreated and left to wander the City centre. Others accessing the City are often confronted by people in this state. The resultant fear associated with their unpredictable behaviour develops avoidance behaviour in the general populace. This in turn leaves the City vulnerable to anti social and criminal activities. It also leaves people who are in this psychotic state even more vulnerable to attack. Services to treat people who may be a danger to themselves or others and also from others, or who induce fear in the general public by their confronting behaviour, is not only a humane response but essential for our City Centre's revitalisation.

Other services also claim they are unable to provide appropriate levels of care for psychotic patients who are also affected by drug and/or alcohol. Within the Illawarra, the Drug and Alcohol HIV/AIDS services, along with the Mental Health services and non-Government crisis services, have met to develop protocols and agreements to best meet the need of patients with dual diagnosis. This dual disorders consultation team developed a business case that has, as yet, never been adopted. As a result, the Illawarra is still suffering from not having adequate provision for dual diagnosis patients.

Below is the business case, in its entirety. Rather than reinvent the wheel, the DAIE request this business case is looked at by the Illawarra and South East Sydney Health Services, and develop it even further to include other agencies like police.

Thank you for this opportunity
Radda Jordan

Safe Community Action Team
Wollongong City Council
Direct Line (02) 4227 7298

On behalf of Drug Action Information Exchange and authorised by

Ian McClintock

Manager Community and Cultural Services

Wollongong City Council

Illawarra Mental Health Service
&
Drug, Alcohol and HIV/AIDS Service

Dual Disorders Consultation Team Business Case

1. Executive Summary

Integrated assessment and treatment for consumers with co-occurring mental health and drug & alcohol disorders has been identified as a priority issue for service enhancement for both Mental Health and Drug & Alcohol Services in the Illawarra. The need to work collaboratively with all service providers across these settings, including our local non-government organisations, has helped us to identify service gaps. One of these gaps is in the provision of a specialist consultation-liaison service for consumers with dual disorders across the region that will allow the best possible care no matter where these consumers choose to access their care.

It has become apparent during the planning exercise undertaken with our stakeholders that more and more consumers are presenting to both service settings with increasingly complex care requirements related to co-occurring disorders. Service planning has assumed that these presentations should be the expectation rather than the exception.

A Model of Care has been agreed upon that assumes changes in the way core services are delivered. This Model of Care underpins service development plans under current resources and arrangements but also provides a framework for the service enhancement outlined in this Business Case.

It is apparent that clinicians with expert knowledge and experience across both mental health and drug and alcohol settings are required to provide a designated Dual Disorders service across a wide variety of service settings if we are to deliver a comprehensive, coordinated and integrated service network to this group of consumers. This service seeks to build upon the Valentines Agreement recently signed by both mental health and drug & alcohol services in providing this level care.

This Business case takes into account best practice arrangements that seek to build upon the Collaborative Recovery Model (CRM) that is being implemented across both service settings over the coming years. The CRM is a model with particular emphasis on collaborative goal setting and collaborative homework assignments. It is designed to be a portable and integrative framework combining evidence from aspects of case management and psychosocial rehabilitation.

The Dual Disorders Team (DDT) would provide expert support for care planning and treatment for consumers with co-occurring disorders presenting to any mental health or drug & alcohol service setting in the Illawarra region. The Team will provide a secondary consultation service. This DDT will include nursing and medical staffing and be closely associated with the medical Detox Unit to be configured at Orana House, which will have four designated Dual Disorder beds. The primary target population for this service are consumers who are *significantly disabled* by both a mental health and substance abuse disorders. The Team will also provide education and support of clinicians in both Mental Health and Drug & Alcohol services to assist in management of a broader group of consumers.

It is envisaged that this service will serve as a pilot project and be rigorously evaluated. Its utility and effectiveness will demonstrate an effective model of care with wide implications for service delivery outside the Illawarra.

A closer networking arrangement between service settings and sites will be implemented as part of this planned service enhancement. Education and training requirements will be addressed as an integral and vital component of the delivery of the Model of Care.

2. The Case for Change

2.1 The Current Situation

The Illawarra Mental Health Service and the Drug, Alcohol and HIV/AIDS Service, in partnership with local non-government service providers have been meeting for some years to work through the issues faced by consumers with co-occurring disorders, provide an educational opportunity through case presentations and a networking opportunity for staff from both service settings in an effort to foster good working relationships. More recently, these meetings have produced a number of policies and protocols, including draft clinical pathways, for this cohort of consumers in recognition of the reality of service delivery – that consumers with co-occurring disorders should be the expectation and not the exception.

A 'Valentines Agreement' between Mental Health & Drug and Alcohol Services was signed in 2003. This Agreement stated that both services:

- Will ensure that there is an integrated approach to service delivery through user friendly access based on identified needs of the service provider, clients and their families.

- Will have systems of shared care for individuals with Dual Diagnosis with agreed referral pathways.

Both services committed to:

- A culture of mutual respect for staff and clients of each service

- Support for staff of each service to access services for clients who require shared care.

- Staff, the time and resources, to receive education and training to support clinical work with people with co morbidities of drug and alcohol dependence and mental illness.

- Review mechanisms to evaluate joint models of service delivery.

- Listening systems to empower staff, clients and their families to raise any issues about the quality and effectiveness of service provision.

It has also become apparent that the nature and complexity of presentations, particularly to services provided by NGOs such as Kedesh House and The Wollongong Crisis Centre, are such that existing resources and support are inadequate to meet the needs of this group of consumers. A Dual Disorders Service Planning Group was therefore convened to develop a Business Case seeking funding enhancement from both the Centre for Mental Health and the NSW Drugs Program, to develop a Dual Disorders

Team for the Illawarra. It has become apparent during the planning process that there is wide stakeholder support for this initiative.

A brief profile of the agencies and organisations[1] providing services to this group of consumers identified a range of issues:

- A significant proportion of consumers presenting to NGOs have dual disorders requiring specialist interventions from both services.
- Additional resources are required to provide a timely response to medical requirements and aggressive and overactive clients.
- A significant proportion of consumers are being assessed as 'high risk' and staff skill levels vary widely across services.
- Assessment protocols and processes vary widely across service settings.
- A willingness to be more involved in collaborative acre planning and treatment.
- A concentration on care planning (including discharge planning) is required
- Education and training requirements for an integrated model of care to operate effectively.

People with dual disorders are not a homogenous group and often present with a number of problems varying in severity and complexity. There is a need of comprehensive assessments and cooperation between services. It is not feasible that all clinicians across both service settings become specialist workers in the field but an increase in their knowledge base is essential. When knowledge and skills are improved, identification and inclusive health care become the norm. [2]

BETWEEN DECEMBER 2002 AND JULY 2003 THERE WERE 1044 DISCHARGES FROM THE ACUTE INPATIENT MENTAL HEALTH FACILITIES IN THE ILLAWARRA. OF THESE 161 (15.4%) HAD A DUAL DIAGNOSIS. A RANDOM SAMPLING OF DISCHARGE SUMMARIES FROM SEPTEMBER TO NOVEMBER 2002 HAS 27.3% OF CONSUMERS WITH A DUAL DIAGNOSIS. IN THE PAST THREE MONTHS, THERE HAVE BEEN 16 CLIENTS ADMITTED TO THE WOLLONGONG CRISIS CENTRE. THE PROPORTION OF CONSUMERS WITH A DUAL DIAGNOSIS PASSING THROUGH BOTH ORANA HOUSE (FOR DETOX) AND KEDESH HOUSE (FOR REHABILITATION) ARE SIMILAR. THE MAIN CAUSES OF ILLICIT DRUG ATTRIBUTABLE HOSPITALISATIONS VARY BY AGE BUT DRUG INDUCED PSYCHOSIS WAS COMMONEST IN ALL AGE GROUPS FROM 15-24 ONWARDS (EXCEPT 45-64 WHERE IT RANKED SECOND). ATTEMPTED SUICIDE RANKED SECOND AMONGST ADOLESCENTS AND YOUNG ADULTS. [3]

[1] Service Profile, Orana House, Kedesh House, Wollongong Crisis Centre & Oolong House, November 2003

[2] *The Management of people with co-existing mental health and substance use disorders* – Service Delivery Guidelines, NSW Health (2000).

[3] Illawarra Health Population Profiler, Issue 8, September 2003, Division of Population Health and Planning.

2.2 Strategic Issues and relationship to Illawarra Mental Health and Drug, Alcohol & HIV/AIDS Service strategic directions.

The Illawarra Mental Health Program Strategy 2003-2008 signals a change in approach to mental health and mental illness. Mental health promotion, prevention and early intervention and the delivery of effective treatment and rehabilitation programs for people with a mental illness is the cornerstone of this strategy.

There are five key areas that will be the focus of change over the next five years. These are as follows:

- Provide effective programs that better meet the mental health needs of the population.
- Provide a wider range of programs to better meet the mental health needs of the local population.
- Develop a culture of innovation and improvement through learning and development.
- Develop productive partnerships through out the service with others to better deliver a range of services proven to improve the mental health status of the population and
- Develop efficient information, communication and management systems to support the delivery and planning of care.[4]

The proposal to develop a Dual Disorders Team aligns with these key strategic directions, in particular in relation to the development of productive partnerships and providing a wider range of programs to better meet the needs of the population. The Program Strategy goes on to state that the IMHS supports effective programs for people with a mental illness who also have problematic substance use.

One of the goals of the *Illawarra Drug & Alcohol Strategic Plan 2000-2005* is the implementation of NSW Health Service Guidelines in conjunction with Illawarra Mental Health Service to improve and coordinate care for people with serious co-existing mental health problems. This has been partially achieved through the work of the Dual Diagnosis Committee that has been able to provide a solid platform to build on enhancing these relationships. However, there is now a need to progress to a phase where strategies can be implemented.

The Strategic Plan goes onto state that the establishment of well managed partnerships between service sectors is also a priority as is the development of training an education programs to evaluate and improve staff clinical competencies and knowledge and skills in best practice models.[5]

One of the objectives of the Illawarra Drug & Alcohol Prevention Plan 2004-2009 is to expand partnerships to develop a safer community as well as provide a leadership role in the increase in knowledge of issues around alcohol and other drugs[6]. The Dual Disorders team will have a role to play in meeting this objective.

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[4] Illawarra Mental Health Program Strategy 2003-2008.
[5] Illawarra Drug and Alcohol Strategic Plan 2000-2005.
[6] Illawarra Drug & Alcohol Prevention Plan 2004-2009.

2.3 Rationale for Proceeding

Early intervention and prevention, harm minimisation, comprehensive health care and evidence-based good practice underpin the *Service Delivery Guidelines for the Management of People with Co-existing Mental Health and Substance Use Disorders.* It is well acknowledged that the expertise on how to identify and manage co-morbidity has diminished and people with co-existing Mental Health (MH) and Substance Use Disorder (SUD) are repeatedly referred from one service to another, or left with nowhere to go. [7]

Consumers with co-occurring disorders are recognized as a high prevalence, poor outcome, and high cost population, often served in ways that make the most inefficient and ineffective use of scarce resources.

The literature suggests that there a number of significant issues contributing to these poor outcomes and include under recognition of service need; lack of access to one or both services; poor engagement and retention within services; a lack of integration and coordination in the provision of care; the inappropriateness of treatment matching for stage of change or phase of recovery and inadequate discharge planning and follow-up services.

There is also likely to be a dramatic under-reporting of consumers with co-occurring disorders.

Consumers who are severely disabled through co-morbidity require shared responsibility and coordinated, integrated approach to ensure continuity of care. Culturally appropriate and sensitive services need to be assured; particularly for people from CALD backgrounds and people who have particular needs relating to language, cultural beliefs and practices. Aboriginal and Torres Strait Islander people have identified a high level of co-morbidity for MH and SUD problems and need to be able to access culturally appropriate and comprehensive services to address these problems. The use of standardised assessment tools will help to improve clinician's ability to assist the assessment process. The focus for acute management of consumers with co-occurring disorders needs to ensure safety through rapid response and informed, systematic and careful assessment[8].

A number of community – wide surveys have revealed that a significant proportion of people with substance use problems also have a co-existing MH disorder and this combination of disorders adds significantly to the morbidity and complexity of treatment. Between 30 and 80% of people with a SUD will also have a mental disorder. [9,10]

The relationship between substance use and mental health is complex. Rates of co-morbidity are particularly high in clinical settings and as the prevalence of drug use

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[7] Burdekin, B (1993), Human Rights and Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness, Australian Government Publishing Service, Canberra.

[8] *The Management of people with co-existing mental health and substance use disorders* – Service Delivery Guidelines, NSW Health (2000).

[9] Kessler, R.C., McGonagh, K.A., Zhao et al (1994), *Lifetime and 12 month prevalence of DSM II R Psychiatric Disorders in US,* Archives of General Psychiatry, 51:8-19.

[10] McDermott, F., Pyett, R (1995), *Not Welcome Anywhere: People who have a serious psychiatric disorder and problematic drug & alcohol use,* Victorian Community Managed Mental Health Service.

continues to climb, so does the incidence of depression and suicide. [11] The increasing numbers of consumers with dual disorders requires a comprehensive assessment, integrated treatment and formal partnership arrangements between MH and D&A services. Training needs to emphasise evidence based learning processes and treatments. [12] People with co-occurring disorders need to have access to health care services for Detox as well as pharmacotherapy treatment, harm minimisation strategies, rehabilitation services and case management. The principles of equity and access to services must be maintained and alternative treatment strategies should be provided for people who are unable to access designated facilities. The Dual Disorders team will provide a leadership role in the realisation of these service principles.

The socio-economic profile of the Illawarra shows that the population is on average more disadvantaged than NSW as a whole, has a greater percentage of people on lower incomes and has a higher rate of youth and adult unemployment. These factors are often associated with consumers with dual disorders.

2.4 Relationship to Government Policy

The **National Mental Health Plan 2003-2008** consolidates the achievement of the First and Second Plans, addresses gaps identified in both, and takes the National Mental Health Strategy forward with restated and new directions. It can be viewed as an ongoing agenda for service and community development that sets priorities for 2003-2008. It represents a partnership between the key stakeholders in mental health. The Plan adopts a population approach.

The new Plan is guided by four priority themes:

- Promoting mental health and preventing mental health problems and mental illness
- Increasing service responsiveness
- Strengthening quality and
- Fostering research, innovation and sustainability.[13]

The development of a Dual Disorders Team in the Illawarra and the implementation of a comprehensive and integrated Model of Care across the region are aligned to the priority areas of the Plan.

The **Drug Treatment Services Plan for NSW 2000-2005** has a primary purpose of ensuring that NSW has in place an effective, responsive and adaptive service delivery system for people affected by harmful drug use. The priority areas are:

- Enhancing the capacity of generalist service providers to deliver effective treatment services and

[11] NHMRC (1997), *Depression in Young People: A Guide for MH professionals, Clinical Practice Guidelines.*

[12] Drug Treatment Service Plan for NSW 2000-2005.

[13] Australian Health Ministers: National Mental Health Plan 2003-2008. Canberra: Australian Government.

- Development and expansion of inpatient and ambulatory Detox services so as to maximise resources and increase access to expertise, facilities and cross boundary partnerships. [14]

The plan seeks to achieve the following objectives:

- Services are integrated, comprehensive, innovative and evidence-based
- Service provision reflects local and regional needs
- That there is regional access to a minimum core set of Drug & Alcohol services
- That a range of quality programs and treatments are accessible and readily available.

The development of a Dual Disorders team is aligned to the priority areas in terms of partnership development and the expansion of ambulatory services. The Dual Disorders team will be part of an integrated service network for consumers with co-occurring disorders that will meet the needs of the local population.

The **National Action Plan for Promotion, Prevention and Early Intervention for Mental Health** was developed as a result of the Second National Mental Health Plan and outlines core outcomes as improved public health strategies to promote mental health, a reduction in incidence and prevalence of mental health disorders and associated disability (including depression), a reduction in the number of suicides, increased consumer and carer satisfaction with clinician's responses to early warning signs of mental disorders and improved mental health literacy at all levels[15]

The National Mental Health Integration Strategy: Guidelines for National Demonstration Projects in Integrated Mental Health Care (1999)

The Commonwealth Department of Health and Aged Care in partnership with States and Territories and the private sector has established a number of National Demonstration Projects in Integrated Mental Health Services.[16] The aim of the projects is to establish and document approaches to integrating private psychiatrist services and public sector mental health services. The primary purpose is to create a more flexible integrated framework for the provision of mental health care and to optimise outcomes for the consumers of those services. The development of the Dual Disorders team for consumers with serious co-occurring disorders is in keeping with the overall integration strategy as it will operate across both services and improve the partnership arrangements with local NGO service providers.

New South Wales (NSW) Health Department Strategic Directions is to *"…work together as a team to achieve Better Health, Good Health Care".* [17]To achieve this, NSW Health is committed to *Healthier People, Fairer Access, Good Health Care, Better Value*

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[14] Drug Treatment Services Plan for NSW 2000-2005.

[15] Commonwealth Department of Health and Aged Care. 2000. *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care: Canberra.

[16] Department of Health and Aged Care. *Planning Guidelines for National Demonstration Projects in Integrated Mental Health Care.* Commonwealth of Australia, Canberra, 1999.

[17] [9] NSW Health Dept. (2000). *Strategic Directions for Health*

Caring for Mental Health: A Framework for Mental Health Care in NSW 1998

The NSW Framework for Mental Health Services has six strategic directions:

- Working together for better mental health-Developing partnerships
- Emergency mental health response
- Mental Health Promotion, prevention and early intervention
- Providing better mental health care across the life span
- Quality and effective mental health services
- Putting the building blocks in place

The framework for mental health provides a policy direction, which gives overriding priority to reducing stigma attached to mental illness, providing integrated and comprehensive mental health services across the continuum and the lifespan. The development of the Dual Disorders team is in keeping with these goals.

Healthy People 2005 – New Directions in Public Health in NSW

This document identifies six attributes as building blocks and foundations of a strong health system and four broad goals for the health system. The attributes are:

- Sharing a clear direction
- Working in partnership
- Informed decision making
- Embracing innovation
- Skilled and valued workforce and
- Engaging the community

The overall goals are healthier people, fairer access to health, quality public health services and better value.[18] The planning process that the MH service and D&A services have been engaged in is clearly driven by the need to share a clear direction and embrace innovation.

2.5 Impact on Stakeholders

It has become clear during the routine meetings of the Dual Diagnosis Committee and Executive above that there is broad support for and commitment to innovation in the care and treatment of consumers with co-occurring disorders. This commitment and support has been reinforced during the planning process that has been undertaken in the development of this Business Case and Model of Care. There is high-level support at an Area level for the development of this service. A focus will be on developing and strengthening intersectorial partnerships and forging strong alliances with General Practitioners and private practitioners in the development of integrated care pathways. There is strong support for the service delivery model amongst all stakeholders.

[18] Public Health Division, Healthy People 2005 – New Directions for Public Health in NSW. NSW Health, Sydney, 2000.

3. Information about Dual Disorders Consultation Liaison Service

3.1 Project Purpose

The purpose of the project is to establish a specialist Dual Disorders Consultation team to provide high-level clinical and educational support across both Drug & Alcohol and Mental Health Services in the Illawarra.

3.2 Planned Outcomes

It is anticipated that the establishment of this service will result in a significant improvement in treatment outcomes for the cohort of consumers with dual disorders. It is also anticipated that there will a significant improvement in the skills, knowledge and attitudes in the staff caring for these consumers across both service settings, and thus enhance the services capacity to provide comprehensive, collaborative care to a group of consumers who have traditionally experienced poor health outcomes. The Dual Disorders Consultation team will also play a leading role in the education and support of clinicians across both service sites, in relation to the development of core competencies.

3.3 Project Description

Service Model

Model of Care principles

The formulation of a Model of Care for people with co-occurring disorders has been based on the following principles:

- That changes to the way services as a whole are delivered for this cohort of consumers are delivered within the context of existing funds despite the outcome of the Business Case proposal.
- That changes are implemented system wide in order to build capacity within general practice, government and non-government organisations in the Illawarra.
- Improving the core capacity across all services and development of core clinical competencies
- Incorporating sound clinical principles of care.

It should also be recognised that education and clinical supervision will be crucial for the success and sustainability of this model of care. The development of education and training related to the implementation of this initiative will incorporate both basic training in core knowledge and skills competencies and specific ongoing training that is responsive to the implementation.

Where practicable, a focus on the development of multidisciplinary teams across all service settings will be preferred.

A detailed description of the preferred Model of Care is attached in Appendix 1.

The development of core competencies across all service settings is to be given priority. These core competencies are:

- Mental State Examination
- Suicide Risk Assessment
- Drug & Alcohol Screening and History Taking
- Motivational Interviewing (including the Stages of Change)
- Cultural Sensitivity training for ATSI and CALD communities.

DUAL DISORDERS TEAM

It is proposed that a specialist team be developed to work as a Dual Disorders Team. This team would be 'based' at Orana House and thus closely associated with the Dual Diagnosis Beds within the newly configured Orana House Medical Detox Unit. The team would have area wide responsibilities however, with two clinicians working in the Shoalhaven and two in the northern Illawarra. There would be a part time Staff Specialist attached to this team.

The Dual Disorders team would have responsibility for providing expert consultation and liaison services across all service sites (including NGOs) by way of high level involvement in assessment, care and discharge planning, ongoing treatment and referral of consumers who are *significantly disabled by both mental health and substance use*. Those consumers requiring a highly coordinated, integrated approach such as through joint case management or where a clinician from either service setting is to play a care coordination role to ensure continuity of care, will be the target population for this service. It is anticipated that the need for input from this service will be greatest in the NGO sector, medical Detox Unit and Acute Inpatient settings (from time to time). Referrals are also anticipated from MERIT and Bungora (Methadone Treatment Service)

Those consumers with a severe mental health disorder (with associated disability) and adversely affected by substance use will continue to receive care in a mental health setting with support from D&A as required.

Those consumers with a severe substance use disorder (with associated disability) and adversely affected by mental health problems will continue to receive care in a Drug & Alcohol setting with support from MH as required.

Lower level support will be available to service staff caring for consumers who have lower level needs. It is anticipated that this team will also provide educational and training support to increase knowledge and skills across both service settings, in consort with appropriate personnel from these service settings and sites.

As per the *Service Delivery Guidelines for the Management of people with co-existing MH and SUD (NSW Health, 2000),* the milder ends of the spectrum for people with mild-moderate MH

and SUD will access both MH and D&A services from time to time but the primary carer will continue to be the GP.

An explicit GP role in the identification, shared care and follow up of this cohort of consumers is to be encouraged and highlighted in relation to both physical health care requirements and dual disorder issues. The Illawarra Division of General Practice (IDGP) has recently developed a Dual Diagnosis education resource and CD-ROM. This collaborative project has involved the IDGP in partnership with the Shoalhaven Division, Illawarra Institute for Mental Health, The Department of Psychology at UoW, Illawarra Mental Health Service and Drug, Alcohol and HIV/AIDS Service. The objective of the project has been to develop, implement and evaluate a GP education resource aimed at improving the skills of GPs in the identification, assessment, management and referral of consumers with dual disorders. The Dual Disorders Team will play a role in connecting the service settings to this resource as an educational tool.

3.4 Proposed Timeframe and Milestones

Date	Activity
1st July 2004	Allocation of Recurrent Funding requirements
15th July 2004	Development of Operational Policies through Dual Diagnosis Committee structures
August 2004	Recruitment and selection of Dual Disorders Team members
September 2004	Dual Disorders Team commence
September 2004	Orientation of Dual Disorders team to D&A and MH services
October 2004	Development of detailed education & evaluation plan and assessment protocols for service
October 2004	Consultation services commence
December 2004	Education & Training commence

4. Implementation

1.1 Project Management arrangements

The Dual Disorders Committee Executive will oversee the development of the service and be responsible for reviewing the outcome monitoring reports produced by the team. Line Management responsibility for the team will be through the Drug & Alcohol Services with a high level of consultation with the Mental Health Service. The Mental Health Service Planning and Projects Manager will provide a high level of support to the Executive bodies of both the Drug & Alcohol and Mental Health Services through the initial implementation phase of project development.

1.2 Change Management

The proposal to establish a Dual Disorders Team is a developmental change very much in keeping with both the Illawarra Mental Health Program Strategy 2003-2008 and the Drug & Alcohol Services Strategic Plan. As such, it will enhance existing aspects of the mental health and drug & alcohol programs available for a group of consumers with a history of poor health outcomes. As the establishment of this integrated service would involve systems change within the service, the service development & initial implementation will be managed as a discrete project, and as such be managed through the Mental Health Executive Project Management process as well as the change processes operational within the Drug & Alcohol Service. Detailed feasibility planning will commence with the approval of the service plan through the Centre for Mental Health and NSW Drugs Program

The IMHS Program Strategy 2003-2008 sets out an ambitious change agenda that directs the organisation towards the embrace of continuous and emergent change.
The Project Management approach provides a model of change management where that change has a beginning and an end. It is also useful where the change will be carried out once, as the development of this service has a degree of uniqueness and involves a project group coming together within the service to implement the change.

A wide-ranging stakeholder consultation has been undertaken already and will continue with approval to proceed. The IMHS and D&A Service have in place a number of processes to drive this process including participation in the Southern Network; the Dual Diagnosis Committees and Executive; the Consumer and Carer Consultative Committee; the Staff Consultative Committee and the Community Partnerships Committee.

Project goals that are both measurable and attainable have already been outlined. Project implementation will be lead from within the Dual Diagnosis Executive with the Director of Planning / Sector Manager Specialist Services likely to be the nominated Project sponsor. A milestone plan and a risk matrix have been included with this Business case. An outline of the Consultation process is provided in Appendix 2.

1.3 External Communication and Issues Management

Relevant external stakeholders will be kept informed of the progress of the Dual Disorders Team Project through the Illawarra Mental Health Service's *Community Partnerships Forum*; Drug & Alcohol Services partnership forums; local Divisions of General Practice MH-ORG meetings and mental health partnership meetings as well as promoting the service through our partner primary health care agencies.

1.4 Quality Management

Standard documentation and routine outcome measurement will be utilised for all clients. Best Practice guidelines for the assessment and treatment of consumers with dual disorders will be operationalised through policy and protocol development for the service. Outcome measurement against planned outcomes will be monitored through the Dual Diagnosis Executive, IMHS Service Development Improvement Committee (SDIC) and internal clinical governance arrangements of both mental health and drug & alcohol services.

1.5 Post-Project Management Arrangements

The Service will be managed through Line Management arrangements within the internal structure of the Drug & Alcohol Service.

1.6 Project Evaluation

Project implementation will be evaluated against the key activities and milestones outlined in the Business Case.

Professor Frank Deane from the Illawarra Institute for Mental Health (iiMH) at the University of Wollongong has indicated that iiMH are happy to be involved in the detailed evaluation design should funding be approved for the service.

Evaluation of this service will form part of the core role and responsibilities of the Dual Disorders team members.

The fundamental building block of the evaluation of the service will be a comprehensive assessment protocol. Assessment data will refer to cross-sectional protocols from both services. Admission and periodic review data (including outcome measures) will be collected and collated by the Dual Disorders Team.

Service utilisation measures including MH Inpatient Admissions and re-admissions, admissions to Orana House and the rehabilitation services such as Kedesh House, Crisis Centre and Oolong House, and OOS from the Community Mental Health Teams and Drug and Alcohol Community Adult Teams will be monitored. Service engagement measurement will also be monitored.

Periodic measurement of Outcome will also be conducted as part of clinical review across the services.

At least one follow up assessment at six months will be coordinated by the Dual Disorders team for targeted clients. Consideration about conducting a small case study series will be discussed on recruitment on team and be dependant on workload and resource capabilities.

A Review of Service objectives and planned outcomes will be conducted on an ongoing basis against the Business Case through the Dual Diagnosis Executive and SDIC. Budget compliance will be monitored through the Drug & Alcohol Service Executive.

1.7 External Funding arrangements

Project implementation will be reliant upon attracting recurrent funding through the Centre for Mental Health and NSW Drugs Program.

5. Evaluating the Options

5.1 Options Considered

It is not possible for the Illawarra Mental Health Service and Drug & Alcohol Service to provide this level of *specialist* service under current resource arrangements. Though both services are developing protocols and joint assessment arrangements for the care of this cohort of consumers, it is apparent that a specialist service is required to support the development of best practice, increase the knowledge and skills of all clinicians across both service settings and sustaining an improvement in health outcomes.

There are very few private practitioners, with long waiting lists and no private psychiatric hospitals in the Illawarra. The historical situation in relation to MBS payments for private psychiatrists in the Illawarra over the past several years indicates that we are well below the national average on a per capita share, due to the small number of practising psychiatrists in the region. The low level of private health insurance in the region is also a barrier for consumers seeking access to private treatment, for which they must travel out of area.

The 'Do Nothing' option assumes that there will be sub-optimal care for consumers, who are significantly disabled by both mental health and substance use under current resource constraints. The consultation process conducted in the preparation of this Business Case indicates both the level of unmet need and the requirement for a locally based, public service.

5.2 Cost Benefit Analysis

Option	Cost (economic, social & environmental)	Benefit (economic, social & environmental)	Cost to Benefit Ratio	Ranking
Do Nothing – *'Business as Usual'*	▪ Nil funding enhancement required ▪ Consumers significantly disabled by both mental health and substance use receive sub-optimal care ▪ Clinicians across both service settings lack skills and knowledge to provide comprehensive care ▪ NGO care providers receive inadequate support in care planning ▪ 'Wrong Door' policy reinforced.	▪ No recurrent cost increase to mental health or D&A service in direct care expenditure	Poor	**3**
Dual Disorder service provided by transfer of existing staff into Dual Disorder positions	▪ Nil funding enhancement required ▪ Service development at expense of current care provision for both mental health and D&A consumers ▪ Overextended and unsupported team ▪ Burnout ▪ Higher rate of cross-referrals to both services attempting to match client to service setting	▪ Designated service providers ▪ No increase in recurrent cost to mental health or D&A service	Poor	**2**
Dual Disorders Consultation Team established	▪ Recurrent funding required	▪ Specialist Service developed and provided ▪ Improvement in health outcomes of consumers ▪ Best practice model of care implementation supported ▪ Reduction in disease burden ▪ Increased educational and training	Medium	**1**

		support across service settings		

5.2a Cost Benefit Discussion

The preferred option is to attract additional recurrent funding to the Illawarra to develop a specialist Dual Disorders Consultation Team. This option provides the greatest benefit around consumer health outcomes and improvements in the capacity of both services to deliver high quality care, through the increase in knowledge and skills around dual disorders. These developments will operate within an environment where there is an agreed model of integrated care, and a shared commitment to collaborative care.

5.3 Detailed Costs

Detailed Costings are attached in Appendix 3.

5.4 Risk Analyses and Risk Management

Not proceeding with proposal – Business as Usual

Risk	Impact	Probability
Sub-Optimal service delivery	Consumers with dual disorders continue to access care through both mental health and drug& alcohol services (medium)	High
Clinicians across both settings lack high level skills across both service settings	Services continue to struggle in providing treatment and care for cohort of consumers (medium)	High
NGO providers receive inadequate support in providing care	Inability to build capacity in local service delivery (medium) Consumers receive sub-optimal care Clinicians struggle to provide comprehensive service and partnership relationships break down	Medium

Proceeding with Proposal

Risk	Impact	Probability
Demand for Service exceeds ability to supply service	Waiting list development Service frustration – customer and internal Acute care requirements increase (medium)	Medium
Recruiting personnel with Specialist skills difficult	Inadequate service delivery (high)	Medium
Specialist skills not spread through services	Service delivered by inexperienced staff Sub-optimal service delivery (high)	Low
Non-integration of support services	Service delivered without integrated referral, care and follow up pathways Communication breakdown between stakeholders (high)	Low

Risk Management Plan - proceeding

Risk	Management Strategy
Demand for services exceeds ability to supply service	Operational Policies as a Secondary consultation service Development of coherent and well-communicated referral pathways and criteria that are operationalised within community mental health settings. Development of 'Wait List' protocols for support of consumes unable to be accepted in short term Development of 'shared – care' arrangements with GPs, Private practitioners and Emergency Services support personnel.
Specialist skills not spread throughout service	Education and Training Needs Assessment Identification of staff across both service settings with specialist knowledge and skills, educational and training experience. Education and Training Plan developed in consultation with Dual Diagnosis Executive and Research & Education Coordinator and other specialist personnel. Monitoring of Plan Evaluation of E&T plan
Recruiting personnel with specialist skills	Job Description to include specialist knowledge requirements in relation to both mental health and drug &alcohol and familiarity / agreement with Model of Care Wide promotion of job advertisement through NSW media outlets Liaison with Illawarra Institute for Mental Health in relation to Supervision and training / support
Non-Integration of Support Services	Service planning to engage all key stakeholders, in particular GPs and private practitioners Development of integrated referral and clinical pathways that includes all relevant stakeholders, and includes forum for routine communication and feedback.

Appendix 1: Model of Care

The Comprehensive Continuous Integrated Systems of Care Model[19] or CCISC.

The CCISC model for organising services for individuals with co-occurring mental health and substance use disorders is designed to improve treatment capacity for these consumers in systems of any size or complexity, ranging from entire states, regions, networks of agencies right down to programs within individual services.

The model has four basic characteristics:

- *System-wide change*: The CCISC model builds upon the concept of "dual diagnosis capability" as a core expectation of the design of *any program* in which individuals with co-occurring disorders might appear, and asserts that because individuals with co-occurring disorders are highly prevalent, with poor outcomes and high cost, throughout the service system, the whole system must design all mental health and substance abuse programs to achieve minimal dual diagnosis capability, and design selected dual diagnosis enhanced programming within each category of existing service

- *Existing resources*: Dual diagnosis capability can be created most efficiently within the context of existing resources by simply designing all mental health and substance abuse programs to meet the needs of the co-occurring clients who are actually in them, rather than designing them as single disorder programs into which the clients do not "fit";

- *Best Practices*: The CCISC model emphasizes that any best practice for either disorder can be applied to individuals with co-occurring disorder, provided there are mechanisms for integrating matched treatments for both disorders at the level of the client in the context of a treatment relationship; and

- *Integrated Treatment Philosophy*: The CCISC model is "principle driven", based on eight clinical consensus best practice principles that define individualized treatment matching and system design. A common language is used that makes sense from the perspective of both mental health and substance abuse disorder services. This model can be used to develop a protocol for individualised treatment matching, that in turn permits a 'matching' of consumers to the range of dual-diagnosis capable services within the system.

The eight principles of treatment that guide the implementation of this model of care are as follows:

Dual Diagnosis is an expectation, not an exception. Services should be planned and developed to reflect this expectation and that both service settings should have core competencies.

[19] Minkoff, K. (1991), Program components of a comprehensive integrated care system for seriously mentally ill patients with substance disorders, in Dual Diagnosis of Serious Mental Illness and Substance Disorder: New Directions for Mental Health Services, no. 50:13-27.

All consumers with dual diagnoses are not the same. The 'four quadrant model' for categorising dual co-occurring disorders can be used as a guide to service planning on the system level, requiring varying degrees of service integration.

Empathetic, hopeful, integrated treatment relationships are on of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence-based best practice for individuals with the most severe combinations of mental health and substance abuse. The system needs to prioritise the development of clear guidelines for how clinicians in any service setting can provide integrated treatment and access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

Case management and care must be balanced with empathetic detachment, expectation, contracting, consequences and contingent learning for each consumer, and in each service setting.

When mental health and substance disorders coexist, establishing the primary diagnosis is recommended. Specific practice guidelines need to be developed for clinically appropriate clients within each service setting.

Both mental illness and addiction can be treated within the philosophical framework of a 'disease and recovery model' with parallel phases of recovery (acute stabilisation, motivational enhancement, active treatment, relapse prevention and rehabilitation / recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change. Literature in both the addiction field and the mental health field has emphasised the concept of stages of change or stages of treatment and demonstrated the value of stage-wise treatment.

There is no single correct intervention for this cohort of consumers; for each individual interventions must be individualised according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery / stage of change and multidimensional assessment of level of care requirements. Each program is a dual diagnosis program but all programs are not the same. Each program in the system is assigned a 'job': to work with a particular cohort, providing continuity or episode interventions, at a particular level of care.

Clinical outcomes for dual diagnosis clients must be individualised, based on similar parameters for individualising treatment interventions. Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualised, and may include reduction in symptoms or use of substances, increase in LOF, increase in disease management skills etc.

Further, CCISC has defined a "Twelve Point Program of Implementation". This implementation program has ***no*** relationship to the 12 step programs of AA and NA and should not be confused with those programs.

The implementation of this model of care has to be designed to fit the culture and needs of a poorly resourced and historically demoralized service system. This involves the following specific strategies:

Strength based implementation: Emphasize the strengths of existing services and build upon those strengths, rather than creating new programs.

Phased, success oriented implementation: Build system self-efficacy through the creation of attainable goals and objectives, maintaining a big vision for the system, but small steps to achieve the vision.

Incorporation, rather than exclusion: In the first year, collaborative systems need to be involved and informed, even though the focus of implementation will be through drug and alcohol services and mental health services

Multi-layered implementation: Involve all levels of the system simultaneously, to ensure a top down AND bottom up process.

Solution-focused implementation: Focus first on concrete issues that are immediately recognizable as requiring measurable solutions, namely identification and reporting; access ("no wrong door"), and universal "dual diagnosis capability" or core competencies, and build change around clients already in the system.

Strategic synergy: Build the model into existing initiatives rather than building in isolation.

Collaboration, not competition: Recognize both mental health and drug & alcohol service providers as valuable participants in the total system design process, each with valuable strengths and opportunities for both teaching and learning.

"Backfilling and Anchoring": Promulgate standards after success is established, rather than use standards as a "stick". Successful change is rewarded and then sustained by being anchored in the bureaucracy.

Administrative support for clinical care: Emphasize creating a rational administrative structure, with clear communication, decision-making processes, and role definitions, that is designed to facilitate good clinical care (rather than forcing clinical services to conform to administrative strictures that create barriers to care) and

Outcome driven, CQI oriented implementation: Identify measurable outcomes with strategically designed incentives within CQI processes

Clinical Practice

The ultimate goal of the implementation of any model of care is to build integrated evidence based practice for mental health and substance disorders into the routine service delivery activities of the existing service system. Strategically, this will involve four levels of activity:

2. Developing draft service planning guidelines for co-occurring disorders based on national clinical consensus best practice standards and circulating this document to key stakeholders, to provide both education regarding the direction of the

system, and to obtain feedback regarding the potential incorporation of these guidelines into service standards;

3. Establishing the principle that existing programs and interventions in both the mental health system and the drug & alcohol system are valuable and appropriate, provided that they are designed to appropriately accommodate individuals with dual diagnosis;

4. Focusing on the specific clinical practice of screening and identification of co-occurring disorders at all points of entry into the system, and on developing a clinically driven assessment process.

5. Disseminating best practice guidelines for the use of medication for individuals with co-occurring disorders and training staff in the utilization of these guidelines.

A range of tools needs to be offered to clinicians under this model, with programs encouraged to develop a screening process that makes the most clinical sense for their settings.

The Comprehensive, Continuous Integrated System of Care Model fits well with the Collaborative Recovery Model being rolled out through mental health and drug and alcohol services over the coming months and years. It is important that any model of care chosen for the proposed service for people with co-occurring disorders, is able to fit with the training and skills that are being developed across both service settings. Clinical pathway development through this system will be a truly collaborative exercise. The development of capacity and core competencies across the different agencies is highlighted as a fundamental requirement.

Appendix 2: Consultation process

The Dual Diagnosis Committee of the IMHS and Drug& Alcohol Services has been meeting for a number of years. Recent discussions between the Area Director of Mental Health and the Team Leaders / Managers of Drug & Alcohol rehabilitation services (Kedesh House and The Wollongong Crisis Centre) served to illuminate the service provision gaps in providing comprehensive care that cohort of consumers who are significantly disabled by both mental health issues and substance use.

A Planning Group was convened in October 2003 and from this emerged a Steering Committee and Reference Group. Member ship of these groups is outlined below:

Steering Committee Membership

Eugene McGarrell (Area Director – Mental Health)
Di Knight (Area Director – Drug, Alcohol & HIV/AIDS Service)
Bernadette Wood (Sector Manager MH Specialist Services)
Steven Maron (Manager MH Planning & Projects)
Will Temple (Manager- Wollongong Crisis Centre)
Jason Lucas (Team Leader - Kedesh House)
Debra Munro (Manager – Oolong House)
Ian Korbel (Staff Specialist – Drug & Alcohol. MH Service)
Trevor Crowe (Illawarra Institute for Mental Health, UoW)
Peter Brown (Northern Illawarra MH Sector Manager)
Sue Karpik (Lake Illawarra MH Sector Manager)
Michael Cox (Shoalhaven MH Sector Manager)
Sharon Ible (NUM, Orana House)

Reference Group Membership

As above +

Alex Cockram (Clinical Director – Mental Health)
Kirk Seddon (CNS MH Liaison – Drug Alcohol Community Adult Team (DACAT))
Amanda White (Intern Psychologist – DACAT)
Miriam O'Toole (Manager – Northern Illawarra DACAT
Tim Kent (CNC – Mental Health)
Jenny Harland (CNC – D&A Service)
David Reid (Manager Shoalhaven DACAT)
Kelly Marshall (IDGP)
Grant Ford (Consumer Rep – Metal Health)
Jayne Wilson (Salvation Army – Consumer Rep, D&A Services).

Steering and Reference Group Members were charged with a variety of informational and liaison tasks, including site visits to Northern Rivers, SW Sydney, SE Sydney, the Hunter and the review of policies, protocols and guidelines from a variety of sources and services. Agreement on the Model of Care was included as part of the consultation process. Site visits by the Manager MH Planning & Projects to The

Wollongong Crisis Centre, The Shoalhaven and Northern DACAT provided staff with an overview of the planning process and the intended outcomes.

Members of the Steering and Reference Groups also provided liaison points between the planning committees and clinical staff.

	2004/05[a] ($)	2005/06 ($)	2006/07 ($)	2007/08 ($)	2008/09 ($)
Staff Specialist [b]	99,377	102,358	105,428	108,590	111,848
Clinical Nurse Consultant [c] (2)	139,256	142,433	146,706	151,107	155,640
Clinical Psychologist [d] (2)	143,302	147,601	152,029	156,590	161,287
On-Costs [e]	54,616	56,112	57,795	59,529	61,315
Goods and Services [f]	34,924	35,880	36,956	38,065	39,207
Evaluation [g]	5,000	1,250	1,250	1,250	1,250
Total Cost	**476,475**	**485,634**	**500,164**	**515,131**	**530,547**

APPENDIX 3: DETAILED COSTINGS

[a] Assumes 3% wages growth from 2004/05
[b] At Level 1 Senior
[c] CNC Grade 2 Year 2
[d] Clinical Psychologist Year 5
[e] On-Costs (Superannuation, Leave loading, Workers compensation etc) at 14.3%
[f] G&S calculated at 8% of S&W budget
[g] Evaluation costs include production of materials (publication of appropriate client education, manuals, pamphlets, fliers) and data entry and production of report