Response to:
Question on notice from the Senate Select Committee on Mental Health
Public Hearing on Wednesday, 6 July 2005

Question from:
Senator MOORE

Question on notice
From your perspective, what is the difference between what is happening with the dual diagnosis model in which you are both working and your preferred model—the one that you are recommending? There must be some things that are similar but there must be some things that are not. In the background paper that you have given us, you refer to your preferred model. I would like to know what is happening now, at least from your perspective, in the dual diagnosis model—which, I am sure, we will hear about from the Victorian government—and how that differs from what you would like to see.

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Thank you for the opportunity to respond to this question on notice.

I would like to preface my response with some contextual observations about the response to co-occurring mental health and substance use disorders in Victoria. Of all Australian states Victoria has placed the highest priority upon and devoted the most significant amount of resources to improving the response to co-occurring disorders. Operational since 2002 the Victorian Dual Diagnosis Initiative (VDDI), jointly funded by the Mental Health Branch and the Drugs Policy and Service Branch, is the largest-scale initiative addressing co-occurring disorders in Australia to date.

Victoria's commitment to improving outcomes for persons with co-occurring disorders was underscored by the 2004 formation of a Ministerial Advisory Committee on Mental Health with a specific remit to 'address a need for better coordination between mental health and drug and alcohol services to improve access and develop innovative models of integrated service delivery'. Learnings from the Victorian initiatives and their evolution will contribute to other Australian states' strategy development. .

Whilst your question asks specifically about the Victorian situation it should be noted that Commonwealth policy and planning bodies and processes have significant potential, at minimal cost, to positively influence the service system's response - hence I have also included some consideration of necessary Commonwealth responses. I have attempted to restrict my response to identifying those ingredients which have contributed to improved responses to co-occurring disorders in other parts of the world but which have yet to be deployed on a substantial basis in the local situation.

In the interests of brevity I have summarised my response into bullet points and sorted the various strategies by suggested loci of implementation responsibility

- Commonwealth level
- State & systems level
- Agency level
- Clinician level

While the list may on first glance appear exhaustive and onerous it is underpinned by the recognition that there are significant barriers to moving systems to more effective responses. A comprehensive array of top-down and bottom-up strategies is necessary in order to effect sustainable change. Reframing as an urgent priority the need to assertively address the system's responses is warranted by the prevalence of / harms associated with co-occurring disorders and the difficulties that all treatment systems have in responding effectively. Many of the suggested strategies may be implemented at negligible cost - they represent a tuning of existing services in recognition of the realities of co-occurring disorders rather than the development of new systems and infrastructures.

As with my initial Senate Mental Health Inquiry submission (#374) much of the following material and proposals have been influenced by the Comprehensive Continuous Integrated System of Care model (CCISC). CCISC has been recognised as a best practice model for system design around co-occurring disorders and designed for implementation in any system of care, largely within existing resources. One possible way forward, with the potential to influence the whole countries response to co-occurring disorders, is for some section of the Australian healthcare system to be funded for CCISC implementation.

There is one final related point that I would like to make, as strongly as I may, after reading through the submissions to the Committee and transcripts of public hearings. One of the common, possible systemic responses often mooted to the challenges of co-occurring disorders is to merge the mental health and A&OD treatment systems (a related confusion concerns the term '*integrated treatment*' with instances of persons perceiving that integrated treatment refers to merging the two service systems - integrated treatment refers only to a single worker or agency providing integrated treatment of both a client's substance use and mental health disorders). I am unaware of any system in the world which has merged or remerged the two treatment systems in response to co-occurring disorders. There is no

substantial evidence that indicates such an action would improve outcomes for persons with co-occurring disorders.

Most often the two service systems provide services to different cohorts of persons with co-occurring disorders (Mental Health systems to the severely mentally ill with co-occurring substance use disorders and A&OD agencies to persons with substance use disorders co-occurring with high-prevalence mental health disorders &/or personality disorders). In most systems the A&OD system is much smaller and less well resourced than the Mental Health system and it is questionable, were the A&OD system to be swallowed up by the larger Mental Health system, whether the Mental Health system (which, by any reckoning, struggles to provide effective mental health services) would then do justice to the needs of the population currently serviced by the A&OD system.

In summary the reflexive response of merging the two systems lacks a sound evidence base and may, in fact, become a significant barrier to achieving better outcomes given the difficulties surrounding such a merger and the reality that the systems provide services to different cohorts of persons with co-occurring disorders with quite different treatment needs.

Commonwealth level

Creation of a federal body similar to the USA's *Co-Occurring Centre for Excellence*:

- Body to be concerned with the Mental Health, the A&OD and the General Practice service systems' recognition of and response to all the cohorts of persons with co-occurring disorders (high or low-prevalence mental health disorders co-occurring with any of licit or illicit substance abuse / substance abuse or substance dependence).
- Body to contribute to future A&OD and Mental Health national plans
- Body to use a diverse range of strategies to identify and promote best -practice responses to co-occurring disorders for each of the service sectors.
- Body to identify, prioritise, auspice and coordinate an Australian co-occurring disorders research agenda
- Body to identify, generate and collate accurate data on the prevalence of comorbidity capable of contributing to targeted planning processes
- Design and publish recommended minimum standards of co-occurring disorders capability (Minkoff, 2005)
- Design and publish tools for clinicians and agencies to self-evaluate their co-occurring disorders competence
- Publish a range of clinician-oriented treatment manuals for reach of the A&OD, Mental Health and General Practice workforces

Actual, collaborative, strategic planning process underpinning future A&OD and Mental Health National plans

- Plans need to be built around the overt recognition that the available evidence requires us to engage in a significant change process involving the service offered by Mental Health, A&OD and General Practice systems, agencies and clinicians.
- Plans to be developed from an actual collaborative strategic planning process and to span similar time frames
- Plans to be informed by accurate data on the prevalence, nature and harms of co-occurring disorders within each of the service systems. Such data will hone the planning of 'resource allocation, program design, policy needs, clinical practice needs, and competency needs' (Minkoff, 2005). (The CCISC model posits that that the whole system, at every level, must be designed to use all of its resources in accordance with recognition of the high prevalence of co-occurring disorders and the strongly-associated 'poor outcomes and high costs in multiple systems' -Minkoff, 2005).
- Plans should assign broad systemic treatment responsibility for the various cohorts of persons with co-occurring disorders, perhaps utilising the four-quadrant model for treating co-occurring disorders

- Plans to be built on an integrated treatment philosophy (Minkoff, 2005) tempered by the recognition that each system will have differing existing and potential capacities to provide integrated treatment to the varying cohorts of persons with co-occurring disorders. Plans should prioritise the development of each system's capacity to provide integrated treatment
- A reasonable broad goal for the mental health system is that *where a person's mental health symptoms qualify them for service from a mental health agency any co-occurring substance use disorder is routinely detected, assessed & treated by the same clinician or agency that is providing treatment for their mental health disorder* (Croton, 2004)
- Plans should establish the policy direction that all services in each service system must meet minimum standards of co-occurring disorders capability (Minkoff, 2005). Standards of co-occurring disorders capability will differ between the mental health and A&OD service systems. Standards are not based on the expectation that the services will *change* their target client group but that they will *increase their capacity to provide integrated treatment to that client group* or, *where integrated treatment is not possible to recognise and facilitate treatment for any co-occurring disorder*.

State Level

Mental Health & A&OD central planning bodies to articulate an agreed vision of how the systems will appear when they are providing more effective treatment of co-occurring disorders

- The single most important factor towards successfully instituting change is to have clearly expressed goals for the change process. Explicitly stated goals leads to clarity in strategy selection, deployment and evaluation of effectiveness of strategies chosen.
- Vision should be collaboratively developed (all stakeholders) and informed by a substantial review of the evidence base around co-occurring disorders. Collaborative development of the vision increases the investment of involved stakeholders in making the vision a reality

Collaborative, *strategic* planning process involving state A&OD and Mental Health planning and funding bodies

- Planning needs to be around implementing a broad spread of strategies towards sustained system change.
- Planning needs to examine and address systemic barriers to change
- Planning needs to be based on the recognition that effecting change to service delivery is an incremental process that will require sustained commitment from leadership
- Planning processes need to be informed by accurate estimates of the prevalence of co-occurring disorders and identification of best practice responses.
- Strategy selection should be informed by a review of effective approaches to achieving systems change, perhaps with the input of particular systems change expertise.
- Planning processes need to consider strategies to generate 'buy-in' from all of the stakeholders whose input is necessary to achieve systems change.
- Planning process should assign broad treatment responsibility for the various cohorts of persons with co-occurring disorders, perhaps using the four-quadrant model.

Policy development and deployment

- Policy represents the most potent, low-cost leverage towards influencing a system towards sustainable change. Policy deployment is an essential top-down strategy complementing and validating bottom-up strategies such as consultation and training delivery
- Policy may be developed in the light of Commonwealth directions but tuned to local system circumstances and possibilities
- Reinforcing and mandating appropriate scopes of practice in regard to co-occurring disorders in policy is an influential step towards sustainable improvements in service delivery

- Policy should contribute to a 'no-wrong-door' system which values and rewards assertive responses by workers and agencies towards linking clients to the most appropriate service wherever they contact the treatment system

Agency and clinician co-occurring disorders capability standards

- Minimum standards of agency and clinician co-occurring disorders capability need to be developed and agreed to for both Mental Health & A&OD service systems
- Development and/or endorsement and promotion of tools for agencies and clinicians to self-evaluate their co-occurring disorders capability is a strong step towards focusing the attention of agencies and clinicians on building their co-occurring disorders capability. Besides demonstrating priority such a strategy provides clear guidance and benchmarks and also 'rewards' agencies and clinicians that have already achieved increased capacity.

Treatment manuals

- Development and dissemination of practical, clinician-oriented treatment manuals tuned to local system circumstances for each of the workforces (A&OD, acute Mental Health and Psychiatric Disability Support) endorses central policy directions, supports training initiatives and provides an on-site, easily-accessed resource for clinicians
- Manuals should cover possible and desired responses around detection, assessment, treatment referral and follow up responses to persons with co-occurring disorders.

Training and Clinical Supervision plans

- Training plans should be formulated with the recognition that training alone is insufficient to meaningfully influence practice (Grimshaw et al, 2001) but is an integral part of the spread of strategies necessary to influence practice change
- The content of a structured, ongoing training plan will develop from the process of defining expected clinician and agency co-occurring disorders competencies.
- Training should address attitude as well as knowledge and skills
- Training plans should incorporate mechanisms, such as access to co-occurring disorders oriented Clinical Supervision to re-enforce and 'work-in' learnings form training
- Training needs to be targeted around the particular needs of key groups such as state-employed psychiatrists (as Psychiatrists have oversight and responsibility for all clinical Mental Health service delivery their engagement and enthusiasm is crucial to implementing integrated treatment of co-occurring substance use disorders)

Strategies to influence the A&OD and co-occurring disorders content in a range of undergraduate courses

- It is common for a wide range of undergraduate Health courses to contain negligible content around substance use disorders alone let alone co-occurring disorders. This despite the reality that most health graduates will spend much of their careers dealing with a range of conditions caused or complicated by substance abuse. Further there is strong evidence that low-input interventions in a range of healthcare settings are effective in preventing much of the costs and harms caused by substance use disorders. It is not uncommon for medical graduates to qualify having received no, or at most a few hours, training around the recognition of and response to substance use disorders
- It would appear to be a worthwhile investment in the quality and effectiveness of our future healthcare workforce for central health planning bodies to be much more active in attempting to influence the content of the education provided to future employees (perhaps learning from the influence that many trade bodies have with relevant education providers).

Agency Level

Selection of co-occurring disorders 'champions'

- Each agency should appoint a co-occurring disorders 'champion' charged with implementing quality improvement activities in regards to the response to co-occurring disorders, evaluating and developing the agencies service delivery in regards to co-occurring disorders.
- Champions will serve as resource persons for other workers in the agency and may provide co-occurring disorders oriented Clinical Supervision and training or link workers to Clinical Supervision and training provided by outside bodies or the broader system
- Champions position and standing within the agency should be such that they have the ability to substantially influence that agency's service delivery

Agency policies & procedures

- Agency policies and procedures need to be examined around the question of how well they reflect the agencies orientation towards providing or facilitating treatment for any co-occurring disorder.
  For example:
  - Do assessment forms assist a clinician to identify and plan treatment around the likelihood of multiple diagnoses?
  - Does information and education provided to carers contain information about co-occurring disorders?
  - Are there policies around the agencies preferred responses to co-occurring disorders?
  - Is skill in responding to co-occurring disorders valued in terms of promotion criteria / incorporated into staff appraisal criteria?

Self-appraisal of agency co-occurring disorders capability

- At routine intervals in order to inform and evaluate relevant quality improvement activities
- Preferably utilising a centrally-generated or endorsed tool to conduct the appraisal

Training and Clinical Supervision needs

- Individual agencies capacities to detect and respond to co-occurring disorders will vary as will their training and support needs. As an ongoing process, individual agencies should be active in identifying particular training needs, in accessing available training and in ensuring that staff have access to co-occurring disorders oriented Clinical Supervision to 'work-in' training learnings.

Routine screening for co-occurring disorders

- The first, necessary step towards responding more effectively to co-occurring disorders is to improve the detection of any co-occurring disorder. A CCISC model strategy is to establish policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.
- Each agency should have a preferred suite of tools for the detection of co-occurring disorders and policies around when they are and are not deployed
- If one of the possible treatment pathways on detection of a co-occurring disorder is referral to another specialist agency then the other specialist agency should also be familiar with the suite of tools used by the referring agency. For example, if an A&OD agency uses the K10 screening tool to detect co-occurring mental health disorders/symptoms then the local mental health agency should also have a developed understanding of implications of a high K10 score and the possible implications for their response

Relationships with the 'opposite' agency

- A&OD and Mental Health agencies have different current and potential capacities to provide integrated treatment (one agency or worker providing integrated treatment of both disorders) to the varying cohorts of persons with co-occurring disorders. Where the response to co-occurring disorders will include referral to or collaborative working with the 'opposite' agency then this should be supported by activities and structures that will enhance the working relationship.
- Strategies to this end include regular formal and informal contacts between workers, interagency protocols, enhanced referral mechanisms, reciprocal worker placements, routinely providing services from the opposite agency, reciprocal training and mechanisms for A&OD workers to access psychiatrist's time.
- A central goal in Mental Health and A&OD management and workers addressing the interagency relationship should be the development of a 'no-wrong-door' service system. A 'no-wrong-door' service system may be defined as systems in which, where a person is assessed and it is deemed that the person's symptoms/ needs do not qualify them for a service from the Mental Health or A&OD agency providing the assessment but that service from another A&OD or Mental Health agency is warranted then the person receiving the assessment will still be warmly welcomed and actively and meaningfully assisted in gaining a service from the appropriate agency. Service recording tools should be modified to value and 'reward' such clinician activity.

Clinician Level

In order to move to more effective treatment it is essential that clinicians are closely involved in planning and implementing changes. Clinicians must be asked to examine their current practices, attitudes and criteria for service and to incorporate new treatment approaches into their practice. The mental health workforce in particular has had to contend with substantial change over a protracted period of time and is understandably wary when asked to make further substantial changes to their role, especially when they have often been struggling to provide minimum services in what can be, at times, a dysfunctional system.

Concluding remarks

In closing I would like to quote from a new text from the New Hampshire Dartmouth Psychiatric Research Centre *Evidence-Based Mental Health Practice - A Textbook* (Drake, Merrens and Lynde, Eds, 2005). This text examines issues around identifying and implementing evidence-based practices (EBP's) in mental health systems. The researchers, clinicians and system change experts at the New Hampshire centre have decades of experience in identifying and implementing EBP's in mental health care. They have identified 6 EBP's which the federal Substance Abuse & Mental Health Administration is disseminating as resource kits to encourage their adoption by mental health services. One of the EBP's identified by the group is Integrated Dual Disorder Treatment for severe mental illness type co-occurring disorders.

Torrey and Gorman's chapter on implementation of EBP's is particularly germane to Senator Moore's question. In their overview of implementation strategies the author's state that '*there are no magic bullets for changing provider behaviour in health care. What does appear clear is that combining multiple strategies to overcome challenges is more likely to be effective than using just one intervention. In studies of practice change intensity of effort appears directly related to success*'……. '*Changing complex practice behaviour such as implementing a complex EBP, requires a higher level of effort than that needed to effect a relatively simple change, such as influencing a prescription choice*'….. Torrey and Gorman further caution that '*Because implementing an EBP is a relatively complex activity an intensive effort over an extended period of time is often required'…..* and again, *'Implementing and sustaining high quality EBP's requires many ingredients, including committed and consistent leadership within an agency or a public mental health system'.*

I hope that the above is helpful and, of course, am happy to discuss any aspect of this response or the initial submission as necessary.

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References

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