

Submission to:

**Senate Community Affairs
Committee**

**Commonwealth Funding and
Administration of Mental
Health Services Inquiry**

Potential:

Australia's evolving responses to co-occurring mental health and substance use disorders



Gary Croton

Eastern Hume Dual Diagnosis Service

Northeast Health Wangaratta

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Disclaimer:

Since 1998 the author has worked, in a cross sector dual diagnosis capacity building role, for **Eastern Hume Dual Diagnosis Service, Northeast Health Wangaratta**. Since 2002 that service has been a component of the **Victorian Dual Diagnosis Initiative**. The views and recommendations articulated in this submission are those of the author and are not necessarily representative of the views or opinions of either Northeast Health Wangaratta or of the Victorian Dual Diagnosis Initiative.

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Contact details:

S/M Gary Croton
Eastern Hume Dual Diagnosis Service
Northeast Health
Green St.
Wangaratta
VIC 3677

T: 03 5722 2677

M: 0409 776 338

F: 03 5722 2877

E: gary.croton@nhw.hume.org.au

W: www.dualdiagnosis.org.au

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Section 1 Territory

About co-occurring mental health and substance use disorders

Terminology

A range of terms are commonly used to describe co-occurring mental health and substance use disorders:

- '*Dual diagnosis*' is the preferred term in a number of Australian states and the United Kingdom
- '*Comorbidity*' was the Commonwealth's and the Department of Health and Ageing (DoHA) preferred term. Recent publications from DoHA have tended to adopt more descriptive terminology such as '*coexisting mental health and substance use disorders*' or '*coinciding mental illness and substance abuse*'. '*Comorbidity*' has been criticised by carer groups for its pathological overtones.
- '*Co-existing disorders*' is the preferred term in New Zealand
- '*Co-occurring disorders*' is the term now predominantly employed in the USA
- '*Concurrent disorders*' is Canada's preferred term
- Abbreviations that are not in common parlance include 'CAMI' ('*Chemically affected Mental Illness*'), 'MICA' ('*Mental Illness Chemically Affected*'), 'SAMI' ('*Substance Affected Mentally Ill*'), 'MISA' ('*Mental Illness Substance Affected*'), 'MISUD' ('*Mental Illness Substance Use Disorder*'), 'ICOPSD' ('*Individuals with Co-occurring Psychiatric and Substance Use Disorders*') ([Minkoff](#), 2001).
- A new convention to describe co-occurring mental health and substance use disorders is the abbreviation '*mental health-substance use*'. This term has recently been adopted by a journal ([Mental Health and Substance Use journal](#)) and a number of texts (Cooper, [2011-a](#); Cooper [2011-b](#); Cooper [2011-c](#); Cooper [2011-d](#); Cooper [2011-e](#); Cooper [2011-f](#)) addressing the various issues around co-occurring mental health and substance use disorders

For consistency with earlier submissions ([Croton 2005-a](#); [Croton 2005-b](#)) this submission will employ the '*co-occurring disorders*' convention.

Cohorts

Co-occurring disorders are not a single diagnostic category such as '*Generalised Anxiety Disorder*'. Rather the term refers to the any of a wide range of mental health disorders that may co-occur with any of a wide range of substance use disorders. Co-occurring disorders refers to a wide range of possible combinations of disorders. Considerable variation in the severity and impact of those disorders leads to substantial diversity in the individual treatment needs of the various people who experience co-occurring disorders.

Some of the cohorts of people with co-occurring disorders that treatment systems, the research community and the media have had a particular focus on include people with:

- Alcohol use disorders co-occurring with anxiety or depressive symptoms or disorders
- Cannabis use disorders co-occurring with psychosis
- Personality disorder co-occurring with opiate or polysubstance dependence
- Post Traumatic Stress Disorder co-occurring with substance abuse
- Psychosis co-occurring with a range of substance use disorders
- Stimulant abuse or dependence co-occurring with psychosis

Spectrum of disorders

One possible –albeit broad - typology for mental health disorders is to sort the disorders by whether they are '*high prevalence- lower impact*' disorders (e.g. mild anxiety or depression) or '*low prevalence-higher impact*' disorders (e.g. psychosis). Similarly Substance Use Disorders – regardless of which substance/s are involved can be placed on a spectrum from Substance Abuse to Dependence (See Appendix 1 – *DSM-1V / ICD 10 criteria for Substance Abuse, Harmful Use and Dependence*).

Specialist mental health services, in the context of scarce resources, have traditionally been principally oriented around the needs of people with '*low prevalence-higher impact*' mental health disorders. Alcohol and Other Drug (AOD) treatment services principle treatment focus, perforce, has been on people with substance dependence rather than abuse – that is the groups to the far right of the spectrums in Diagram 1- *Mental health and substance use disorders spectrum*.

Notwithstanding these traditional orientations, when considering our systemic recognition of and response to people with co-occurring disorders, it should be borne in mind that:

- By reason of prevalence the greatest costs and harms associated with mental health disorders are for high prevalence –lower impact disorders (Diagram 2)
- Similarly, again due to prevalence, the greatest costs and harms associated with Substance Use Disorders are for the large group of people who are positive for Substance Abuse but not Dependence (Diagram 2)

- For both people with Severe Mental Illness (SMI) or Substance Dependence rather than Abuse treatment trends to be high input and less effective(Diagram 3)
- Whereas for both cohorts - people with high prevalence – lower impact mental health disorders or people with Substance Abuse rather than Dependence - treatment tends to be lower input and effective (Diagram 3) (as long as the disorders are recognised for treatment to be provided)

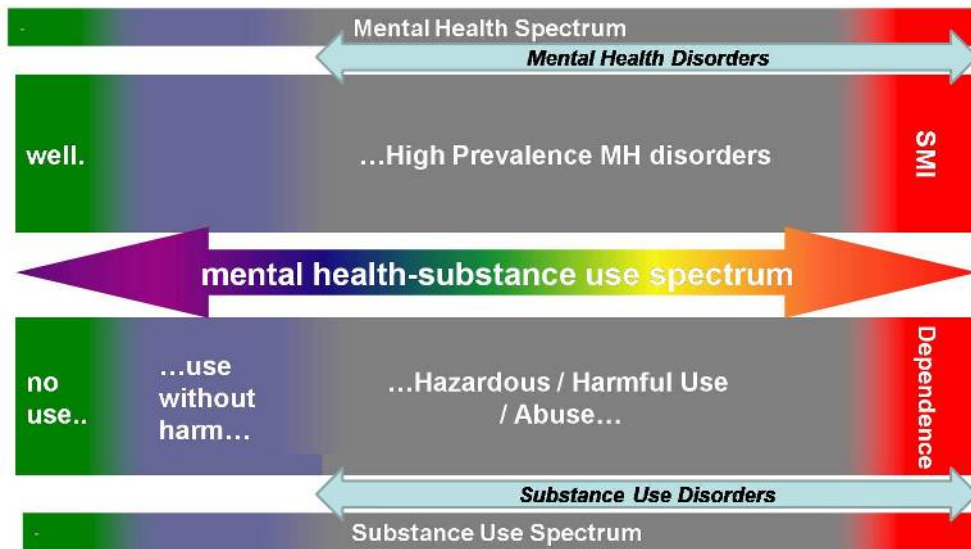


Diagram 1: Mental health and substance use disorders spectrum.

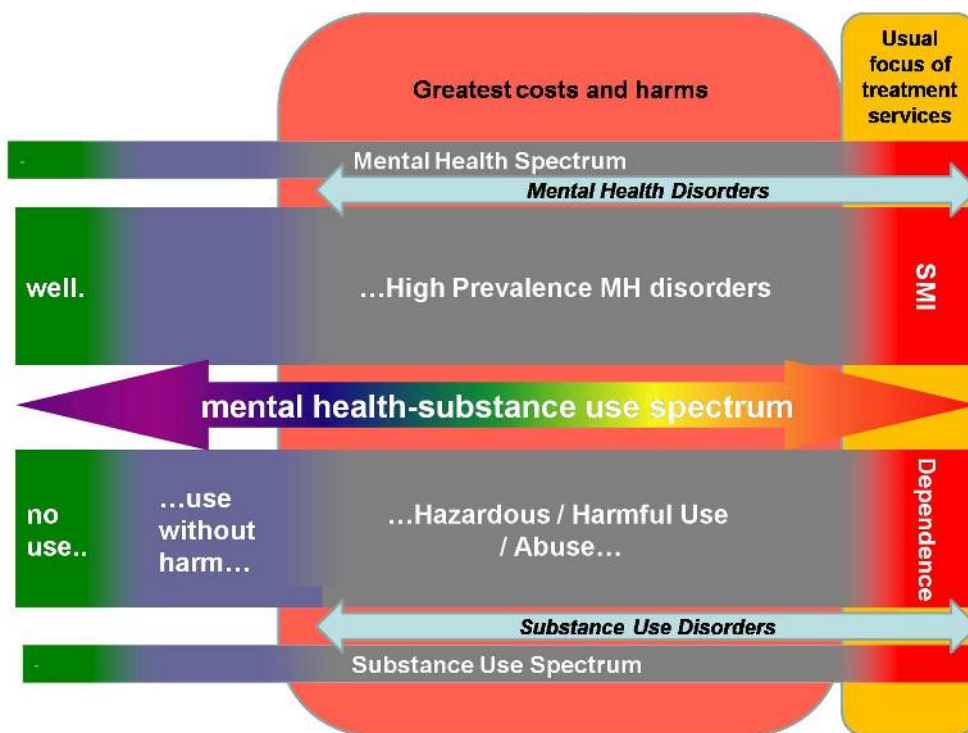


Diagram 2: Costs and harms / focus of treatment services

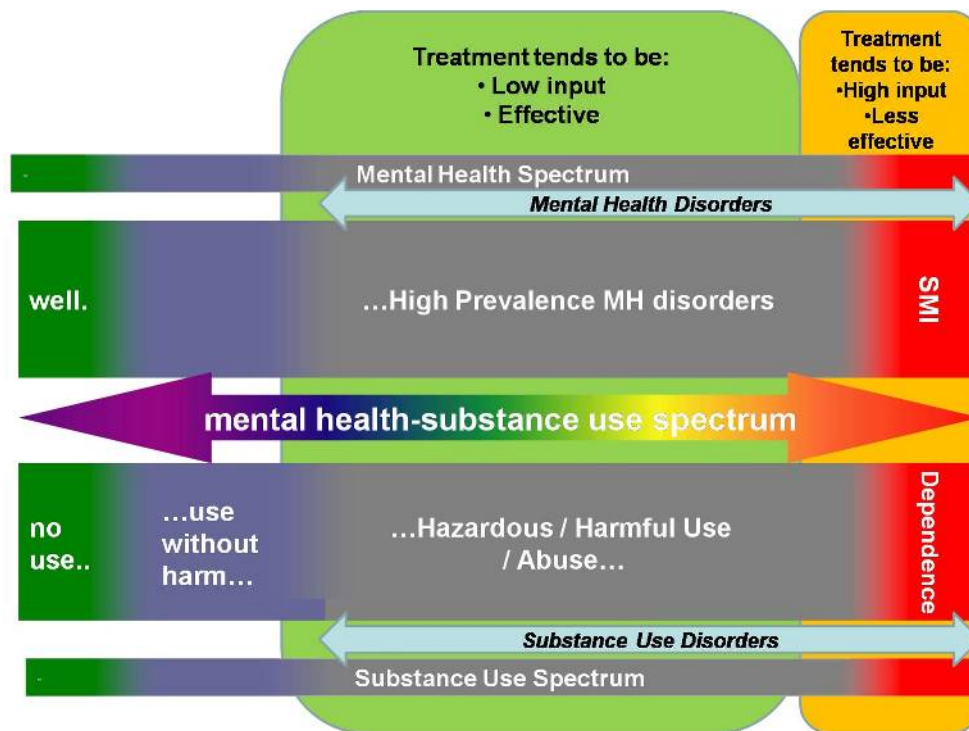


Diagram 3: Treatment inputs and effectiveness

An implication of the above is the need to have a broad and inclusive definition of co-occurring mental health and substance use disorders – one that embraces cohorts of people with (often less visible, less easily detected) Substance Abuse and/or high prevalence mental health disorders. Of course, in a socially just society, investing in providing the most effective possible responses to the cohorts with Severe Mental Illness and/or substance dependence has to be of the highest priority.

At the same time it is strategic to recognise that the greatest potential gains and savings associated with co-occurring disorders are to be found in developing our recognition of and effective responses to those cohorts of people whose co-occurring disorders includes either Substance Abuse or high prevalence mental health disorders.

Relationships between the disorders

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

1. **Common risk factors:** posits that common risk factors – such as trauma or poor cognitive functioning – may have influenced the person to develop both disorders.
2. **Mental health disorder causes co-occurring substance use disorder:** included in this model are relationships such as – *the self medication hypothesis* in which a person develops a substance use disorder in using substances to alleviate the symptoms of a mental health disorder e.g. person develops an Alcohol Abuse disorder as a result of the repeated use of Alcohol to relieve the symptoms of an Anxiety disorder

- *dysphoria model* argues that life can sometimes, for some people with mental health disorders, have few pleasurable moments – making the person more susceptible to the more 'instant', predictable, pleasures of substance abuse
- *super sensitivity model* posits that some people with mental health disorders, whether through the symptoms of the illness or the effects of the medications used to treat the illness, are exquisitely susceptible or vulnerable to the effects of substances

3. Substance use disorder causes mental health disorder: sometimes a clear causal relationship can be observed between substance use and the subsequent development of a mental health disorder e.g. amphetamine psychosis

4. Bi-directional model: perhaps the most clinically useful of the models this model posits that each disorder develop in relationship to the other – substance use influence mental health symptoms which in turn influence substance use and so on. Most commonly, when working with someone with co-occurring disorders, a clear causal relationship of one disorder leading to the other cannot be identified with any confidence.

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

Section 2

Priority

Why is it urgent to address co-occurring disorders?

There are three compelling reason why it is urgent that Australian mental health, AOD and primary care service systems continue to develop their recognition of and effective responses to people who experience co-occurring disorders:

1. **Prevalence** of co-occurring disorders
2. **Harms and costs** strongly associated with co-occurring disorders
3. **Potential** for more effective treatment of 'target' disorders



1. **Prevalence** of co-occurring disorders

- People presenting with co-occurring disorders are highly prevalent in each of mental health, Alcohol and Other Drug (AOD) and Primary Care settings. Co-occurring disorders are also common in the general population.
- In mental health and AOD settings the exceptionally high prevalence rates have led to the axiom that co-occurring disorders are the '***expectation not the exception***' ([Minkoff and Cline](#), 2004 ; [Senate Select Committee on Mental Health](#) 2006).
- Prevalence rates will vary depending on the particular co-occurring disorders that are focused on, the methodology used to identify the prevalence rate and the service setting in which the prevalence study is conducted.
- *Mental health treatment settings*: between approx 20-75 % of people receiving treatment for a mental health disorder will have a co-occurring substance use disorder ([Croton](#) 2005-a). People with the most severe mental health disorders tend to have the highest rates of co-occurring substance use disorders ([Drake, Mueser & Brunette](#), 2007).
- *AOD treatment settings*: between 19 – 85% of people receiving AOD treatment will have a co-occurring mental health disorder ([Mills et al.](#) 2010; [Croton](#) 2005-a).
- *General Practice settings*: A large Australian study ($n = 46,515$) found that 12% of patients attending General Practice – for any reason – had co-occurring mental disorders and substance misuse ([Hickie et al.](#), 2001).
- *In the general population*: The 2007 National Survey of Mental Health and Wellbeing ([Slade et al.](#), 2009) found that 20.0% or 3.2 million Australians, aged 16-85, experienced mental disorders in the previous 12 months. Of those 1 in 4 people experienced more than one disorder:
 - 1.8% of Australian males and 0.8% of females experience co-occurring substance use and anxiety disorders in the past 12 months.
 - 0.6% of Australian males and 0.2% of females experience co-occurring substance use and affective disorders in the past 12 months.
 - 0.8% of Australian males and 0.6% of females experienced all 3 of co-occurring substance use, affective and anxiety disorders in the past 12 months.



2. **Harms and costs** strongly associated with co-occurring disorders

A considerable body of research has investigated the harms that are strongly associated with co-occurring disorders – especially around the cohort of people with co-occurring severe mental illness and substance use disorders. There is substantial evidence ([Croton 2005-a](#)) that people with those co-occurring disorders, compared to people with only one of the disorders, are at a substantially greater risk of experiencing:

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

While the bulk of harms research has focused on the cohorts whose co-occurring disorders include more severe mental illness there is also an accumulating body of evidence that people with less severe mental health and substance use disorders also experience considerable disability ([Hickie et al, 2001](#)).



3. **Potential** for more effective treatment of 'target' disorders

Co-occurring disorders, in any individual experiencing them, tend to influence each other in their development, their severity, their response to treatment and in their relapse circumstances. Because each disorder has such an influence on the other treatment that only focuses on one of the disorders (the 'target' disorder of the treating worker or service) is less likely to be successful than treatment that identifies and responds to all the disorders that a person presents with.

The corollary of this is that, if AOD or mental health clinicians, agencies and systems can build their capacity to recognise and respond effectively to co-occurring disorders they will be more successful in their treatment of 'target' disorders.

Section 3

Vision

What does a co-occurring capable service system look like?

Over the last 20 years healthcare policy and planning bodies, administrators, clinicians and the research community – responding to the prevalence, harms and potential associated with co-occurring disorders - have been increasingly involved in an array of efforts and initiatives to develop treatment systems, agencies and clinician's capacity to recognise and respond effectively to people with co-occurring disorders.

We have come from service systems which struggled with:

- *'Silo' systems*: in which there was a distinct separation between AOD and mental health treatment at central policy and planning, agency and clinical levels
- *Multiple wrong door, often- unwelcoming service systems*: in which people with co-occurring disorders regularly 'fell through the gaps' - not receiving treatment for either disorder as both mental health and AOD agencies tend to perceive that the 'other' problem was causal
- *Clinicians with limited co-occurring disorders skills*: in detecting, assessing and responding effectively to co-occurring disorders
- *Clinicians /agencies/ systems oriented only to single disorders*: where clinicians had the skills and orientation to respond to co-occurring disorders they may have experienced this being discouraged by their employing agency
- *Inflexible systems*: clients needing to adapt to 'our' systems rather than our systems having the flexibility to meet client needs

It is clear that our service systems are engaged in an evolutionary development process in which we are developing our capacity to contribute to better outcomes for people with co-occurring disorders. Section 5 of this submission traces some of the landmarks to date in Australia's journey towards a 'comorbidity-capable' or 'complexity-capable' service system.

Co-occurring capability: describes the capacity of a healthcare worker, agency of system to routinely recognise and respond effectively to the range of co-occurring mental health and substance use issues that people commonly present for help with. [Minkoff and Cline](#) (2009) in considering co-occurring capability at a program level, state that: *'recovery-oriented co-occurring capability involves designing every aspect of that program at every level on the assumption that the next person "coming to the door" of the program is likely to have co-occurring issues and needs, and they need to be welcomed for care, engaged with empathy and the hope of recovery, and provided what they need in a person-specific and integrated fashion in order to make progress toward having a happy productive life.'*

Complexity capability: ([Minkoff and Cline](#) , 2009) recognises that, increasingly, people present to services for help with an array of combinations of issues - not only mental health and substance use issues but commonly physical disorders, housing, domestic violence, learning difficulties, acquired brain injury, forensic involvement.... Complexity capability describes the capacity of a healthcare worker, agency of system to routinely recognise and provide or facilitate effective responses to all the issues that a person presents with.

Our efforts to develop co-occurring -capable systems are likely to be more effective if they are informed by a clear vision of how the system/s will look, feel and function when they are providing effective responses to the needs of persons with co-occurring disorders. Having such a clear vision will contribute coherence, purposefulness, direction, credibility and an evidence base to the efforts of the various stakeholders working towards a co-occurring capable service system.

Some of the emerging 'pillars' of a co-occurring or complexity-capable system are:

- Routine screening and/or assessment
- Integrated treatment
- No Wrong Door, welcoming service systems

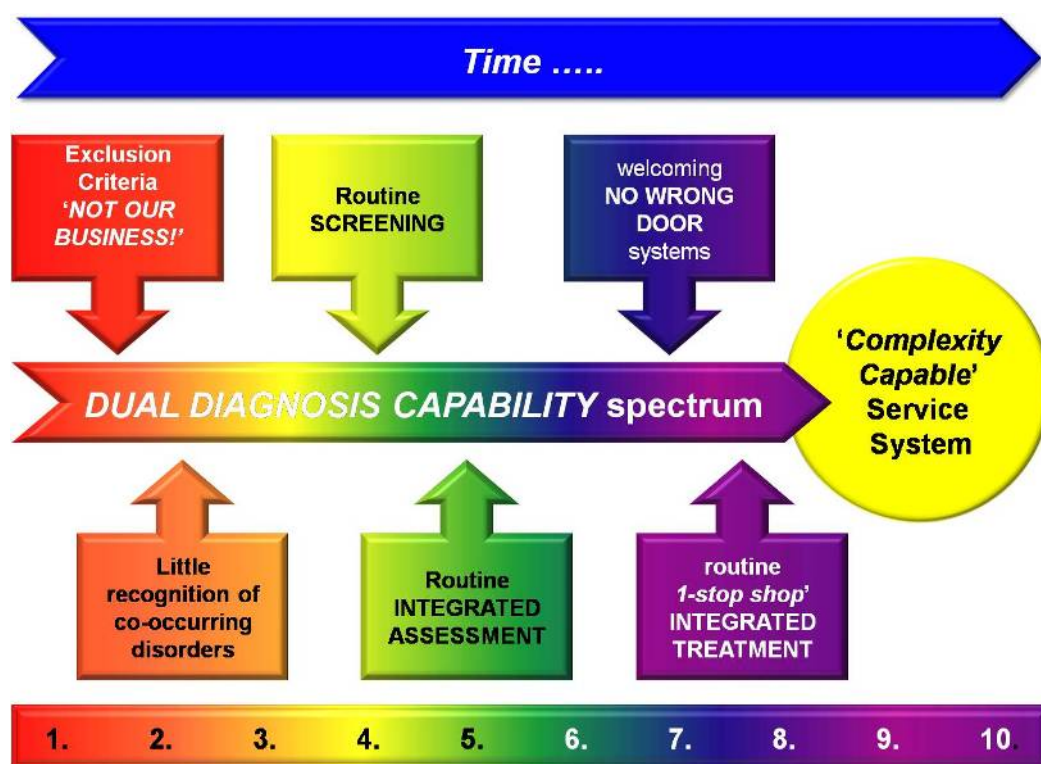


Diagram 4: Landmarks in the evolution of a complexity-capable service system

Routine screening and/or assessment

Co-occurring disorders are often not immediately evident - even when they may be having a substantial influence on an identified disorder. Unless agencies or systems incorporate into their policy expectations and service array mechanisms to detect (highly-prevalent, treatment-impacting) co-occurring disorders it is likely that many people will 'fall through the gaps' and either receive less than optimum treatment or no treatment for their co-occurring disorders.

Routine screening, ideally, provides a quick 'Yes/No' indication as to whether a particular disorder may be present. After screening, more detailed assessment is usually required to firstly confirm whether the disorder is actually present and then to provide the depth of information necessary to inform evidence based treatment planning and provision for the co-occurring disorder.

In those situations where an assessing clinician or agency has the skills and time to conduct routine assessment of co-occurring mental health or substance use disorders screening may be superfluous. Many clinicians find it easier to incorporate routine assessment of both disorders – rather than screening for co-occurring disorders – into their practice.

Integrated treatment

In its simplest form integrated treatment describes one worker or agency providing 'one-stop-shop', coherent treatment for both presenting disorders. Integrated treatment is generally also deemed to occur '*when clinicians from separate agencies agree on an individual treatment plan addressing both disorders and then provide treatment. This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client*' ([Victorian DHS](#), 2007; CSAT, 2007)

In the co-occurring disorder literature integrated treatment is often contrasted with

- *Parallel treatment*: in which treatment is provided for each disorder by different clinicians generally from different agencies. Deficiencies recognised in parallel treatment models include the potential for the person to receive conflicting messages from the various treating clinicians and agencies and poor communication and coordination between treating workers.
- *Sequential treatment*: in which treatment focuses on only one of the disorders at a time. This model has been criticised because the disorders are usually so intertwined that treatment that focuses only on one of the disorders is likely to be compromised by the effects of the disorder that hasn't been focused upon ([Kavanagh & Mueser](#), 2007)

More recently *stepped care models* – in which clients are provided with the lowest possible intensity intervention, only 'stepping up ' to more intensive interventions where indicated by their response to the previous intervention – have been proposed as possible treatment models for some of the cohorts of people with co-occurring disorders ([Baker & Dawe](#), 2005; [Roche & Pollard](#), 2006; [Mills et al.](#) 2010)

The evidence base supporting the efficacy of integrated treatment over other models has been debated for some time ([Donald, Dower & Kavanagh](#), 2005; [Kavanagh & Mueser](#), 2007; [Cleary et al](#) 2008; [Brousselle et al](#) 2010). It is noteworthy that, since early 2010, the USA's federal Substance Abuse and Mental Health Services Administration (SAMHSA) has recognised and promoted integrated treatment - for the

cohort of people whose dual diagnosis comprises both serious mental illnesses and co-occurring substance use disorders - as an evidence based best practice ([SAMHSA, 2009](#))

It is relevant to also examine *Appendix 2* which contains excerpts from the co-occurring literature on the distinctions between 'Integrated Treatment', 'Services Integration' and 'Systems Integration'.

No Wrong Door, welcoming, service systems

No Wrong Door service systems are systems in which, when clients '*appear at a facility not qualified to provide some type of needed service, those clients are carefully guided to appropriate, cooperating facilities, with follow-up to ensure that clients receive proper care*' ([CSAT, 2005](#)).

A focus on welcoming and the development of No Wrong Door systems has developed out of co-occurring disorders capacity building efforts because of the recognition that

- people with co-occurring disorders have tended to 'fall through the gaps' missing out on needed treatment no matter where they present to the service systems
- hope and optimism are central to the recovery process – many people with co-occurring disorders, in being experienced as misfits by AOD or mental health services, may have experienced a loss of hope

[Minkoff and Cline](#) (2005), in proposing strategies to develop welcoming systems for people with co-occurring disorders, state that:

At the broadest level, a welcoming system, from a CCISC (Comprehensive, Continuous Integrated System of Care) perspective, implies that at every level (system, program, clinical practice, clinician competency and training, and outcome evaluation), "welcoming" individuals with co-occurring disorders is written into policy, anchored into contract language and program standards, defined as both a clinical policy requirement and practice expectation in each program for each clinician, incorporated into human resource policies and staff training and credentialing requirements, and embedded in systemic continuous quality improvement and outcome evaluation processes.

.....it is especially important to be "welcoming" to an individual who cannot be immediately served in one's program, both to communicate a sincere desire to engage that individual in care as soon as possible, as well as to welcome that person into the system as a whole, and to proactively help the person make a connection with someone in the system who will assume responsibility for making a beginning empathic, hopeful relationship to help that person get the services that he or she needs.

Section 4

Challenges

Treatment systems and co-occurring disorders

Building a service system's capacity to recognise and respond effectively to the various cohorts of people with co-occurring disorders is long term work. Some of the identified barriers to influencing a system towards co-occurring capability include:

- Failure to recognise co-occurring disorders -often they may not be immediately apparent
- Clinicians trained and structured to respond only to single disorders
- Clinicians may lack knowledge and self-efficacy about effective treatment of the 'other' disorder
- Clinicians may lack expertise and confidence in deploying AOD or mental health treatment approaches
- Clinician's may be 'change-weary and change-wary'
- Clinician's may perceive an implication that their current practice is 'wrong'.
- Clinicians may perceive providing integrated assessment and treatment as added work rather than more effective work
- Complexity can lead to difficulties in engagement and treatment, clinician frustration and a tendency to stigmatise
- There may be a lack knowledge about the interplay of disorders and confusion over which disorder is 'primary' and 'secondary'
- Individually both mental health and SU disorders are highly stigmatised – there may be 'compounded stigma'
- Agencies and systems trained and structured to respond only to single disorders
- Both mental health and AOD treatment systems tend to focus scarce resources on treating people with the most severe disorders whereas the greatest potential gains and savings may be in the cohorts with less severe mental health and substance use disorders
- Service exclusion criteria
- Stakeholders may lack familiarity with prevalence, harms and the potential for better outcomes associated with co-occurring disorders
- Lack of understanding of other treatment system's philosophies, strengths and constraints
- Ineffective mechanisms to achieve clinical care coordination across systems
- Tertiary education institutions can be slow to build mental health and substance use treatment modalities into health undergraduate courses
- Policy and planning bodies and other change agents may fall into the 'training trap' (training alone - without attention first to the web of other factors needed to change complicated behaviour such as mental health and substance use treatment provision – will do little and may even do harm).

Alongside the array of barriers to system change we now have an evolving body of evidence and learning's around what works in building co-occurring disorder capable service systems ([Brunette et al 2008](#)). Section 5 describes some of the milestones to date in Australia's journey towards a co-occurring capable service system while Section 6 discusses some of the elements and strategies that are necessary in further evolving systemic co-occurring capability.

Section 5

Evolution

Landmarks in Australia's journey thus far

Australian national level approaches to building co-occurring capability

Comment:

As noted Australia's preferred term at a national level for co-occurring mental health and substance use disorders was 'comorbidity'. Since 2003 the Australian government has allocated significant funding to addressing comorbidity however the federal focus, to date, has been primarily on the AOD and primary care sectors. While much has been achieved in regard to comorbidity in the AOD and primary care sectors Australia, at a national level, has yet to develop a vision or a plan or a web of strategies to influence the mental health service sector's recognition of and response to co-occurring disorders.

This is of particular concern because:

1. In terms of size and amount of people who receive a service the mental health treatment system is considerably larger than the AOD treatment system. Prevalence rates in AOD and mental health settings, depending on populations studied and methodology used, are broadly similar and, in both settings *'the expectation not the exception'*. Hence, if we only conceptualise co-occurring disorders as an issue for AOD services, we miss the opportunity to provide more effective treatment to the greater population with co-occurring disorders who receive treatment from mental health services.
2. It could imply that the Australian Governments intention is that people with co-occurring disorders should receive treatment of their substance use disorders primarily from specialist AOD services. Indeed Australia's Third National Mental Health Plan 2003-2008 ([Australian Health Ministers](#) 2003) and the National Standards for Mental Health Services 2010 ([Commonwealth of Australia](#), 2010) state that ... *'In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system'*.

Such a stance:

- fails to recognise the prevalence, harms and potential for better outcomes associated with developing mental health services recognition of and effective responses to (highly prevalent, treatment impacting) co-occurring substance use disorders among people receiving mental health services
- fails to recognise the available evidence around the efficacy of integrated treatment
- fails to recognise that, while people with co-occurring disorders are highly prevalent in both settings, they tend to be different groups of people with different combinations of disorders – i.e. many people who access mental health services would not, for a variety of reasons, access AOD services
- fails to recognise that AOD services, while they routinely do an extraordinary job of responding to high prevalence mental health disorders, do not have the funding, structural supports or legislative mandates necessary to treat people in the acute phases of serious mental illness

History:

Oversight bodies for national level efforts addressing co-occurring disorders have included:

- 1998 to 2003: National Comorbidity Project
- 2003 to 2010: National Comorbidity Initiative
- 2010 to 2011: National Comorbidity Collaboration

National Comorbidity Project

1998 to 2003

The National Comorbidity Project developed as a result of the National Drug Strategic framework (1998 to 2003) & the 2nd National Mental Health Plan (1998 to 2003).

The NCP had a 3 fold-focus:

1. to identify what comorbidity is
2. to identify effective treatments for comorbidity
3. to identify how the overall response to the issue of comorbidity can be improved.

A **National Comorbidity Workshop** was held in Canberra in March 2000.



Teeson M, Byrnes L (Eds.) (2001).

National Comorbidity Project

This report documents the first stage of the National Comorbidity Project, a national workshop on comorbidity ([link here](#))

Read **Minister for Health and Aged Care, Michael Wooldridge**, speech at the National Comorbidity Project Workshop [here](#)

National Comorbidity Initiative

2003 to 2010

The **National Comorbidity Initiative** was announced as part of the 2003-04 Federal Budget. The National Comorbidity Initiative was allocated \$17.9 million over seven years from 2003-04 to 2009-10 with a further \$8.2 million coming from the Improved Services Initiative (below)

The National Comorbidity Initiative aimed to:

1. Raise awareness of comorbidity amongst health professionals:
2. Promote examples of good practice:
3. Support general practitioners and other health professionals to improve treatment outcomes
4. Facilitate resources and information for individuals needing care.

Programs and projects out of the **National Comorbidity Initiative** included:



'Can Do' - Managing Mental Health and Substance Use in General Practice: aimed to enhance General Practitioner's knowledge and skills in identifying and managing comorbidity and increase networking between GP's and relevant health professionals.

- **Can Do website** [link](#)
- **Can Do 6-hour on-line clinical education** [link](#)
- **Can Do 2007 Evaluation** [link](#) (Pagnini & Schultz, 2008)

National Comorbidity Clinical Guidelines: focus on comorbidity service delivery in the AOD sector.

Mills et al (2010), [Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings](#) .



PsyCheck: evidence-based treatment program for AOD services to use to detect and treat people with co-occurring depression or anxiety and substance problems

<http://www.psycheck.org.au/>

Comorbidity Professional Development Scholarships to assist AOD and mental health workers to build their clinical expertise in the detection and treatment of people with comorbidity. Were administered by NCETA - see: Roche et al (2008). [Alcohol & Other Drugs, Mental Health & Comorbidity: A Training Review.](#)



Comorbidity Service Model Evaluation: of 17 Australian service delivery models for comorbidity treatment in AOD and mental health sectors

Clinical supervision: for postgraduate psychologists and social workers undertaking placements in AOD services – administered by the [Australian Psychological Society](#)



Review of data collections: A priority area under the Initiative was to improve data systems and collections methods within the mental health and AOD sectors to manage comorbidity more effectively. This project identified, reviewed and reported on the then state of data collections relating to people with comorbidity in Australia.

[National comorbidity initiative - A review of data collections relating to people with coexisting substance use and mental health disorders](#) (AIHW, 2005)

National Comorbidity Collaboration

2009 to 2010

From [Siggins Miller](#) (2009) and [Intergovernmental Committee on Drugs](#) (2010)

The National Comorbidity Collaboration (NCC) consisted of senior Commonwealth and State and Territory alcohol and other drug (AOD) and mental health officials. This partnership was established to assist the Commonwealth and the States and Territories to focus on comorbidity issues and identify opportunities for shared priorities and interests in a whole-of-government way. The aim of the NCC was to improve coordination across mental health and drug treatment services, develop best practice guidelines for service delivery and increase professional education and training.

The Collaboration was established and met for the first time in September 2008.

In June 2011 it was announced that the NCC had been disbanded.

There is no readily accessible, public record of the activities or outcomes of the NCC

Since the disbanding of the NCC it is unclear if any federal body has a dedicated mandate to oversee the coordination of national/state responses to co-occurring disorders.

Improved Service Initiative

2006/07-2012



From:

<http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/drug-alcohol-mental-illness-1>

The [Improved Service Initiative](#) (ISI) built on the National Comorbidity Initiative and specifically focused on building the capacity of non-government drug and alcohol treatment services to provide best-practice services that effectively identify and treat coinciding mental illness and substance abuse. This initiative formed part of the Australian Government's \$1.9 billion Mental Health Reform Package and contribution to the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006 - 2011. Responsibility for the Improved Services Initiative rests with the Australian Government Department of Health and Ageing (DoHA).

The Australian Govt. committed **\$73.9 million to the ISI over five years from 2006-07**. Of this, **\$65.7 million was to build capacity** of drug and alcohol non-government organisations **and \$8.2 million to expand the National**

Comorbidity Initiative.

122 non-government drug and alcohol treatment services were funded through a competitive grants process to undertake a range of capacity building activities including workforce training, developing partnerships with local area health services and developing and implementing policies and procedures that support the identification and management of clients experiencing coinciding drug and alcohol problems and mental illness.

State non-government drug and alcohol peak bodies (**Cross Sectoral Support and Strategic Partnership Initiative**) were funded to support these services to undertake capacity building and service improvement measures within their organisations; and enhance cross-sectoral support and strategic partnerships between state and territory mental health services and alcohol and other drug services, GPs and other key peak bodies.

ISI Publications:

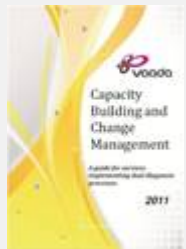


Outcomes from the National Improved Services Initiative Forum: A Tale of Two Systems

[Improved Services Initiative Forum](#), (2011)

NGO peaks report on the 2010 ISI Adelaide conference

Note conference recommendations



VAADA in May 2011, at the ISI/VDDI conference, launched a new manual **Capacity Building and Change Management - A guide for services implementing dual diagnosis processes.**

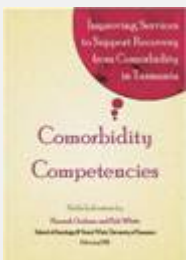
[Williams, Logan & Rose](#), (2011)



Allies for Recovery - Information and support options for families living with mental illness and alcohol & drug use in Tasmania.

[Graham H.](#) (2011)

University of Tasmania, Salvation Army.



Comorbidity Competencies Skills Indicators

[Graham H, White R.](#) (2011).

Comorbidity Competencies designed specifically for practitioners in the Tasmanian AOD sector.

ISI websites and pages:

A number of the state peak bodies supporting those agencies that were successful in receiving ISI grants have developed valuable websites and pages. See Appendix 3 – *More information–useful websites*

Future of the ISI:

DoHA recently extended its funding for ISI. Both Tranche 1 & 2 ISI projects will now sunset by June 30, 2012.

DoHA have indicated that there will be further ISI funding rounds and is currently in a consultation / design process about the specifics of the next model.

Comment:

ISI was designed as a time-limited initiative to build the co-occurring capability of those AOD agencies that were successful in bidding for a project.

While most of the ISI projects have taken some actions to address the relationship between the AOD services and their local clinical mental health services only a few of the projects were designed as whole of system – AOD and mental health – capacity building projects (notably the **No Wrong Door Project** – auspiced by Ovens & King Community Health Service and the **Eastern Hume Dual Diagnosis Project** auspiced by Gateway Community Health – both projects in the Hume region of N.E. Victoria – see www.nowrongdoor.org.au)

DoHA's current consultation/design process around the next iteration of ISI is an opportunity to extend the model to address the co-occurring capability of specialist mental health services as well as specialist AOD services.

There has yet to be a system-wide evaluation of the ISI projects (however QNADA have contracted a study of the cultural change mechanisms used by ISI services to become competent in dealing with DD. The QNADA (unpublished) report captures the experience of the process used to share with the sector so that the sector benefits from the experience (Craze & Mendoza, 2011)). Such an evaluation would be one strategy towards attempting to diffuse and transfer the valuable learning's and capability development that the current ISI projects have been responsible for.

One of the many learnings from the current ISI projects has been the importance of designing in strategies towards sustainability – these need to be complemented by a robust web of strategies towards disseminating and transferring the learnings and gains to other AOD agencies that haven't had such a project.

Policy context – national level

National level mental health and AOD plans have continued to evolve in regard to their recognition of the prevalence, harms and potential associated with co-occurring disorders.

Comment:

While the current [National Mental Health Plan 2009-14](#) and the [National Drug Strategy 2010-15](#) (MCDS, 2011) now incorporate more recognition of the issues around co-occurring disorder they do not yet contain:

- a vision of how the systems will look, feel and function when providing more effective responses to the various cohorts of people with co-occurring disorders
- plans to lead, deploy and evaluate the web of strategies that are required in order to change a complex behaviour such as mental health and substance treatment service delivery.

It is particularly regrettable that the recently published National Standards for Mental Health Services 2010 ([Commonwealth of Australia](#), 2010) still holds to the assertion that ... *'In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system'*.

State level approaches to building co-occurring capability

The Australian states have had a wide range of responses to the prevalence, harms and potentials associated with co-occurring disorders. The states where the most notable developments have occurred are Victoria, Queensland and New South Wales.

Comment:

Service systems in all states have had some, principally AOD sector, service system development arising from their ISI projects. However, in a few states, to date, there has been near-imperceptible, corresponding activity at the state government level.

Victoria

Of all the states Victoria has the largest and longest investment in achieving better outcomes for people with co-occurring disorders. Victoria has been in substantial, developing action towards evolving systemic co-occurring capability since 1998. Appendix 4 charts the evolution of Victoria's responses to co-occurring disorders to date.

The Victorian Dual Diagnosis Initiative (VDDI), operational since 2002, is comprised of four dual diagnosis teams working across metropolitan and rural mental health services, psychiatric disability support services (PDRSS) and alcohol and other drug (AOD) services. The VDDI uses a broad spread of strategies to facilitate the further development of clinician, agency and systemic levels of co-occurring capability. In its four-team structure the VDDI includes:

- specialist **youth dual diagnosis workers**
- the **VDDI Rural forum**
- The **VDDI Education and Training Unit** – a clear 'best buy' which, with only a small, innovative staff, has been responsible for developing a range of pathways to engage workers and students in accredited education and training

Policy: Victoria's cross-sector 2007 policy- **Dual diagnosis – Key directions and outcomes for service development** ([Victorian DHS](#), 2007) is particularly noteworthy in that it:



- has a recovery focus
- contains mandated service development outcomes (SDOs) which mental health and AOD agencies are responsible for achieving
- contains associated KPIs, timelines and attribution of responsibility for achieving the SDOs
- assigns reporting responsibility on agency progress towards achieving the SDOs to service managers – a powerful strategy to increase their understanding, 'buy-in' and investment in building

agency levels of co-occurring capability. This strategy also sends the message that building co-occurring capability is everyone's business rather than the domain of a

few people working in dedicated capacity building roles

- a core SDO is around ongoing, meaningful consumer and carer involvement in achieving the policy's goals
- states clearly that recognising and responding to co-occurring disorders is *core business* for Victorian AOD and mental health workers
- assigns broad treatment responsibility to different sectors for the principle cohorts of people with co-occurring disorders
- prioritises the system's capacity to routinely detect, assess and provide integrated treatment of co-occurring disorders
- contains clear goals of (and operationally achievable definitions for)
 - integrated treatment
 - clinician dual diagnosis capability
 - a 'No Wrong Door' service system

Coherent responses: Victoria's recognition of and responses to co-occurring disorders is not limited to a single policy document but is meaningfully interwoven in all the principle state AOD and mental health policy documents.

Multiple strategies: In 2005-06 Victoria instituted the **Reciprocal Rotations Project** in which mental health or AOD workers were funded to spend 3-months in the 'other' sector as the hub of a 12-month staff development program. This program is still running and has been evaluated. **Clinical treatment guidelines** assisting AOD workers to respond to client's co-occurring mental health disorders were published in 2007.

Future directions:

The Victorian Dual Diagnosis Platform was evaluated in 2003 and a fresh evaluation was completed in March 2011. It is likely that the outcomes of that evaluation will be in the public domain in the near future and that they will provide directions and a springboard for a fresh round of strategies and developments towards the further development in Victoria of recovery oriented, no wrong door, complexity-capable service systems.

Queensland

Queensland is rapidly developing increasingly-focused, strategic, activity towards systemic co-occurring capability. Queensland has funded a range of dual diagnosis capacity building and direct service workers and coordinators across the state

Key recent documents have included:



Queensland Health Policy - Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems)

[Queensland Health](#) (2008)

Cross sector policy with clear statement that responding to people with co-occurring disorders is core business, principles and responsibilities

Dual diagnosis clinical guidelines Co-occurring mental health and alcohol and other drug problems

[Queensland Health](#) (2011)



Dual diagnosis clinician tool kit Co-occurring mental health and alcohol and other drug problems

[Queensland Health](#) (2011b)

New South Wales

Key recent documents have included:



Comorbidity framework for Action: Mental Health/Drug and Alcohol

[NSW Health](#) (2008)

'The Framework for Action provides the strategic direction for NSW Health to manage comorbidity of mental health and drug and alcohol in the State's health settings'



Mental Health Reference Resource for Drug & Alcohol Workers

[NSW Health](#) (2007)

'resource contains basic information on mental illness, including an overview of the causes, symptoms and treatments for most common conditions, designed for drug and alcohol workers who have not been trained in mental health.'



NSW Clinical Guidelines For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings

[NSW Health](#) (2009)

' guidelines for practitioners working in the drug and alcohol and/or mental health sectors who provide care for people with comorbid mental health and substance use disorders'

The Patient Journey Kit 2 – Supporting GPs to manage comorbidity in the community.

([Winstock & Molan](#), 2008).

' developed to support general practitioners working with other professionals and with patients who have comorbid mental health and substance use problems to develop combined care and business plans'



ACT

An **ACT Comorbidity Strategy 2010-2013** has been formulated - the Mental Health Community Coalition ACT [critique of the strategy can be read here](#)

ACT Health has supported some mental health staff to undertake AOD training and clinical placement in AOD settings

Western Australia / Tasmania / South Australia / Northern Territory

A range of state-aided co-occurring disorders education and training events have been conducted in these states

Section 6

Strategy

Steps to further develop systemic co-occurring capability

Building systemic co-occurring capability in Australia remains both urgent and possible. This section will briefly review some of the elements and considerations necessary in being effective in building systemic co-occurring capability.

Rationale for the change

For healthcare systems the prevalence, harms and potential for better outcomes associated with co-occurring disorders are the 'burning platform' that has driven the last two decades of ever increasing focus on developing co-occurring capability.

Reflecting on and identifying the prevalence, harms and potentials associated with co-occurring disorders can represent significant leverage for change agents wishing to influence clinicians, agencies or system's recognition of and responses to co-occurring disorders.

Leadership

It is critical that, at a central leadership level, there is a depth of understanding of the need for change and agreement and sustained enthusiasm and commitment to being leaders in developing systemic co-occurring capability.

Healthcare systems are large and complex – hence the need for layers of leadership committed to and capable of instigating, facilitating and collaborating on change strategies and monitoring the systems progress in achieving change. Regional leadership needs to be identified and be active in planning, receiving reports, oversight and monitoring, celebrating and providing feedback to agencies on their achievements in developing co-occurring capability.

Vision

Also critical is the development and effective dissemination of a collaboratively developed, evidence-informed vision of how the various treatment sectors will look, feel and behave when they are providing the most effective possible responses to the various cohorts of people with co-occurring disorders. Processes need to be devised to enlist the meaningful input and collaboration of consumers and carers, front line clinicians, managers and researchers in the design and articulation of the vision.

Essential elements of such a vision will include:

- recognition of the prevalence, harms and potential for better outcomes associated with co-occurring disorders
- statement that recognising and responding to co-occurring disorders is core business

- a service planning device to assign broad treatment responsibility for the various cohorts of people with co-occurring disorders
- No Wrong Door, welcoming service system goals
- Clear goals of and broad, operationally achievable, definitions for:
 - integrated treatment
 - co-occurring capability (at agency and clinician levels)
- Clear statements around the system's ongoing priority on sustainably developing its capacity to routinely detect, welcome and provide integrated, recovery focused assessment and treatment to people with co-occurring disorders

Plans

Most often a vision will be expressed in the form of a plan developed to achieve that vision. There is a growing body of knowledge around effective change implementation, especially in regard to developing co-occurring capability, and the plan should be informed by this technology.

Plans need to be crafted with a strong recognition of the array of barriers to effective system change (section 4 of this submission) and hence the need:

- to deploy an array of complementary strategies to coherently address the evolution of co-occurring capability at all levels of the treatment system – systemic, agency and clinician. Systematically addressing co-occurring disorders at all levels is the most efficient, cost-effective means of initiating the web of strategies necessary for sustained system change
- to adopt a patient, longer term, evolutionary stance. Influencing complex behaviours and cultures such as healthcare service delivery may take some time.
- to build in measurable service development outcomes for the various healthcare agencies to achieve and incentives to do so. Service development outcomes need to have associated performance indicators, timelines, attribution of responsibility for their achievement and reporting requirements.
- Mechanisms to monitor and feedback to reporting agencies on their progress and to celebrate progress.

Layers of plans:

In large complex healthcare systems a single central plan needs to be supported by regional plans devised by *Regional Implementation Groups* charged with regional implementation of the central plan. In Eastern Hume the activities of the *Eastern Hume Dual Diagnosis Group* (EHDDxG) has seen the development of two successive regional plans that complement the Victorian dual diagnosis policy.

Further, one of the outcomes from using the *Checklists of dual diagnosis capability – Agency level* (Croton, 2008a) and the *Checklists of dual diagnosis capability – Clinician level* (Croton, 2008b) tools is that the state and regional plans have been complemented by agency plans and, on occasion, individual clinician plans around the further development of co-occurring capability.



Diagram 5: Eastern Hume Layers of co-occurring capability plans

Without leadership, vision and plans the efforts of the various stakeholders to build co-occurring capability will tend to be diffused and may lack coherence, purposefulness, direction, credibility and an evidence base. Effective leadership, a vision of how the system will look, feel and behave when it is co-occurring capable and tiered plans to achieve that vision are critical to success.

System transformation models:

Comprehensive, Continuous Integrated System of Care (CCISC) model

The CCISC model is now in widespread use by a host of systems in the USA and Canada to develop systemic co-occurring /complexity capability.

(See Appendix 5- Profile of CCISC model).

CCISC is a 'vision-driven system transformation process for redesigning behavioral health and other related service delivery systems to be organized at every level (policy, program, procedure, and practice)—within whatever resources are available—to be more about the needs of the individuals and families needing services, and values that reflect welcoming, empowered, helpful partnerships throughout the system.' (Minkoff & Cline, 2009c)

Tools and handrails:

Tools and handrails to align services with changed practices and to support workers in new practices are also necessary. Ideally many of these tools will have been identified or developed before any attempt is made to change current clinical practices.

They include:

- **Tools** for self assessing reflecting on, identifying training needs and a plan to further develop AGENCY levels of co-occurring capability ([Croton, 2008a](#); [Minkoff & Cline, 2009](#))
- **Tools** for self assessing reflecting on, identifying training needs and a plan to further develop CLINICIAN levels of co-occurring capability ([Croton, 2008b](#); [Croton 2008c](#); [Minkoff & Cline, 2009b](#))
- **Clinical Treatment Guidelines**: specific to the needs of each of mental health and AOD workers
- **Agency descriptions and mission statements** that reflect the service's recognition of the prevalence, harms and potentials associated with co-occurring disorders and their commitment to responding as effectively as possible to the treatment needs of people with co-occurring disorders
- **Job descriptions** that contain criteria around required levels of co-occurring competency
- **Orientation manuals and procedures** to rapidly introduce new staff to the agency's preferred methods of detecting and providing integrated assessment, treatment planning and treatment to people with co-occurring disorders
- **Outcome measures** that are recovery focused and measure people's response to treatment for both mental health and substance use disorders
- **Data collection mechanisms** that are clinician friendly and capable of recording the prevalence of people with co-occurring disorders
- **Policies, protocols and proformas** around
 - No Wrong Door goals and responsibilities
 - Secondary Consultation
 - Interagency protocols (e.g. Hume Region's, whole of system, multi-agency protocol at www.nowrongdoor.org.au)
 - Agency's preferred methods of detecting, screening, assessing people with co-occurring disorders

There are numerous templates readily available for most of the above resources that can be tailored to the specific needs of the agencies or systems involved.

Education and training:

Few agencies or systems, in undertaking a system change process, haven't at some time fallen into the 'training trap' – the belief that if you simply provide a dose of training to (often besieged and time poor) clinician that that will be a sufficient

intervention to prompt system wide, culture and practice, change. That systems repeatedly deploy training initiatives as a standalone strategy towards significant system change may perhaps be perceived as a triumph of hope over experience.

Education and training *are* critical but they represent they are best viewed as the '*salt not the substance*'. Timing of education and training is critical and should not be attempted until the system has a clear agreed vision and plan and at least some of the above tools and handrails in place to support and reward clinicians for undertaking new treatment approaches. Education and training launched prematurely can do harm in that it can invalidate clinicians because of the dissonance between the practices promoted in the training and the realities of working in systems that aren't aligned with or supportive of those new practices.

Particularly, given that mental health workforces tend to be older age with a range of other commitments, we need to deploy a range of education and training options and supports to capture and meet the various learning needs and possibilities of the various workforces. The availability and provision of 'co-occurring capable' clinical supervision is, where possible, a best-practice approach to 'working-in', re-enforcing, sustaining and building on learnings from any training attempted.

In Victoria the 2006 creation of a central dual diagnosis education and training unit, even with a small staff profile, was a clear 'best buy' and has been responsible for the creation of a diversity of accredited and non-accredited education and training options tailored to a variety of service providers and individual training needs.

Looking to the near future it is also critical that strategies are devised to influence the mental health, substance use and co-occurring disorders content in a range of undergraduate courses. This makes much more sense than 'chasing our tail', playing catch-up trying to educate our existing workforces.

Many of Australia's medical, social work and nursing courses have virtually no content on recognising and responding to highly prevalent alcohol use disorders (AUDs) – despite the overwhelming evidence around the availability of low-input, effective treatments, the prevalence of people with AUDs in all healthcare settings and the causal and/or aggravating contribution that AUDS make to a wide range of physical and mental health disorders.

Change Agents:

For a plan to succeed it needs people whose assigned roles include working to achieve the plan's goals. Ideally responsibility will be diversified as widely as possible in order to build all stakeholders understanding of and investment in building co-occurring capability. However it is also useful to have people with a more specific remit to assess, monitor and contribute to the development of agency co-occurring capability.

At a minimum each AOD and mental health agency should have a portfolio holder with specific roles and responsibilities in contributing to the development of agency co-occurring capability. This person should have sufficient formal and informal standing within the team to allow them to assist in the development of the agency's and colleague's co-occurring capability evolution.

Where resources permit a specialist change agent workforce, such as the Victorian Dual Diagnosis Initiative or the ISI, can be a considerable asset towards developing systemic, agency and clinician levels of co-occurring capability. It should be emphasized that, in systems with such dedicated co-occurring workers /change agents, their role is that of helpful adjuncts to the system in its evolution towards co-occurring capability i.e. it would be misleading, unhelpful and poor strategy to assign them responsibility for the whole systems responsibility to develop co-occurring capability. At an agency level reporting responsibilities, around achievement of relevant co-occurring goals and KPIs sits best with agency managers.

Partnerships:

Diverse, gains and synergies occur when systems succeed in forming cross-sector alliances aimed at collaboratively building systemic co-occurring capability. *Regional Implementation Groups*, formed to cohesively efficiently drive regional achievement of a central co-occurring capability plan, will typically be comprised of consumers, carers, managers, clinicians, portfolio holders and specialist co-occurring disorders workers.

Costs / resource allocation

Evolving co-occurring capability does not have to involve significant resources and the actual costs involved are up to the systems that designs the plan.

Building appreciation of the prevalence, harms and potential associated with co-occurring disorders represents powerful, no- cost leverage on the system. A collaboratively developed, systemic vision costs very little to develop and a well-crafted plan only slightly more ([Croton 2010](#)). Regional Implementation Group meetings can be managed in a cost-effective manner and facilitated by use of email and web technologies, especially in rural and remote regions.

Many of the handrails and tools are available at no cost and numerous templates are available to tailor them to the system or agencies involved in the change process. Attributing reporting to service managers is a low-cost, powerful strategy to maximize their understanding of and investment in achieving a systemic plan.

Summary

Building systemic co-occurring capability in Australia remains both urgent and possible. It involves large scale evolution of a range of established workforce practices and cultures and hence is not short term work however it does not have to involve significant costs. Rather it requires the carefully planned, systematic deployment of an array of complementary strategies as part of a plan to achieve a collaboratively developed vision of how the various treatment systems will look, feel and behave when they are providing the most effective possible responses to the various cohorts of people with co-occurring disorders.

Section 7

Recommendations

This submission recommends:

1. That the Australian Government adopts the Comprehensive Continuous Integrated System of Care (CCISC) model as a broad implementation framework nationally.
2. That the Australian Government subsequently seeks volunteer systems to commence CCISC implementation.
3. That the planned National Mental Health Commission be assigned a specific remit to monitor national progress around the development, deployment and impact of a coherent web of strategies designed to achieve universal co-occurring/ complexity capable mental health and AOD service systems.
4. That a public, collaborative consultative process be instituted around the development of an Australian vision of a co-occurring, complexity capable effective service system.
5. That this process shapes the delivery of a national plan to further develop Australian co-occurring, complexity capable service systems. That that plan embodies specific objectives, KPIs, timelines, attribution of responsibilities and mechanisms to monitor and celebrate progress in achieving the goals of the plan.
6. That future *National Mental Health* and *National Drug Strategy* plans are devised in tandem and complement and reflect national and state co-occurring disorders plans.
7. That the Australian Government design and provide incentives to encourage all Australian states to develop meaningful state-level plans and a state-level web of actions that contribute to systemic co-occurring capability in each of their mental health, AOD and primary care service systems.
8. That the existing website *Dual Diagnosis Australia and New Zealand* be funded to further develop into the national clearing house for resources that will contribute to better outcomes for people with co-occurring disorders

9. That national Clinical Treatment Guidelines (CTGs) designed to assist mental health workers to recognise and respond effectively to people with co-occurring disorders are commissioned. That these CTGs parallel and complement the existing national CTGs for AOD workers responding to people with co-occurring mental health issues
10. That DoHA be assigned a specific task of devising and deploying a web of strategies to influence and assist tertiary education institutions providing healthcare undergraduate course to build into those courses appropriate levels of education around recognition of and effective responses to people with substance use disorders and to people with co-occurring disorders
11. That a revision of the current National Mental Health Standards is commissioned so that those standards develop a commensurate recognition of and response to the prevalence, harms and potentials associated with co-occurring disorders.
12. That DoHA consider and make further recommendations around the range of tools available for systems, agencies or clinicians to self assess, reflect on and develop individual plans to further develop systemic, agency or clinician levels of co-occurring capability
13. That future iterations of the Improved Services Initiative are broadened in scope to embrace mental health as well as AOD agencies or whole systems of AOD and mental health agencies.
14. That future iterations of the Improved Services Initiative be designed to incorporate, from the early planning stages, robust evaluation mechanisms.
15. That the emphasis, in future iterations of the Improved Services Initiative, is on capacity building rather than direct service models
16. That an *Australian Co-occurring Centre for Excellence* be established with ongoing roles in identifying and disseminating best practice responses to the various cohorts of people with co-occurring disorders

17. That fine-grained co-occurring disorders prevalence studies (with a diagnostic interview methodology) are commissioned in a diverse range of Australian mental health, substance treatment and primary care settings.
18. That research is commissioned around identifying or devising clinician-friendly, recovery focused mental health-substance use outcome measures.
19. That future development of either mental health or substance treatment data bases prioritise the data bases ability to assist clinicians to routinely record all the disorders that people engaged in treatment present with.

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Appendices

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Appendix 1: DSM-1V / ICD 10 criteria: Substance Abuse, Harmful Use and Dependence

DSM-IV Substance Abuse & Dependence Checklists

DSM-IV Criteria for Substance Abuse:			
Maladaptive pattern of use leading to impairment or distress as manifested by one (1) or more of.... (within a 12 month period):			
	Alcohol	Cannabis	Other (specify)
Use results in a failure to fulfil obligations at work / school / home:			
Recurrent use in hazardous situations:			
Use continues despite recurrent problems caused by or exacerbated by use:			
Use continues despite recurrent problems caused by or exacerbated by use:			

DSM-IV Criteria for Substance Dependence:			
Maladaptive pattern of use leading to clinically significant impairment or distress as manifested by three (3) or more of.... (within a 12 month period):			
	Alcohol	Cannabis	Other (specify)
Tolerance:			
Withdrawal			
Using larger amounts or for longer than intended			
Desire or unsuccessful efforts to cut down			
Time spent obtaining/ using/ recovering from substance			
Social /occupational recreational activities reduced or given up for substance use			
Use continues despite recurrent problems caused by or exacerbated by use			

Estimate			
Percentage of my clients who meet the criteria for Substance Abuse:	%	Percentage of my clients who meet the criteria for Substance Dependence:	%

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ICD 10 Harmful Use & Dependence Checklists

ICD 10 Criteria for Harmful Use:

A pattern of psychoactive substance use that is causing physical or mental damage to health.

The damage may be:	Alcohol	Cannabis	Other (specify)
Physical: e.g. hepatitis from self administration of injecting drugs <i>OR...</i>			
Mental: e.g. episodes of depression secondary to heavy consumption of alcohol			

The diagnosis requires that actual damage must have been caused to the mental or physical health of the user.

ICD 10 Criteria for Dependence Syndrome:

- A cluster of physiological, behavioural and cognitive phenomena in which the use of the substance/s takes a much higher priority for an individual than other behaviours which once had greater value.

- Diagnosis of dependence should only be made if 3 or more of the following are present in a 12-month period:

	Alcohol	Cannabis	Other (specify)
A strong desire or sense of compulsion to take the substance.			
Difficulties in controlling substance-taking:			
Physiological withdrawal:			
Tolerance:			
Neglect of alternative pleasures or interest / Increased time to obtain/use or recovery from the substance			
Persisting use despite harmful consequences:			

Estimate

Percentage of my clients who meet the criteria for Harmful Use:	%	Percentage of my clients who meet the criteria for Dependence:	%
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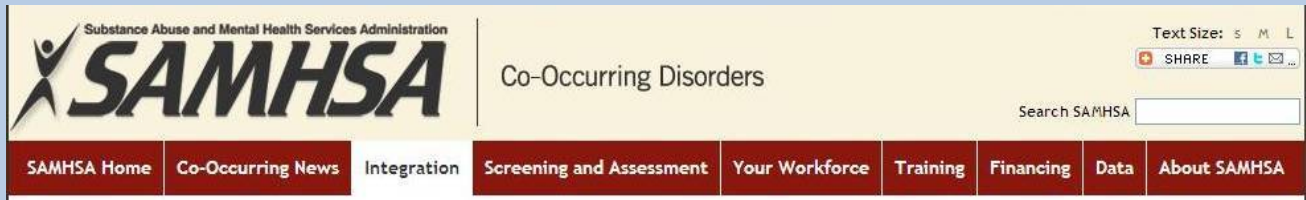
Appendix 2: Excerpts from the literature: distinctions between 'Integrated Treatment', 'Services Integration' and 'Systems Integration'

Excerpts from USA's federal:

Substance Abuse Mental Health Services Administration / Co-occurring Disorders / Integration web pages

<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/index.aspx>

(accessed August 1st, 2011)



Integrated treatment:

'Consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery.' ([SAMHSA](#), 2009)

'In Integrated Treatment programs, the same practitioners, working in one setting, provide mental health and substance abuse interventions in a coordinated fashion' ([SAMHSA](#), 2009)

Services Integration:

Services integration refers to the process of merging separate clinical services to meet the individual's substance abuse, mental health, and other needs. Services integration has two levels:

- Integrated programs are changes within an entire agency that help practitioners provide integrated treatment.
- Integrated treatment occurs at the individual-practitioner level and includes all services and activities.

Services integration means providing *at a minimum*:

- integrated screening for mental and substance use disorders
- integrated assessment
- integrated treatment planning
- integrated or coordinated treatment
- continuing care

N.B. Systems and service integration are closely interrelated

Systems Integration:

Systems integration involves the development of infrastructure within mental health and substance abuse systems to support integrated service delivery. It can occur in systems of any size, including an entire state, a region, county, agency or program. *Systems integration* focuses on reorganizing the framework within which agencies and programs operate. It includes integrated system planning, implementation, and continuous quality improvement including developing mechanisms for addressing:

- financing
- regulations and policies
- program design and certification
- inter-program collaboration and consultation
- clinical "best practice" development

- clinician licensure
- competency and training
- information systems
- data collection
- outcome evaluation

Excerpts from:



- **Definitions and Terms Relating to Co-Occurring Disorders**
Co-occurring Centre for Excellence Overview Paper 1. (CSAT, 2007)

- **Systems Integration.**
Co-occurring Centre for Excellence Overview Paper 7. (CSAT, 2007b)



Integration

Integration requires the participation of providers trained in both substance abuse and mental health services to develop a single treatment plan addressing both sets of conditions and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client.

The threshold for "integration" relative to "collaboration" is the shared responsibility for the development and implementation of a treatment plan that addresses the COD. Although integrated services may be provided within a single program in a single location, this is not a requirement for an integrated system. Integration might be provided by a single individual, if he or she is qualified to provide services that are intended to address both conditions.

Different levels and types of integration are possible, and there is no one way to achieve integrated treatment. Further, not all agencies have the same capacity or resources for achieving treatment integration. Recognizing an organization's capabilities and providing for both substance and mental health services within those capabilities can enhance treatment effectiveness.

Services Integration Any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with COD or between providers or programs serving these individuals. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients.

Systems Integration The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with COD and their families.

What is meant by integration and integrated?

The terms “integration” and “integrated” appear throughout the literature on COD: for example, systems integration, services integration, integrated care, integrated screening, integrated assessment, integrated treatment plan, integrated interventions or treatment, integrated models, integrated systems, integration continuum, and so on. The pervasiveness of “integration” and “integrated” in the language of COD reflects the following factors:

- The awareness that the co-occurrence of these disorders is not simply by chance and occurs frequently
- An understanding that there is always a relationship between the disorders that affects outcomes
- The recognition that effective responses to persons with either mental illness or substance use disorders are compatible

.....

The various types of integration listed above refer to different service components (e.g., screening, assessment, treatment planning, treatment provision) or levels of the service system (e.g., individual practitioners, agencies, local systems of care, States). The specifics of what is to be integrated and the mechanisms by which integration is accomplished will, of course, be different for different service components and at different levels of care.

However, the goal of integration is always the same identifying and managing both disorders and the interaction between them. Moreover, the objective of all forms of integration is to *support integrated treatment for the individual client*. Integration that *does not result in changes in services at the client level serves no useful purpose*.

Appendix 3: More information - useful websites

More information – useful websites



Dual Diagnosis Australia and New Zealand
www.dualdiagnosis.org.au



Dual Diagnosis Support Victoria
<http://dualdiagnosis.ning.com>



No Wrong Door
www.nowrongdoor.org.au



VAADA Comorbidity website
www.comorbidity.org.au



ZiaPartners Inc
<http://www.zipartners.com/>



SAMHSA co-occurring disorders pages
www.samhsa.gov/co-occurring

Improved Services Initiative = Websites & pages



ACT:

ATODA – Alcohol Tobacco & Other Drug Association ACT
[comorbidity web pages](#)



Northern Territory:

Northern Territory Council of Social Service
[comorbidity web pages](#)



NSW:

NADA – Network of Alcohol and Drug Agencies
[comorbidity web pages](#)



Queensland:

QNADA - Queensland Network of Alcohol and Drug Agencies
[comorbidity web pages](#)



South Australia:

SANDAS – South Australian Network of Drug Alcohol Services
[comorbidity web pages](#)



Tasmania:

Alcohol Tobacco & other Drug Council Tas Inc.
[comorbidity web pages](#)



Victoria:

VAADA – Victorian Alcohol and Drug Association
www.comorbidity.org.au website



Western Australia:

WANADA – Western Australian Network of Alcohol & Other Drug Agencies
[comorbidity web pages](#)

Appendix 4: Evolution of Victoria's responses to co-occurring disorders

Evolution of Victoria's responses to co-occurring disorders	
1998:	<ul style="list-style-type: none"> • SUMHNet: <i>Substance Use Mental Health Network</i> formed. A state-wide coalition of health care providers, consumers and carers with an interest in dual diagnosis. SUMHNet was auspiced by VICSERV and met regularly till 2002. • SUMITT: <i>Substance Use Mental Illness Treatment Team</i> pilot service. A partnership of two central policy and planning bodies - the (then) Victorian Mental Health Branch and the Drugs Policy Branch - created the SUMITT pilot in the western regions of Melbourne and rural Victoria. • Eastern Hume Dual Diagnosis cross-sector project commenced in NE Victoria • Tom and Lindy Fox from the New Hampshire Dartmouth research group provide training and consultation to SUMITT and with central policy and planning bodies • Conference: <i>Problematic Drug and Alcohol Use and Mental Illness</i> auspiced by Connexions at Melbourne University
2001	<ul style="list-style-type: none"> • VDDI rural forum formed in April (active & ongoing)
2002:	<ul style="list-style-type: none"> • Victorian Dual Diagnosis Initiative (VDDI): The two central planning bodies built on the SUMITT model with the state-wide VDDI. Around a structure of four metropolitan lead agencies and linked rural workers the VDDI was initially assigned responsibility for capacity building and direct clinical services to agencies and workers in the 3 sectors of AOD, Clinical Mental Health and Psychiatric Disability Rehabilitation Support Services.
2003	<ul style="list-style-type: none"> • 5 VDDI specialist youth dual diagnosis workers positions instituted • 21 Mobile Support & Treatment Teams dual diagnosis positions created • Evaluation • Victorian Travelling Fellowship – VDDI fellow undertook 6-week fellowship investigating integrated treatment responses in UK, USA and NZ with subsequent report
2004	<ul style="list-style-type: none"> • Creation of <i>Dual Diagnosis Australia & New Zealand</i> – www.dualdiagnosis.org.au website (currently c. 6,000 individual visits per month / No 1 site in Google for the search term 'dual diagnosis')
2005	<ul style="list-style-type: none"> • Rotations project: Funds mental health or AOD workers to undertake a 3-month rotation in the 'opposite' sector as core of a 12-month staff development and education process. • State-wide Dual Diagnosis Education & Training Unit: The VDDI E&T Unit has developed nationally recognised diploma level dual diagnosis competencies delivered by a number of education providers via online and in-person delivery. • Strengthening psychiatrist support project: Extra specialist MH-SU psychiatrist time for the four lead agencies
2006	<ul style="list-style-type: none"> • At State Government cabinet level a dedicated <i>Ministerial position for Mental Health and Drugs</i> was created.

- At the central policy and planning level, the former *Mental Health Branch* and the *Drugs Policy Branch* merged into the *Division of Mental Health and Drugs*

2007

- **Policy:** Launch of the state-wide, cross-sector 'Dual Diagnosis: Key directions & priorities for service development' policy.
- **VDDI Indigenous Dual Diagnosis Project** Phase 1
- Drs Minkoff & Cline – CCISC - 1-day forum
- [Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol & Other Drug and Mental Health Services](#) published
- Daylesford VDDI conference

2008

- **ISI commences:** 27 Victorian NGO AOD agencies funded under ISI
- 6 Victorian General Practice Divisions received 'Can Do' Grants Program Comorbidity Projects
- VDDI Screening and Assessment Training for AOD workers trained >500 AOD clinicians from > 80 agencies across Victoria.
- Beechworth Mental Health Winter conference : *Substance Use across the lifespan*
- Gippsland VDDI conference
- Suite of **Checklists of Dual Diagnosis Capability** – Agency & Clinicians levels published

2009

- Creation of **Dual Diagnosis Support Victoria** –web2 social networking site(currently c. 2,800 members)
- Beechworth ISI / VDDI conference
- **BUDDYS** – *Building Up Dual Diagnosis Youth Service* – VDDI/ ISI partnership addressing the issues around dual diagnosis in younger people and their families

2010

- **Evaluation:** of the Victorian Dual Diagnosis Platform
- **HYDDI** – Homeless Youth Dual Diagnosis Initiative positions commenced around Victoria
- Lorne VDDI/ISI conference

2011

- VDDI capability project
- Werribee ISI/VDDI conference – Drs Minkoff & Cline keynotes
- 3-year Bachelor of Mental Health and Drugs undergrad course commences at Chisholm Institute.
- **BUDDAS** – *Building Up Dual Diagnosis Aged Services* commenced

Appendix 5:

Overview: Comprehensive Continuous Integrated System of Care (CCISC)

Comprehensive, Continuous Integrated System of Care (CCISC)

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

Description

The Comprehensive Continuous Integrated System of Care (CCISC) process (Minkoff & Cline, 2004, 2005) is a vision-driven system “transformation” process for redesigning behavioural health and other related service delivery systems to be organized at every level (policy, program, procedure, and practice)—within whatever resources are available—to be more about the needs of the individuals and families needing services, and values that reflect welcoming, empowered, helpful partnerships throughout the system. The ultimate goal of CCISC is to help develop a system of care that is welcoming, recovery-oriented, integrated, trauma-informed, and culturally competent in order to most effectively meet the needs of individuals and families with multiple co-occurring conditions of all types (mental health, substance abuse, medical, cognitive, housing, legal, parenting, etc.) and help them to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.

In a CCISC process, every program and every person delivering clinical care engages in a quality improvement process—in partnership with each other, with system leadership, and with individuals and families who are receiving services—to become welcoming, recovery- or resiliency-oriented, and co-occurring-capable. Every aspect of clinical service delivery is organized on the assumption that the next person or family entering service will have multiple co-occurring conditions, and will need to be welcomed for care, inspired with hope, and engaged in a partnership to address each and every one of those conditions in order to achieve the vision and hope of recovery.

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

Principles

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

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

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

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

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

Assignment of responsibility for provision of such relationships can be determined using

the four-quadrant national consensus model for system-level planning, based on high and low severity of the psychiatric and substance disorder.

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

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

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

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

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

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

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

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

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

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