CHAPTER 14

DUAL DIAGNOSIS

'THE EXPECTATION NOT THE EXCEPTION'

Introduction

14.1   Over the last twenty years the number of people with mental illness who also have a substance abuse disorder has been increasing. Service providers now report dual diagnosis is the 'expectation not the exception' in treated populations.[1] Tragically, many of those affected are young.

14.2   This chapter explores the experience of people with co-occurring mental and substance abuse disorders and identifies some of the obstacles to service provision for them. Reflecting on some of the good models described or proposed during the inquiry, the chapter then suggests a better and more comprehensive way of caring for this vulnerable, high prevalence group.[2]

The nature of the problem

14.3   Dual diagnosis is a term that describes the situation of a person experiencing two or more pathological or disease processes at the same time.[3] Other terms for this are co-occurring disorders or co-morbidity.[4]

14.4   There are two main clinical interpretations of the term 'dual diagnosis'. The first refers to the co-existence of intellectual, developmental or physical disability with mental illness.[5] The other describes the experience of having a mental illness along with a substance abuse disorder. This latter definition, which is the one applied in this report, has the longest history and is most widely used in Australia.[6]

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1   Eastern Hume Dual Diagnosis Service, Statement in support of *Submission 374*, tabled Melbourne Public Hearing, 6 July 2005, p. 2.

2   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 17.

3   *The American Heritage Stedman's Medical Dictionary,* Houghton Mifflin Company, 2002.

4   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 17.

5   See for example Queensland Centre for Intellectual and Developmental Disability Mater Hospital, *Submission 463* and attachments.

6   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 17.

14.5   People with dual diagnosis disorders are not a homogeneous group—substantial diversity exists in the combinations of disorders, in their severity and their individual treatment needs. Eastern Hume Dual Diagnosis Service advises there are three basic categories used for clinical assessment of co-occurring disorders:

- substance use disorders co-occurring with high-prevalence, low-impact mental health disorders (such as anxiety and depression);

- substance use disorders co-occurring with low-prevalence, high-impact mental health disorders (such as psychosis and major mood disorder); or

- any mental health disorder co-occurring with either substance abuse or substance dependence.[7]

14.6   Substances used by people with dual diagnosis may include prescription drugs or other substances, whether legal or illegal, including alcohol, opiates, stimulants and cannabis. The most common form of substance abuse disorder is alcohol dependence. Other legally available substances are solvents and petrol, ingested by 'sniffing'.[8]

14.7   Tobacco use, although frequent among people with mental illness, is not treated as part of the dual diagnosis spectrum.[9]

Self medication and dual diagnosis

14.8   Treatment of substance abuse and mental health disorders is complicated by the fact that alcohol or drugs are often used by mental health consumers to alleviate the stresses of their mental illness, including psychotic systems, depression or to deal with the side effects of medication or the stigma of being mentally ill.

14.9   The Jesuit Social Services Connexions program advised that: 'Young people with mental illness take drugs for a multitude of reasons including to treat their disorder, to reduce anxiety, peer group activity' and to 'assume an identity as drunk or drugged rather than mad because this is socially acceptable'.[10] A Jesuit Connexions case study reports:

> Clients participating in group program for young people with coexistent mental health and substance abuse misuse problems discussed the perceptions they encountered with having dual diagnosis. They felt they were commonly seen as criminals, junkies and worth less than others. One

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7   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 17.

8   Drawn from Ms Nene Henry, *Submission 282,* p. 1.

9   Ms Nene Henry, *Submission 282*, p. 1.

10   The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358*, p. 8.

client said he would prefer to be seen as drug affected than labelled a 'nutter'.11

14.10   Professor Ian Webster advised that alcohol abuse can alleviate the discomfort of deprivation and homelessness, making it difficult to determine whether mental illness is the cause or the consequence of the substance abuse:

> People with mental illness drink alcohol to control their feelings and thoughts, alcohol "blots our time" it "takes time away", and it is not always the primary cause of person's circumstances. And when you have chronic pain from an early injury or chronic disease, alcohol is not a bad analgesic when no one will refer you to a pain clinic. If sleep is hard to get when living rough, or when trying to sleep in a crowded dormitory—alcohol is a cheap sedative.[12]

14.11   The Australian Injecting and Illicit Drug Users League suggested that illicit drugs are often used by people with severe psychotic disorders to control symptoms, and to counteract the side effects of prescribed medications:

> Many people self-medicate by using illicit drugs to manage the symptoms of their mental health problems. Anecdotal evidence suggests the effects of heroin and cannabis are 'helpful' in peoples attempts to focus away from the distress and pain of hearing voices (auditory hallucinations), and the effects of cocaine and amphetamine in counteracting the extreme sedation and lethargy induced by anti psychotic medications, and negative symptoms.[13]

14.12   The Centre for Mental Health Studies commented on the high level of substance abuse among people with depression:

> People with depression often respond to everyday situations with a negative interpretation. Symptoms of depression also include low mood, loss of interest in activities, people or places and loss of energy which makes them feel terrible about themselves and the world they live in. Many people then turn to alcohol and drugs for temporary relief.[14]

14.13   The medical contraindications of self-medication are that dual diagnosis sufferers may be less compliant with prescribed treatment regimes.[15] Intravenous drug injection makes people with co-morbid conditions more vulnerable to blood borne infections such as AIDS and Hepatitis C.[16] Moreover, the 'drug cultures' surrounding

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11   Connexions staff interview, 2005, Jesuit Social Services, The Ignatius Centre for Social Policy and Research, *Submission 358*, p. 8.

12   Professor Ian Webster, AO, Emeritus Professor of Public Health and Community Medicine, University of New South Wales, *Submission 458*, p. 29.

13   Australian Injecting and Illicit Drug Users League, *Submission 281*, p. 4.

14   Kay-Lambkin Centre for Mental Health Studies at the University of Newcastle, 2004, quoted in Families and Friends for Drug Law Reform, *Submission 319*, p. 8.

15   The Australian Injecting and Illicit Drug Users League, *Submission 281*, p. 4.

16   Ms Nene Henry, *Submission 282*, p. 3.

illicit substance use often means that sufferers, particularly dual diagnosis youth, are both less acceptable to, and less inclined to access, standard support structures provided by mental health services.[17]

14.14   Involvement with illicit drugs also brings the likelihood that people with dual diagnosis will engage in other illegal activities to support drug habits, bringing them into contact with the criminal justice system.

Contact with the criminal justice system

14.15   Studies have shown that dual diagnosis sufferers come into contact with the criminal justice system more often than people with a mental health disorder only.[18]

14.16   Police are the first point of contact with the criminal justice system for people with dual diagnosis. The committee received strong representation from the Police Federation of Australia that police officers are inadequately prepared to deal with the high level of need exhibited by dual diagnosis sufferers in the community. These people end up in custody, then prison, rather than receive appropriate care.[19]

14.17   The Drug Action Information Exchange (DAIE) reported on the situation in the Illawarra:

> Police within the Illawarra are continually confronted with members of the public who are displaying severe symptoms of mental illness. Police acting within the guidelines of the Mental Health Act will transport the patient to a proclaimed hospital for assessment. On numerous occasions the resulting assessment diagnoses a drug induced psychosis. The end result is the patient being released and left with the Police to deal with. Police do not have the training or resources to deal with those patients. If left alone, they are a danger to themselves, if left with friends or relatives similarly those people are now in danger. Police do not have access to drugs which may be able to sedate the person and further do not have the facilities to hold them for any length of time. The persons are inevitably released out onto the street where they commit offences and then are criminally charged.[20]

14.18   Substance use has been identified as an important contributor to the risk of mentally ill people engaging in violent crime.[21] The Victorian Institute of Forensic Mental Health cited recent research that revealed:

> Just as substance abuse alone is a significant risk factor for violence, those who have both a substance abuse or dependence disorder and a major mental illness (i.e., those with a so-called dual diagnosis) also have been

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17   Mental Health Legal Centre, *Submission 314,* p. 18.

18   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 23.

19   Police Federation of Australia, *Submission 254*, pp. 5–7.

20   Drug Action Information Exchange (DAIE) (Wollongong Illawarra) *Submission 222*, pp. 1–2.

21   Cited in Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 23.

found to have an increased level of risk for violence. Dual diagnosis has been associated with high rates of violence and criminal behaviour.[22]

14.19   The rate of criminal conviction for persons with schizophrenia with substances abuse problems was found to be 68.1 per cent, compared to those without substance disorders at just 11.7 per cent.[23]

14.20   Research conducted at the Thomas Embling Forensic Hospital found that 74 per cent of mentally ill offenders have a lifetime substance abuse disorder and 12 per cent have a current substance abuse or dependence disorder.[24] A breakdown of offenders in the criminal justice system indicated that:

- 30 per cent of male prisoners and 50 per cent of females had a diagnosable mental illness before entering the system;

- around 40 per cent of women reported problems with alcohol abuse prior to incarceration, and 60 per cent used illicit drugs;

- illicit drug use for men was at the same rate for women, but alcohol use had been higher, at 50 per cent.[25]

14.21   A disproportionately high number of these offenders are young. The Youth Mental Health Coalition reports that over 30 per cent of the total prison population is under twenty five years of age. Of these, four out of five have been incarcerated for offences relating to alcohol and other drug use; two in five meet the diagnosis for personality disorder and one in five have attempted suicide.[26]

14.22   The Centre of Social Justice records that untreated mental illness and drug addiction are also significant predictors of recidivism.[27] A study of Thomas Embling Hospital inmates confirmed that concurrence of mental illness and substance abuse exponentially increased the risk of recidivism compared with prisoners who had only one or the other disorder.[28]

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22   Victorian Institute of Forensic Mental Health, *Submission 306,* pp. 9–10.

23   Cited in Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 23. Other evidence suggests that people with schizophrenia and no substance disorder may exhibit less criminal tendencies than those with other forms of mental illness, such as people with personality disorder. See *Submission 319*, p. 111.

24   'Current' means symptoms occurring within the past month.

25   Select Committee on the Increase in the Prisoner population 2001, quoted in *Submission 300*, Centre for Social Justice, p. 66.

26   Statistics 2001, Youth Mental Health Coalition, *Submission 285*, p. 7.

27   *Submission 300*, Attachment 1: Tamara Walsh, *INCORRECTIONS: Investigating Prison Release Practice and Policy in Queensland and Its Impact on Community Safety*, Faculty of Law, Queensland University of Technology, 2004, p. 6.

28   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 10.

14.23   Some submitters contended that the combination of a 'tough on drugs' approach in law enforcement and 'zero tolerance' treatment regimes with under-funded service models for dual diagnosis is driving more people with mental illness into the criminal justice system. Jesuit Social Services made a direct correlation between the absence of adequate services, the growing incidence of self-medication and this exponential growth:

> Much of the recent dramatic increase in the Australian prison population can be explained by the relationship between untreated mental health needs, subsequent illegal use of drugs as a form of self-medication, and the eventual intervention by instrumentalities of the criminal justice system.[29]

14.24   The Centre for Social Justice noted that being in gaol significantly reduces any prosect for symptom management and recovery. The 'zero tolerance' approach to alcohol and drugs in the penal systems of most states means that prisoners are expected to go 'cold turkey' without any assistance.[30] Moreover, prisoners have no access to Medicare.[31] These factors contribute to poorer treatment outcomes for prisoners with dual diagnosis.

The extent of the dual diagnosis problem

14.25   As noted in the introduction, expert opinion is that dual diagnosis is the 'expectation not the exception' for people receiving treatment for either a mental illness or a substance abuse disorder. Studies have shown that having either a mental health or a substance use disorder substantially increases a person's risk of developing the other disorder.[32] Any increase in mental health problems therefore reaps a related increase in substance abuse disorders, and vice versa.

14.26   Statistical evidence confirms that substance abuse among those with mental health problems is pervasive.[33] Submissions cited the findings of the 1997 Australian National Survey of Mental Health and Wellbeing (NSMHW), a household survey which assessed 10 641 respondents for symptoms of high prevalence mental health disorders, including substance disorders. The survey found a high correlation between mental illnesses and substance abuse disorders, so that in any 12 month period:

- 9.7 per cent of the population met criteria for an anxiety disorder;

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29   Father Peter Norden, Policy Director, Jesuit Social Services, 'Prison Is Not A Healthy Place': ANEX Harm Reduction Conference, July 2004 , quoted in Catholic Health Australia, *Submission 276*, p. 14.

30   Centre for Social Justice, *Submission 300, Submission 319* and Australian Injecting and Illicit Drug Users League, *Submission 281*, p. 5. NSW has a methadone maintenance program, see Prof. Chris Puplick, *Submission 226*, p. 113.

31   Mr Michael Gavin Burt, CEO, Victorian Institute of Forensic Mental Health, *Committee Hansard*, 6 July 2005, p. 47.

32   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 6.

33   See ORYGEN Research Centre, *Submission 284*, pp. 1–2 for discussion.

- 7.7 per cent met criteria for a substance use disorder; and

- 5.8 per cent met criteria for an affective (mood) disorder.[34]

14.27   The NSMHW concluded that one in four persons with an anxiety, affective or substance use disorder also had at least one other mental disorder, so that one in four of the persons with one of the disorders also had one of the other disorders (such as an anxiety and affective disorder, or an anxiety and a substance use disorder).[35] The study also found that those with low prevalence disorders, such as schizophrenia, are most likely to have a substance abuse disorder. However, given the high prevalence of anxiety and depression, the majority of cases of dual diagnosis occur in people with these disorders.[36]

14.28   The Black Dog Institute reported that the growing incidence of both depression (high prevalence) and bipolar disorder (low prevalence) has contributed significantly to an overall increase in 'co-morbid' and secondary psychiatric conditions.[37]

14.29   Alcohol dependence remains the most prevalent substance abuse disorder for males,[38] but mental disorders are more prevalent as a percentage among alcohol dependent women. Figures overall indicate that alcohol dependent people are 4.5 times more likely to have an affective or anxiety disorder than other Australians, whereas cannabis dependent people are 4.3 times as likely to do so.[39]

Age profile

14.30   Since the late eighties, the age profile of people experiencing dual diagnosis has undergone a significant shift.

14.31   Catholic Health Australia reports that an accurate depiction of its client profile was once the stereotypical one of the elderly alcoholic: usually male, isolated, dishevelled and living in rundown accommodation or homeless on city streets. The submission suggests that deinstitutionalisation has brought about a significant shift in the age profile of the group. CHA's typical client is now a middle-aged male between 35 and 60 years. His living conditions are the same but he may be reluctant to access help because of the iatrogenic effects of past treatment:

> Many people who had bad experiences in the past are now reluctant to approach the mental health system for help because of this ongoing fear.

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34   National Drug and Alcohol Research Centre, University of NSW, *Submission 109,* p. 1; and see Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 19.

35   National Drug and Alcohol Research Centre, University of NSW, *Submission 109,* p. 1.

36   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 18.

37   Black Dog Institute, *Submission 170,* p. 1.

38   Australian Medical Association, *Submission 167,* p. 8.

39   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 19.

> The style of treatment they experienced in the past may have been traumatic and in many cases did not focus on educating people about their mental illness. In these cases, people have no sense that there are other options available for treatment and management of their illness.… In many cases, people in this group have both chronic mental and physical health conditions. Often, because of the difficult life they have led, they have physically aged with chronic health conditions such as chest infections, hepatitis, rotting teeth etc. In many cases they need just as much physical care as would an older person in an aged care hostel or nursing home but their age precludes them from eligibility for aged care services.[40]

14.32 The emergence of the 'street kid' phenomenon has also changed the profile of the dual diagnosis cohort. Dr Georgina Phillips advised that it is now 'mostly young, very vulnerable, chaotic people' who suffer from dual diagnosis.[41]

14.33 A disproportionate rise in dual diagnosis presentation among young people appears to be an international trend. The ORYGEN Research Centre cited recent results of United Kingdom studies showing a clear increase, particularly since 1986, in co-morbidity rates, along with conduct and emotional disorders, among young people.[42]

14.34 Drawing on Australian assessments, the Australian Divisions of General Practice (ADGP) advised:

> Co-morbidity is of particular concern for young people aged 15-24 years…
> the recent Australian burden of disease and injury study found that nine out of the ten leading causes of burden in young males, and eight out of ten leading causes in young females were substance use disorders or mental disorders. Co-morbidity of these disorders is high with over 50 per cent having co-morbid disorders.[43]

14.35 The increased prevalence of bipolar disorder among youth may be significant, given its frequent co-occurrence with substance abuse. The Black Dog Institute has found a dramatic increase in Bipolar II disorder among youth and adolescents over the last ten years.[44] Consistent over decades at between 0.5 to 1 per cent, estimates now suggest that some five to six per cent of the population might now experience Bipolar II over their lifetime.[45]

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40   Catholic Health Australia, *Submission 276*, p. 17.

41   Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 16.

42   ORYGEN Research Centre, *Submission 284,* pp. 1–2.

43   Australian Divisions of General Practice (ADGP), *Submission 308,* p. 38.

44   Bipolar II manifests as long periods of profound depression, without the severely manic 'high' episodes characterising Bipolar I (previously known as manic depression). These states drive suicidal preoccupations and, on occasions, violence and have associated substance disorder.

45   The Black Dog Institute, *Submission 170,* p. 3.

Social profile

14.36   A history of trauma and abuse, social dislocation and distress is prominent in the life experiences of most people with dual diagnosis. The personal account of the dual diagnosis survivor at the beginning of this chapter[46] provides disturbing confirmation of this fact, as do the many other personal stories the committee has received.

14.37   Research confirms this relationship. Overseas studies have found strong correlations between mental health problems and social disadvantage. Children exposed to domestic violence, abuse or neglect or community violence are at greater risk of mental and social dysfunction in later life. Moreover, early trauma may significantly affect brain development in children.[47] Drug abuse by parents creates generational problems in children who experience emotional, cognitive, behavioural and other psychological problems.[48]

14.38   Studies have also shown that foster children and other young people in out-of-home care have a particularly high risk of mental illness, and of drug and alcohol addiction. The Australian Government submission reports a steady rise in the number of children and young people in out-of-home care,[49] implying there may be an increase in youth mental illness as this group grows in size.

14.39   The high incidence of dual diagnosis among Indigenous Australians, who typically have experienced extremes of family and community disintegration, makes a powerful statement about the role of social factors in generation of co-occurring disorders.[50] Indigenous people experience poor diagnosis, higher rates of imprisonment and substance abuse, self harm and suicide than the general population.[51]

14.40   Recent studies have shown that the use of illicit drugs such as cannabis and the psycho stimulants, amphetamines and cocaine is higher amongst young adults with severe mental illness compared to either the general population or to other psychiatric comparison groups.[52] There was some agreement in the evidence that intake of methamphetamines is increasing the number of presentations of youth with

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46   Name withheld, *Submission 456.*

47   Women and Mental Health Inc, *Submission 310*, p. 3.

48   St Vincent de Paul Society, *Submission 478,* p. 18.

49   Australian Government, *Submission 476,* p. 46.

50   Australian Infant, Child Adolescent Family Mental Health Association (AICAFMHA), *Submission 83*, pp. 20; 26.

51   See for example, Department of Psychiatric Medicine, Children's Hospital Westmead and Tamworth (CAMHS), *Submission 99*, p. 1.

52   Families and Friends for Drug Law Reform, *Submission 319*, p. 5.

drug-induced psychosis.[53] Nevertheless, while there is a clear correlation between substance abuse and mental illness, the causal relationship between the two is not definite. Mr Gary Croton, Clinical Nurse Consultant at Eastern Hume Dual Diagnosis Service advised that it is a case of the 'chicken or the egg':

> I think the wisdom at the moment is that there is a huge range of possible relationships between the disorders depending upon the individual. One disorder may be primary, one disorder may be secondary. The principle that is really emerging strongly now is that, in terms of treatment, you often will not be able to tease out what was the primary disorder and what was the secondary disorder. It will come down to clinician judgement.[54]

14.41   The Youth Substance Abuse Service (YSAS) reported that the 'typical' young person accessing their dual diagnosis services have experienced 'multiple adverse events', involving 'significant levels of trauma and abuse during their childhood and adolescence'. Resulting distress manifests in a range of self harming activities. YSAS explained:

> Young people accessing the services provided by YSAS therefore typically present with a multiplicity of mental health concerns such as self-harm, eating disorders, anxiety and depression. While the behaviours may vary from time to time, the cycles are similar – for example research and practice wisdom demonstrate that substance abuse, bulimia and self-harm show a tendency to occur in clearly patterned cycles of increasing tension, followed by bingeing/purging and then relief. In most cases, emotional regulation is reported to be the primary intent of such behaviours.[55]

Dual prisoners—doubly damaged

14.42   People with dual diagnosis in prison are typically from among the most disadvantaged groups in society. The Probation and Community Correction's Officers Association advises:

> Typically young, male, single, with a history of conduct disorder and family substance abuse, these are the people to whom are applied such pessimistic terminology as 'falling through the gaps'.[56]

14.43   As mentioned, women have a higher incidence of mental illness than male inmates but equivalent histories of substance abuse:

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53   Gold Coast Drug Council, *Submission 553*, p. 5; Families and Friends for Drug Law Reform, *Submission 319,* p. 5.

54   Mr Gary Croton, Eastern Hume Dual Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 16.

55   YSAS, *Submission 211,* p. 1.

56   A NSW Health publication, quoted by Probation and Community Correction's Officers Association Incorporated (PACCOA), *Submission 503*, p. 4.

> Women prisoners are casualties from harmful early life experiences and social deprivation showing mental health and other harms to a very high degree. They are truly outsiders.[57]

14.44   Sisters Inside records that over 50 per cent of women in prison had been placed 'in care' as children and approximately one quarter have been imprisoned in a juvenile detention centre. Further, prior to incarceration, 98 per cent of women prisoners had experienced physical abuse and 89 per cent had experienced sexual abuse.[58] Sisters Inside reports that the number of women in prison in Queensland has being growing as a percentage relative to men, with a rise of 13 per cent over five years to 2003 (up to 325).[59]

14.45   The plight of Indigenous women within this spectrum has been described as one of 'triple disadvantage'. Alcohol, drug abuse and violence are endemic and more often lead to offending. With lower levels of education and employment, Indigenous women also suffer from a higher incidence of past physical and sexual abuse than other prisoners.[60]

The service burden of dual diagnosis

14.46   People with a dual diagnosis have a higher level of need than other mentally ill cohorts and a poorer prognosis compared with those with either a mental or substance abuse disorder alone.[61] This is in part because the complex interrelationship of disorders creates obstacles to effective diagnosis and treatment:

> …the co-occurrence of mental health and substances disorders cases influences the development and severity each condition, and affects the individual's response to treatment and circumstances of relapse.[62]

14.47   Co-occurring disorders are pervasive and have poor treatment outcomes:

> The co-occurrence of drug dependence and mental health disorders is widespread and is associated with higher levels of hospitalisation, incarceration, suicide, homicide, housing instability and homelessness, unemployment and financial difficulties, and lower treatment compliance requiring more complex and more expensive care.[63]

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57   Professor Ian Webster, *Submission 458*, p. 20.

58   Sisters Inside, *Submission 283*, p. 7.

59   *Submission 283,* p. 7.

60   *Submission 283,* Attachment 1, p. 4.

61   National Drug and Alcohol Research Centre, University of NSW, *Submission 109*, p. 1.

62   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 6.

63   Western Australian Network Alcohol and Other Drug Agencies (WANADA) *Submission 171*, p. 2. See also, Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 6.

14.48   People with low prevalence disorders and dual diagnosis experience the worst social and health outcomes:

- experiencing more frequent relapse and hospitalisation;

- are more exposed to violence and exploitation, both as victim and perpetrator;

- are more likely to have a physical disorder;

- a higher incidence of homelessness; and

- more forensic involvement (as discussed above).[64]

Clinical support services

14.49   The high needs of people with a dual diagnosis incur a significant service burden with attendant costs. Eastern Hume Dual Diagnosis Service reports that the overall treatment costs for persons with co-occurring substance use disorders are twice those of people with other co-occurring disorders. These costs are largely attributable to additional acute care needs.[65]

14.50   The prevalence of physical illnesses and injury within this group, consequent to the mental instability suffered, contributes significantly to these costs:

Co-morbidity of substance use and severe mental disorders is associated with an increased risk of illness and injury including self-harm and suicide. Co-morbid disorders are more likely to become chronic and disabling, and result in greater service utilisation and increased health care costs.[66]

14.51   The inability of the public health system to deal compassionately with threats of suicide and self harming behaviours among the mentally ill has been discussed in other chapters in this report. The record of failure is even more profound for patients with dual diagnosis. Emergency departments are ill-prepared to deal with repeated presentations of this type:

Patients with both substance abuse and mental illness issues are particularly vulnerable to social and medical risks, including accidental or deliberate self-harm. They are heavy users of the emergency department and are extremely stressful for ED staff to manage, not only because of acute behavioural disturbance but also because of frequent re-presentations and a lack of willingness or capacity of either mental health or drug and alcohol services to own the patient and direct their care. These patients are too

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64   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 19.

65   B. Dickey and H. Azeni, 'Persons with dual diagnosis of substance abuse and major mental illness: their excess costs of psychiatric care', *American Journal of Public Health,* vol. 86, pp. 973–97, 1996, cited in Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 23.

66   National Drug and Alcohol Research Centre, *Submission 109,* p. 1.

complex for the limitations of our current system, yet they are at real risk of harm.[67]

14.52   There can be great difficulty disentangling the effects of drugs from the symptoms of mental illness when patients present at emergency departments with psychosis. Some patients can enter and leave hospital without proper diagnosis or treatment.

14.53   Studies have shown that people with co-occurring psychotic and substance use disorders are also at higher risk of experiencing certain physical disorders than people with mental illness alone. These include diabetes, hypertension, heart disease, asthma, gastrointestinal disorders, skin infections, malignant neoplasms and acute respiratory disorders.[68] The South Australian Division of General Practice advised that these health needs are largely unaddressed by overwhelmed emergency services and doctors who are disconnected from alcohol and drugs services.[69]

14.54   The absence of dedicated tertiary beds or hospital wards to treat people with dual diagnosis, consequent to their closure under deinstitutionalisation, was raised as an area of urgent unmet need. Professor Kavanagh, of the Mental Health Centre at the Royal Brisbane Hospital, noting extremely high rates of co-morbidity in inpatient wards and in younger patients, warned that 'effective management of co-morbidity is likely to be critical to the cost-effectiveness of [inpatient] services':

> If these patients are not effectively treated, this will have a substantial impact on the overall effectiveness of the service. In practice, management of co-morbidity becomes 'core business' for the service, whether or not this is recognised.[70]

14.55   Aged people with dual diagnosis have extremely poor access to drug and alcohol services. Dr Roderick McKay of the Royal Australian and New Zealand College of Psychiatrists noted that the national drug and alcohol plan has no policy initiatives with regards to the elderly, and that the area seems to have been overlooked as part of dementia services.[71]

14.56   Another significant area of unmet need is in treatment of those with anxiety or depression and substance abuse disorder. This is the largest dual diagnosis cohort. As discussed elsewhere in the report, substance abuse and depression are behind the high

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67   Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 8.

68   Dickey, Normand, Weiss, Drake, and Azeni, 'Medical Morbidity, Mental Illness, and Substance Use Disorders', *Psychiatric Services*, vol. 53, pp. 861–867, 2002, quoted in Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 23.

69   The South Australian Division of General Practice, *Submission 88,* pp. 9–10.

70   Families and Friends for Drug Law Reform, *Submission 319*, p. 2.

71   Dr Roderick George McKay, on behalf of the New South Wales Branch of the Faculty of Psychiatry of Old Age, the Royal Australian and New Zealand College of Psychiatrists, *Submission 219,* p. 6.

incidence of suicide recorded in Australia.[72] Beyondblue has identified this as a priority area in its programs promoting education against stigma and General Practitioner (GP) access.[73] This is discussed in Chapter 7.

14.57   Healthscope and the Australian Health Insurance Association reported that the private sector currently provides care for some high prevalence co-occurring disorders.[74] However, other submissions observed that options for this are limited for the majority of the dual diagnosis cohort, because they typically have low income levels. There is also a shortage of private psychiatrists able or willing to work with people with dual diagnosis.[75]

14.58   Healthscope identified potential to build care capacity in rural areas through use of private providers.[76] This depends, however, on ensuring that health insurance fund cover remains accessible for mental health care, and that health insurance portability is in place.[77] This is discussed in Chapter 12.

Community support services

14.59   Barriers to service provision for dual diagnosis youth in the community include a lack of appropriate accommodation with suitable primary care outreach, and of specialist and 'youth friendly' service models.[78] The Mental Health Coordinating Council (MHCC) submitted that the existence of these barriers contributes to the high imprisonment rate of young people with dual diagnosis:

> Persons suffering co-morbidity, particularly young people, frequently end up living on the streets, their needs unable to be met by the limits of the existing services and the barriers to access due to risk management, inadequate availability of professional clinical staff and suitable accommodation…[they] find themselves involved in the criminal justice system as a result of inadequate mental health and support services rather than inherent criminality.[79]

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72   Professor Ian Webster, *Submission 458,* p. 3.

73   Mr Jeff Kennett and Ms Leonie Young, beyondblue, *Committee Hansard*, 5 July 2006, pp. 2; 6–7.

74   Healthscope Ltd, *Submission 82,* p. 1, and Australian Health Insurance Association Ltd (AHIA), *Submission 292*, p. 6.

75   Dr Ruth Vine, Department of Human Services, Victoria, *Committee Hansard*, 7 July 2005, p. 32.

76   Healthscope Ltd, *Committee Hansard*, 5 July 2006, p. 19.

77   Healthscope Ltd, *Submission 82,* p. 1.

78   ADGP, *Submission 308,* p. 38.

79   The Mental Health Coordinating Council, *Submission 173*, p. 5.

14.60   Catholic Health Australia indicated that current services do not address the needs of the broader cohort of people with dual diagnosis, including the alienated aged and middle-aged homeless who congregate in urban areas:

> … there needs to be much better coordination between drug and alcohol, mental health and disability services together with housing and supported accommodation programs. Mental health services need to be tailored to respond to the needs of inner city dwellers (often people who have a dual diagnosis, are homeless and who have no family support).[80]

14.61   People with co-morbid conditions experience high levels of unemployment. At the same time, they are least able to meet Centrelink and disability payment requirements, because these services do not comprehensively assess or take into account the extent of the debilitation caused by behavioural and mental disorders:

> Very frequently the homeless and other marginalised people are depressed, have great difficulty in personal contact, and lack confidence in their own capacity to relate to other people or indeed to initiate contact with them. The way income support arrangements are implemented at this level does far more harm than the intended good (namely encouraging people back to work).[81]

14.62   The Australian government submission confirms that it is not possible to assess how many people with co-morbid disorders access the Disability Support Pension (DSP). Mental illness represents a major category of disability condition under the Australian Government's DSP.[82] However, the DSP statistics only report the primary disability that qualifies the person for payment; the data does not indicate how many people with co-morbidities, such as anxiety and substance use, receive these payments.[83]

Service delivery response—'service silos'

14.63   People with dual diagnosis have been characterised as 'the forgotten people' of the mental health system.[84] They have more difficulty accessing services than any other people experiencing mental illness and their life circumstances reflect this.

14.64   Dr Andrew Gunn reported that stigma plays its part in poor outcomes for people with co-morbid disorders.[85] People with dual diagnosis and low prevalence

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80   Catholic Health Australia, *Submission 276A,* p. 4.

81   Professor Ian Webster, *Submission 458*, pp. 33; 36.

82   Of the total number of DSP customers at June 2004, those with a psychiatric/psychological condition were the second largest customer group (25.4 per cent) behind those with musculo-skeletal and connective tissue conditions (34.0 per cent).

83   Australian Government, *Submission 476*, p. 43, and see note b.

84   Name withheld, *Submission 251,* p. 5.

85   Dr Andrew Gunn, *Submission 52,* p. 1.

disorders in particular, are likely to be homeless or socially isolated and in poor physical health. Hard to diagnose, hard to treat, and often hard to motivate to attend available services in a system which relies on voluntary participation, the dual diagnosis cohort are difficult and unreliable patients.[86]

14.65   However, while these factors are important, the main problem for the dual diagnosis group is that they fall outside of the discrete treatment spectrums of the mental health system on the one hand, and alcohol and drugs services on the other. Professor Patrick McGorry of ORYGEN Research Centre provides a concise summary of the situation: the 'service silos' are a 'recipe for fragmented care and very poor quality care' of dual patients:

> In the past, 20 years ago, drug and alcohol services were run completely integrated with mental health services, certainly in the two states I have worked in, New South Wales and Victoria. They have been separated off into two separate systems of care. At the bureaucratic level, we have a state director of mental health and we have a state director of drug and alcohol. On the ground, they are separate service systems and separate cultures now. It makes absolutely no sense for it to be like that. They are the same kinds of problems and, quite often, it is the same people with different thresholds of mental health or drug and alcohol problems. If you were to recommend that that be addressed seriously, the territoriality would probably defeat it. But if it were about patient care, you would bring those systems together tomorrow under the same leadership and the same principles of service provision.[87]

Mental health and alcohol and drug services—distinct and different

14.66   Historically, people with drug and alcohol addiction were routinely incarcerated in mental institutions, sometimes indefinitely, even though they may not have suffered mental illness. Modern health legislation has been drafted to address this problem. Each state and territory in Australia has legislation which provides that people with alcohol or drug addiction cannot be subject to involuntary treatment by the mental health system, although they can be detained for a short period.[88]

14.67   While the legislation was drafted this way for sound human rights reasons, the legal distinction underpins the development of the now distinct and different service

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86   ADGP, *Submission 308*, p. 40.

87   Professor Patrick McGorry, ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 19.

88   State and territory mental health legislation tightly defines the nature of mental illness and sets out reasonable grounds for assessing whether involuntary admission might be required. In each case, the definitions state that a person is not to be considered mentally ill because they are affected by alcohol and other substances, although the Queensland legislation allows that a 'person my have a mental illness caused by the taking of drugs or alcohol'. Schedule 2, section 12(3) (2) (i), Queensland *Mental Health Act 2000*.

streams for mental health disorders as against substance abuse disorders.[89] Evidence suggested that overwhelmed mental health service providers are now using this distinction as a legal loophole to deny access to people with dual diagnosis.[90]

14.68   Under current service criteria, people with alcohol and drug problems can be turned away from mainstream mental health systems, which are not required to treat substance affected people. Meanwhile drug and alcohol services may also reject clients with mental health problems. People with dual diagnosis are thus effectively excluded from both 'service silos' and left to wander from provider to provider seeking treatment.

14.69   Submissions provided ample confirmation that the 'buck passing' of high need dual diagnosis patients between the 'service silos' is widespread:

> In the area of drug and alcohol services we still find that people with a dual diagnosis involving mental illness and drug dependence almost invariably fall "between the two stools". People who get referred to Drug and Alcohol services often get told that their mental health problem must be dealt with first, while people with a drug or alcohol problem and a mental illness who are referred to mental health get told the opposite ie that their drug or alcohol problem needs to be dealt with first. This often results in neither disorder being adequately treated.[91]

14.70   Distinct and different clinical perspectives inform the two sectors, allowing people with coexisting disorders to 'slip through the cracks' between both regimes. Dr Georgina Phillips advised: 'psychiatric illnesses are seen as medical and the drug and alcohol problems are seen more as lifestyle issues'.[92]

14.71   The Youth Substance Abuse Service (YSAS) reported the consequence of these differences: 'Inconsistency of concepts, language, and approach remain an obstacle to engagement, retention, and compliance in dual treatments…and reduce capacity to effectively assess both problems'.[93] In particular:

> …the AOD [Alcohol and Other Drug] frameworks highlighted within dual diagnosis models have historically been confrontational, disease based, 12-step approaches. It has been noted that such approaches often sit in direct contradiction to mental health frameworks that advocate pharmacological maintenance approaches to management of mental health issues. It is thought such differences are hard to integrate when moving

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89   See Professor Ian W Webster, *Submission 458,* pp. 16–18 for discussion.

90   This is not a new phenomenon. In 1993 the Burdekin Report observed that 'increasing specialisation and exclusivity of services' has erected significant barriers to clients experiencing multiple needs simultaneously across distinct service systems. See YSAS, *Submission 211*, p. 6.

91   Consumers and Carers NSW Far South Coast, *Submission 5*, p. 3.

92   Dr Georgina Phillips, *Committee Hansard,* 6 July 2005, p. 16.

93   YSAS, *Submission 211*, p. 5.

between the two service systems, and can often lead to confusion over appropriate treatment approaches for clients.[94]

14.72   People with dual diagnosis are thus effectively excluded from mainstream care in many states. Their care falls back on to an overwhelmed non-government sector. Brotherhood of St Laurence advised:

> Individuals who have a mental illness as well as a drug or alcohol problem are even more limited in their access to services. Drug and alcohol agencies are not set up to deal with issues of mental illness, and mental health agencies often declare their work sites to be drug and alcohol free. People with a dual disability find themselves in a bind. There are services available that cater for them, but like most other organisations, they are under resourced and over burdened.[95]

14.73   The Gold Coast Drug Council reported that its drug and alcohol service has been extended and transformed in recognition of the growing burden of need, in absence of dedicated health services for its clients on the Gold Coast:

> Whilst we are primarily a service designed to treat people who have a drug and/or alcohol problem, we are finding now—and have been finding for many years—that in up to 80 per cent of cases there is a co-existing mental health disorder. Consequently, we have had to expand our service delivery. I suspect many other services have either had to expand or very soon will have to do so, in order that we can treat mental health problems as well. So whilst from the public's perspective we are providing a drug and alcohol treatment service, we are also providing a very comprehensive service to treat mental health problems as well.[96]

14.74   Non-government service providers maintained they are overwhelmed by the extent of unmet need and must turn away many seeking help. Evidence also provided many examples of the tragic human price that is being exacted because of the failure to develop a proactive mainstream approach to treatment of dual diagnosis. The White Wreath Association related this account:

> One woman, who did not wish to be named, talked about her son who died from a heroin overdose a year ago. She said her son, who was 27 when he died and was a heroin addict from the age 14, developed a mental dysfunction after trying to get off a methadone 'cold turkey' program. He spent several months in a psychiatric ward, but she said the hospital did not treat his drug problem. 'It's almost like you go to hospital with hospital with cancer and a broken arm, and they treat your broken arm but not your

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94   YSAS, *Submission 211*, p. 5.

95   Brotherhood of St Laurence, *Submission 97*, p. 3.

96   Ms Mary Alcorn, Executive Director, Gold Coast Drug Council Inc., *Committee Hansard*, 2 February 2006, pp. 15–16.

cancer,' she said. 'That's what happened. They don't liaise with the drug counsellors, and its killing kids'.[97]

14.75 The committee did hear about government and non-government initiatives trying to bridge the gaps created by the divisions between services, discussed below, but also about other gaps that were creating problems for those seeking help.

Dedicated youth services—bridging the gap

14.76 Access to adequate treatment for youth with dual diagnosis is compounded by another 'silo' problem: the division between child and adolescent services on the one hand and adult services on the other.

14.77 Stakeholders advised of the gaping service gap in this area of most urgent need: the 16 to 24 year-old age dual diagnosis group:

> Drug and alcohol service delivery for young people, especially in their late teens and early adulthood are inadequate. Opportunities for effective prevention programs (targeting early adolescence) have been poorly realised nationally and effective early intervention programs are yet to be made generally available in the community. This is a major gap. The significant overlap of risk factors for drug and alcohol and mental health disorders in young people suggest some potential synergies for prevention/early intervention programs for children and adolescents.[98]

14.78 Non-government organisations, under various funding arrangements, step in to fill this gap. ORYGEN, which runs one of the few targeted youth services of this type, reports there is nevertheless 'tremendous resistance' among state and territory governments to a mainstream response to this category of unmet need. Principal to the problem is that targeting 'youth' as a cohort, would involve the adding of an additional youth to young adult tier to the existing three age bracket system, comprising child and adolescents services, adult services and aged services.[99]

14.79 There are, nonetheless, methodological and socio-cultural reasons to suggest that this should be a discrete group for service provision purposes.

14.80 As discussed in Chapter 15, treatment within the adult mainstream services offers a depressing introduction to life with a mental illness for the young and, incidentally, is an indictment on adult services. One young person wrote to the committee:

> Where I have felt like less of a person is within the adult mental health system. There is a general atmosphere there that you have no future, your

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97   The White Wreath Association, *Submission 91*, p. 9.

98   The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), *Submission 83*, pp. 14–15.

99   Professor Patrick McGorry, ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 8.

> illness means you can be ignored, spoken to rudely, be made to feel like you are taking up too much time and you don't deserve any patient respect because you are struggling with living.[100]

14.81   Service providers report that the clinical model for mental health services is particularly repellent to young people with dual diagnosis, and not conducive to their accessing or continuing to engage with available services. The Mental Health Legal Centre advised that young people with mental illness often rely on drug use to provide them with a peer group which accepts their mental illness. They find that drug and alcohol services are more respectful of these needs. The Centre recommended that service agencies should address this by giving consumers options for self-management, including in development of treatment plans and access to services.[101]

14.82   A number of submissions referred to the services provided by ORYGEN Youth Health services in Victoria as meeting these criteria.[102] ORYGEN's model addresses the mix of clinical and social needs of the targeted group, and received glowing endorsement by young clients who had found hope for recovery and a sense of self-determination within its youth program. On the basis of her experiences, Ms Jolan Tobias of the ORYGEN Youth Health Platform Team stated:

> We recommend that all young people who need a mental health service should be able to access services that are specifically for young people, no matter where they live. All mental health services should have group programs and do more than just prescribe medicine. Social, vocational and emotional goals are crucial to psychiatric recovery. We recommend that young people should be involved in the design and delivery of mental health services for young people.[103]

14.83   Dr Dan Lubman of ORYGEN explained that the success of the approach relies on strong regional links between youth and the drug and alcohol services.[104] Other submissions agreed that linkages must be built between local services to allow for the integrated approach to service provision to the youth dual diagnosis group, and this should include housing support, extended counselling assistance, and mechanisms to better address health needs.

14.84   The ADGP suggested that adjustments should be made to Better Outcomes requirements to allow co-location of GPs in environments targeting dual youth needs, observing:

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100   Youth Mental Health Coalition *Submission 284*, case study, Jolans' story, pp. 14–15.

101   The Mental Health Legal Centre, *Submission 314,* p. 18.

102   For example, NCOSS—Council of Social Service of New South Wales, *Submission 274*, p. 9.

103   Ms Jolan Tobias, ORYGEN Youth Health, *Committee Hansard,* 7 July 2005, p. 22.

104   Dr Dan Lubman, Consultant and Senior Psychiatrist, ORYGEN Youth Health and ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 9.

> They require a different psycho-social approach to meet their health needs which relies on good rapport with general practitioners and other care providers and access to "youth friendly" systems. Marginalised young people and those disconnected from family and school do not necessarily access mainstream services such as general practice. There is a need for specialised services to reach these young people, and for these services to have a strong primary care interface so that discharge for recovery and rehabilitation in primary care can occur…Better Outcomes needs to allow enrolled GPs to deliver mental health care in settings where young people 'hang out' such as youth centres and clinics. At present, this is not possible if the centre is not accredited.[105]

14.85   The Gold Coast Drug Council endorsed these views, noting that bulk-billing of GPs and psychiatric specialists is essential if sustainable, integrated, community-based support is to be available for this cohort.[106] It recorded a definite increase in dual diagnosis among amphetamine users, reporting that younger clients are now seeking treatment earlier. This reinforces the need for 'holistic' service approaches to cater for the younger teenager through to the young adult age group.[107]

14.86   The next section will consider some of the issues surrounding proposals for a more integrated care model of public health services to better meet the complex care needs of people with dual diagnosis.

Service integration—the state of play

14.87   There is a strong body of evidence which supports the view that a more integrated approach to service provision for people with dual diagnosis will not only improve outcomes for those affected but will be more efficient and cost effective.[108]

14.88   Dr Phillip Morris, Executive Director, Gold Coast Institute of Mental Health, reported World Health Organisation data that demonstrates that in countries where there had been reform of drug and alcohol services along with mental health acts and policies, there has been a fall in suicide rates.[109] By contrast ORYGEN Research Centre, commenting on the situation of Australia's dual diagnosis youth, advised:

> The lack of integration between drug and alcohol and mental health services in Australia has significantly contributed to the poor detection and treatment of mental illness amongst young people with substance abuse.

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105   ADGP, *Submission 308*, p. 32.

106   Ms Mary Alcorn, Executive Director, Gold Coast Drug Council, *Committee Hansard,* 7 July 2006, p. 17.

107   Gold Coast Drug Council Inc, *Submission 553*, p. 5.

108   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 5

109   Dr Phillip Morris, Executive Director, Gold Coast Institute of Mental Health, *Committee Hansard*, 2 February 2006, p. 3.

> This results in waste of resources and long-term psychiatric and substance use problems for individuals who could otherwise be helped.[110]

14.89   Nevertheless, some advances have been made in individual states and territories. A number of stakeholders referred positively to developments in Victoria, which introduced a state-wide dual diagnosis initiative—the Victorian Dual Diagnosis Initiative (VDDI)—in 2002. The initiative, jointly funded by both mental health and drug services, was given $9 million in the Victorian state 2005-06 budget to improve service integration and workforce development over four years.[111] The VDDI aims to:

> …support the development of better treatment practices and collaborative relationships between drug treatment and mental health services. The key activities of the initiative are the development of local networks; training, consultation and modelling of good practice through direct clinical intervention, and shared care arrangements.[112]

14.90   Victorian-based Youth Substance Abuse Service (YSAS) commented on the success of the model in its submission:

> The development of dual diagnosis positions in each metropolitan Department of Human Services (DHS) region, including the development of youth focused dual diagnosis positions, appears to have improved cross-sector knowledge around target populations, demand characteristics, service response capacities, and the understanding of co-morbid substance use and mental health conditions.[113]

14.91   Other states also reported progress on integration and reform to better address the needs of people with dual diagnosis. Queensland has undertaken a two year strategy of reform, appointing nine new managers to head up an integrated mental health and alcohol, tobacco and other drugs services department.[114] The Tasmanian Government told the committee of its appointment of two co-morbidity executive positions to progress a memorandum of understanding between mental health and drug and alcohol services. The MOU will cover a range of initiatives to assist partnership and joint service delivery, and to link services that will remain separate. The Minister has also announced the establishment of an expert co-morbidity task

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110   ORYGEN Research Centre, *Submission 284*, p. 11.

111   Victorian Government, *Submission 445*, p. 6; and Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 30.

112   Victorian Government, 2005, quoted in Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 30.

113   YSAS, *Submission 211*, p. 4.

114   Queensland Government, *Submission 377*, p. 20.

force.[115] Western Australia has an integrated mental health and AOD service operating in the Kimberley and Pilbara regions.[116]

14.92   While these developments are commendable, there were concerns that each state is progressing the issue without the benefit of a consistent plan, or with any agreed theoretical direction, for implementation of service integration.

Debate about integration models

14.93   There were different views about how integration of services might be best achieved. Discussion of the Victorian model, which is the most developed, revealed emerging criticisms of the approach in that state.

14.94   In particular, it was suggested that VDDI programs are not resulting in the desired coordination of treatment between the two services but may instead be developing a 'third tier' of 'niche' dual services. Jesuit Social Services reported advice from its service providers:

> Discussions with Connexions staff around the impact of dual diagnosis teams in Victoria, considered positive outcomes to be the increased capacity of drug and alcohol staff and mental health staff to recognise mental health issue or substance use issues in their respective clients … on the negative side it was felt that the problem of staff in each sector not wanting to work with dually diagnosed clients persists. They also expressed concerns that dual diagnosis was in danger of becoming a niche market and services were becoming more fragmented as organisations within different sectors establish dual diagnosis specific services. Coordination was seen as a key component of integrating treatment.[117]

14.95   In its submission Eastern Hume Dual Diagnosis Service warned that specialisation of skills in a 'third tier', providing treatment only for those with co-occurring disorders, may exacerbate rather than alleviate the likelihood of these individuals 'falling through the gaps'. The reason for this is that access to appropriate treatment relies on staff being adequately trained to identify and assess complex disorders, which they would not be inclined to do if dual diagnosis is regarded as the domain of specialists.[118]

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115   Associate Professor Des Graham, Tasmanian Department of Health and Human Services, *Committee Hansard*, 1 February 2006, pp. 76; 19.

116   The Northwest Mental Health Service and Kimberley Community Drug Service Team provides community based mental health services in both regions, and AOD services in the Kimberley. See Department of Health, Western Australia at: www.health.wa.gov.au/services/detail.cfm?Unit_ID=267, (accessed March 2006).

117   The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358,* p. 6.

118   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 35.

14.96   Eastern Hume also predicted that treatment of people with dual diagnosis in a third tier may generate a turf war among service providers given that drug and alcohol services could lose between 30 and 70 per cent of patients, which would be counter productive to development of a sustainable approach.[119]

14.97   Most stakeholders argued that it was preferable for existing services to be utilised for any reformed dual diagnosis treatment, although there were different opinions about whether drug and alcohol services or mental health services should take primary responsibility for coordination of care for dual diagnosis clients. YSAS for example, considered the ideal would be for AOD services to provide integrated care for dual diagnosis clients in consultation with mental health services, rather than simply referring them to a mental health service. In contrast, the Western Australian Network of Alcohol and Other Drug Agencies (WANADA) and St Vincent de Paul Society recommended referrals be made to mental health services.[120]

14.98   There was also debate about comparative models for integrated care, such as whether a single agency or 'one-stop shop' would better service the needs of the target group compared with the referral-based service paradigms currently applied.

14.99   As noted, Eastern Hume warned against trends towards specialisation in a distinct service tier. It also referred to United States findings that specialisation of skills in a particular agency, or in an individual within an agency, does not develop the system's overall capacity to provide integrated care.[121] By contrast, Ms Nene Henry, a mental health case manager and registered nurse, cited United Kingdom Department of Health studies which concluded that integrated care, delivered by one team, appears to deliver better outcomes than serial care (sequential referrals to different services) or parallel care (more than one service engaging the client at the same time).[122] Ms Henry recommended:

> Urgent implementation of an integrated model which provides the concurrent provision of both psychiatric, and drug and alcohol interventions. This would require the same staff member (or clinical team), working in a single setting, to provide relevant psychiatric and substance misuse interventions in a co-coordinated fashion.[123]

14.100 The single service model was also advocated in particular for Indigenous dual diagnosis needs, with successful integrated models in operation in South Australia.[124] Indigenous mental health needs are discussed in more detail in Chapter 16.

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119   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 35.

120   YSAS, *Submission 211*, p. 6, WANADA *Submission 171*, p. 2, St Vincent de Paul Society, *Submission 478*, p. 11.

121   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 35.

122   Ms Nene Henry, *Submission 282*, p. 4.

123   Ms Nene Henry, *Submission 282*, p. 4.

124   SA Division of General Practice, *Submission 88*, p. 8.

14.101 Whatever the service paradigm, it was agreed that viable access points to services must be established for people with dual diagnosis. As YSAS and others argued, a prime objective is to ensure that there is a genuine 'equity of access' or a 'no wrong door' policy so that, irrespective of which organisation or service system is initially engaged, the dual diagnosis client can be accurately assessed and directed to an appropriate service response for treatment.[125]

14.102 To achieve this crucial objective it was agreed that there must be a focus, both at national policy and service delivery level, on systemic 'capacity building' to achieve the necessary linkages within and across the mental health and drug and alcohol systems. Eastern Hume Diagnosis observed that this could be achieved cost effectively if the approach is comprehensive:

> International experience has demonstrated that rapid development of a system's recognition of and response to co-occurring disorders can occur without the input of significant extra resources. Improving the system's recognition and response requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals. Integrated strategic planning processes and policy deployment are central to effecting enduring improvements to systems' recognition of and responses to co-occurring disorders.[126]

14.103 The remainder of the chapter will explore the requirements for 'capacity building' of integrated services for people with dual diagnosis.

The building blocks of service integration—'top-down'

14.104 The following 'top-down' strategies were advocated as the building blocks of service integration:

- national vision and appropriate policy levers, including legislative requirements, to direct the system towards more effective integrated treatment;

- education and training strategies based on national curricula, accreditation, competency standards and including modules aimed at adjusting clinical attitudes; and

- improved diagnostic screening tools and clinician focussed training manuals.[127]

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125   YSAS, *Submission 211*, p. 6.

126   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 5.

127   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 5.

National policy levers

14.105 Progress on integrated service delivery requires that dual diagnosis be recognised as 'core business' for mental health services. This relies on strong leadership and commitment on the part of governments.

14.106 Eastern Hume cited advances in the United Kingdom on the government's announcement that dual diagnosis is 'a mainstream responsibility for mental health services'. The publication of a mental health policy implementation guide, the *Dual Diagnosis Good Practice Guide,* had supported and reinforced progress.[128]

14.107 The United States government has also shown strong leadership, delivering an integrated approach potentially useful to inform an Australian model.[129] In the US, the improvement of treatment and services for individuals with co-occurring disorders is one of the highest priorities for the Federal Substance Abuse Mental Health Services Administration (SAMHSA), which liaises with the Co-Occurring Centre for Excellence, established to provide training and methodological direction and linkages between SAMHSA and the states' communities and providers. The Comprehensive Continuous Integrated System of Care (CCISC) is operational in a number of states. It takes the position that dual diagnosis is an expectation of service, and leverages substantial development of treatment largely within existing resources.[130]

14.108 However, it was contended that the Australian Government, despite repeated strong rhetorical commitments to better integrate mental health and drug and alcohol services, has failed to put in place effective 'policy levers' to secure that objective. Submissions referred to the following deficiencies:

- lack of articulation between key policy documents and of supporting guidelines to direct comprehensive reform;[131] and

- lack of consultation mechanisms and centres of research to assist and inform the process.[132]

Providing leadership: policy documents and guidelines

14.109 The Australian Government reports a range of initiatives aimed at enhancing mental health service delivery for the dual diagnosis cohort. The vision for integrated service is set out in two key policy documents:

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128   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 27.

129   *Submission 374,* p. 27.

130   *Submission 374*, p. 28.

131   *Submission 374*, p. 9.

132   Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service*, Committee Hansard*, 6 July 2005, p. 22.

- The National Mental Health Plan 2003–2008, the third plan, aims to strengthen and consolidate the vision of the second plan mental health services. It recognises the effect of mental illnesses occurring together with drug and alcohol problems and other conditions;[133]and

- The National Drug Strategy Australia's Integrated Framework 2004–2009, which aims to provide 'a framework for a coordinated, integrated approach to drug issues in the Australian community'.[134]

14.110 Despite this commitment to interlinking services, Eastern Hume Dual Diagnosis Service notes that the National Mental Health Plan undercuts the potential for connection in declaring:

> In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system.[135]

14.111 Consequently, the key documents fail to provide advice on strategic directions for integrated treatment of individuals with coexisting substance abuse and mental health problems. Families and Friends for Drug Law Reform observed:

> These peak policy documents fail in any meaningful way to address the links between mental health and illicit drug substance abuse. The National Mental Health Plan 2003-2008 passes responsibility for drug and alcohol problems to the national drug strategy. The National Drug Strategy: Australia's integrated framework 2004-2009 makes the platitudinous point that there should be strong partnerships between the treatment services. It also specifies that there should be integration of policies and programs without indicating what this involves.[136]

14.112 In this regard, Eastern Hume Dual Diagnosis noted that the NMHP provides no advice on key implementation issues, such as the relative efficacy of different integration models. It concluded: 'it is difficult to discern at what points and in what manner the two strategies [alcohol and drug, and mental health] are linked.[137]

14.113 Submissions asked that the government exhibit strong leadership on integrated service reform. The Australian Medical Association suggested that service integration might be better advanced if mental health strategies were brought together with AOD as part of the national chronic disease strategy initiative.[138]

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133   Australian Government, *Submission 476,* p. 20.

134   Australian Government, *Submission 476,* p. 67.

135   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 29.

136   Families and Friends for Drug Law Reform, *Submission 319*, p. 2.

137   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 9.

138   The Australian Medical Association, Submission *167,* p. 34.

14.114 Another option is the introduction of national guidelines and performance reporting to encourage integration of services. It was noted that progress in the United Kingdom was underpinned by national mental health policy implementation guidelines for treatment of dual diagnosis.[139]

14.115 In the Australian context, where mental health legislation in each state may vary treatment outcomes, such guidelines could be an important means of promoting comprehensive and consistent service integration. National guidelines could promote inter-agency cooperation and potentially promote, for example, a broader recognition of the role of generic welfare services in achieving good outcomes for people with dual diagnosis than current state mental health legislation encourages.[140] They could also be used to establish inter-agency service agreements and memoranda of understanding as well as agreed approaches to training and performance delivery.[141] At present a number of states and some regions have initiated drafting or implementation of these guidelines independently.[142]

Mechanisms for coordination, consultation and research

14.116 Advancement overseas has also been due to the establishment of national vehicles for coordination, consultation and research. A federally convened and funded forum or research body could assist states and territories to agree on a service trajectory, in a 'whole of government' approach. The Office of the Public Advocate, Queensland, recommended:

> A whole-of-government approach to mental health policy and funding should emerge from the Commonwealth, in order to see the same level of integration in the States' delivery of services…resources could be better utilised if various silos of government were to develop more effective collaborative arrangements.[143]

14.117 Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service, advised the committee that at present the states and territories have no opportunity to learn from each other, nor any repository for shared knowledge:

> I hesitate to comment on someone else's system but it is interesting that Western Australia, from the outside—from my perspective— devoted a large amount of resources and expertise to putting an integrated response together and now seems to have moved away from that. I would really like

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139   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 27.

140   UnitingCare NSW, *Submission 279,* pp. 11–12.

141   WANADA, *Submission 171*, pp. 4–5.

142   See Queensland *Submission 377*, p. 20; and see The Drug Action Information Exchange (DAIE) Wollongong, *Submission 222*, p. 8 for discussion of regional implementation of NSW health guidelines under the Illawarra Drug and Alcohol Strategic Plan 2000-2005.

143   Office of the Public Advocate—Queensland, *Submission 303*, p. 9.

to know from a national and Victorian perspective why that happened so that we can learn from that. One of the things that happens is that people in different states are doing different things and we are not learning from one another. There is no capacity to be able to share experiences and to be able to learn other than at the very informal level. There is no single centre or body of people that holds this knowledge. That is a real difficulty, I think.[144]

14.118 It was suggested that national initiatives such as the National Co-morbidity Taskforce need to be reinstated.[145] The Taskforce ceased to function as a co-morbidity specialist forum twelve months ago, its functions being absorbed into the intergovernmental task force on drugs.[146] Dr Timothy Rolfe, a member of the former Taskforce, took the view that the Australian Government should now demonstrate leadership by funding a new national consultative body to foster information exchange. The body could also coordinate funding and research to build more cost effective and improved dual diagnosis service delivery:

> It would be in a good place to coordinate such efforts of collaboration. It should encourage collaboration between the states or encourage collaboration through the distribution of research moneys and the sharing of information about the effectiveness of services so that people are not in the position of reinventing the wheel over and over.[147]

14.119 The Eastern Hume Diagnosis Service submission suggested that this centre should be like the US's Co-Occurring Disorders Centre of Excellence, which works to identify and disseminate evidence-based practices, develop training approaches and provide linkages between the states, communities and providers.[148]

Professional practice and skills

14.120 As discussed in Chapter 6, mental health services are experiencing chronic skill shortages. The erosion of the skills base among psychiatrists and nurses is in part a consequence of the specialisation of service delivery into separate streams, for example, mental health as against substance disorder services, and in part due to systemic dysfunction since deinstitutionalisation.[149] This has considerably reduced the

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144   Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 22.

145   Australian Injecting and Illicit Drug Users League, *Submission 281,* p. 5.

146   Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 22.

147   Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 22.

148   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 39.

149   For example, the Burdekin Report's finding, which concluded that 'increasing specialisation and exclusivity of services' has erected significant barriers to clients experiencing multiple needs simultaneously across distinct service systems. See YSAS, *Submission 211*, p. 6.

capacity of mental health services to respond flexibly to patient needs, in particular to complex needs.

14.121 A national commitment to build skills among service providers in both mental health and AOD services is vital if 'services silos' are to be broken down. This would involve investment in widespread upgrading of the skills base, with a focus on cross-skilling of health professionals to support service integration. Specialist staff and services could be developed within this framework, but should not dominate in a third service tier:

> NCOSS supports the need for cross-sector training and skilling so that mental health workers and drug and alcohol workers can effectively support people with a dual diagnosis of both mental illness and substance dependence, no matter which service they are initially referred to. Maintaining a separate work force for each area would only continue the effect of "siloing" of service delivery and down skilling of staff, apart from being non conducive to a holistic view of health, however NCOSS also supports a limited network of specialist workers and specialist services for those who have particularly complex needs.[150]

14.122 The strongest message from health professionals was that they do not have the competencies to deal with the growing number of complex dual diagnosis cases.

14.123 The submission from the Association for Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and the Royal College of Nursing Australia (RCNA) reported that a lack of government commitment to training is affecting rural staff retention and services:

> The National Mental Health Strategy outlines integration of mental health services with alcohol and drug services as a key objective. However, there has been a lack of investment in initiatives to address training of staff in dual diagnosis. Rural staff who work in districts without clinical alcohol and drug services have often not had education in terms of dual diagnosis competency development. This lack of training impacts on the ability to retain nursing staff in the rural and remote setting, and has obvious negative connotations for the services delivered.[151]

14.124 In particular:

> There are intense demands on acute mental health treatment related to substance misuse. The input of the general community increase in illicit substance misuse is seen impacted in the number of presentations of first episode psychosis in young people and also in the increased levels of violence concomitant to these presentations. North Queensland (for example), which is viewed as a young overseas tourist destination, has a

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150   NCOSS—Council of Social Service of New South Wales, *Submission 274*, p. 9.

151   Association for Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and Royal College of Nursing Australia (RCNA), *Submission 321*, p. 8.

higher than average increased use of potent methamphetamine. The increased potential for violence associated with psychotic disorders for clients when intoxicated impacts significantly on occupational health and safety issues for staff and clients of health services.[152]

14.125 The ADGP advised:

GPs encounter difficulties similar to those experienced by most health care providers involved in the care of people with mental health and substance use co-morbidity. Patients with co-morbidity are considered by GPs to be problematic to work with, difficult to evaluate, and even harder to find treatment for. These views are exacerbated by low levels of education and training in co-morbidity issues and little access to clinical support or supervision for GPs by specialists.[153]

14.126 There are severe shortages of psychiatrists able to treat people with dual diagnosis.[154] Dr A Gunn commented on professional prejudices among psychiatrists:

Prosperity and pleasantness are common casualties of severe mental illness. One would hope that psychiatrists, of all people, could accept this but like most doctors, psychiatrists rarely show enthusiasm for, or understanding of, patients who are neither cashed up nor personable. In a rural area, the local psychiatrist once refused my referral of an actively suicidal patient with major depression. She was drinking and he didn't see drinkers—but could a psychotic depressive live in a rural Aboriginal community without drinking?[155]

14.127 These problems call for a national action plan to upgrade skills for assessment, referral and treatment of dual diagnosis. Stakeholders recommended that this plan involve:

- the development of national training competency standards and training modules for dual diagnosis for undergraduate nurses and other service providers in mental health and drug and alcohol services;[156]

- establishment of a national accreditation system for training of psychiatrists, which addresses clinical attitudes as well as knowledge and skill competencies;[157]

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152 AARN, ANZCMHN and RCNA, *Submission 321*, p. 8.

153 ADGP, *Submission 308*, p. 40.

154 Dr Timothy Rolfe, Eastern Hume and South Hume Dual Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 23.

155 Dr A Gunn, *Submission 52*, p. 1.

156 Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 37; AARN, ANZCMHN and RCNA, *Submission 321*, p. 8.

157 For example, Health Services Union, *Submission 223*, p. 15.

- incentive-based training opportunities for doctors though the Better Outcomes Initiative to build knowledge of dual diagnosis;[158] and

- training for all medical practitioners to better recognise the relationship between physical and mental conditions, such as the concurrence of depression, heart disease with substance abuse, including nicotine addiction.[159]

14.128 Other training initiatives to promote integration could include:

- targeted training strategies for state-employed psychiatrists to lead the management of service integration;[160]

- provider training on how to implement protocols and memorandums of understanding at a local level;[161]

- establishment of a network of specialist co-occurring fieldworkers to assist in training development, delivery and clinical supervision;[162]

- rotation of staff across agencies in the different service sectors to promote cross-skilling;[163] and

- targeted strategies to increase numbers and upgrade skills among Indigenous health care workers to address the complex needs of Aboriginal and Torres Strait Islander communities.[164]

Improved diagnostic tools

14.129 The development of appropriate diagnostic tools such as screening processes, practitioner manuals and referral databases is important to facilitate service integration. Submissions maintained that the development and use of such tools will support other training initiatives and will improve the capacity of professionals to accurately diagnose and refer people with dual diagnosis to appropriate services.

14.130 Under the present service paradigm a different diagnosis may exclude a person with co-occurring disorders from receiving treatment or accessing an appropriate degree or type of service:

> The opinion of one 19 year old female about mental health services was "they don't help when you need them and they won't go away when you don't want them". With a history of drug induced psychosis, depression and

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158 Australian Medical Association, *Submission 167,* p. 34.

159 The SA Division of General Practice Inc, *Submission 88,* pp. 9–10.

160 Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 37.

161 NCOSS, *Submission 274,* p. 9.

162 Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 38.

163 Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 33.

164 AICAFMHA, *Submission 83*, p. 18, and Ms Jenine Bailey, *Submission 93*, p. 3.

abuse of heroin, cannabis, amphetamines, benzodiazepines and alcohol, this young woman was an involuntary patient at age 15 and 17. She felt that CAHMS [Child and Adolescent Mental Health Services] was too intrusive and too quick to diagnose. The diagnosis of psychosis became a label that did not fit. She was later diagnosed with depression and has been unable to access mental health care though AMHS [Adult Mental Health Services].[165]

14.131 General practitioners are often the first point of contact for people experiencing co-existing mental and substance abuse problems.[166] However, surveys of unmet need in 2001 revealed that GPs did not recognise mental health disorders in 56 per cent of cases and were less likely to do so if the disorder was common (such as depression) or the client was less than 25 years old, male or not born in Australia.[167]

14.132 To address this problem it was considered vital that appropriate diagnostic screening tools must be developed and applied in all service practice areas. Eastern Hume recommended that, as a high priority, practical, user-friendly, clinician-focused manuals (describing integrated screening, assessment and treatment approaches) be developed for each of the mental health and AOD workforces.[168]

14.133 YSAS members asked for specific screening mechanisms for youth with dual diagnosis:

The development of tools facilitating the identification, screening, assessment, case planning, treatment and evaluation of outcomes related to young people under 25 years of age presenting with co-morbid conditions across all sectors of the service system, not just mental health services.[169]

14.134 Screening mechanisms in different languages could also be developed for CALD groups, which experience difficulties accessing service due to lack of translation and multilingual services.[170] There is also an urgent need to improve mechanisms for identification of mental health disorders among Indigenous people, who record lower identification, but have high incidence of behavioural and psychological disturbance by population percentage than other groups.[171]

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165   The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358*, pp. 3–4, citing NSW Association for Adolescent Health, *Caught in the Gap: Dual Diagnosis and Young People*, A Report on Issues, August 2003.

166   Eighty-three per cent of all patients see GPs each year; 5 per cent of these patients have alcohol dependence; 10 per cent of these patients have other AOD problems. See AMA, *Submission 167*, p. 29.

167   The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358*, p. 3.

168   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 15.

169   YSAS, *Submission 211*, p. 8.

170   See for example, Australian Polish Community Services, *Submission 168*, p. 2.

171   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 8.

14.135 The Centre for Psychiatric Nursing Research and Practice reported that it is leading the development of a multi-disciplinary project to examine the practice of screening for drug and alcohol use in in-patient mental health services in metropolitan Melbourne and Rural Victoria:

> It is intended that the findings from this study will be utilized to identify, implement and evaluate strategies to enhance nurses' preparedness and ability to routinely screen for drug and alcohol usage on admission to mental health services. It is expected that training programs will be developed to enhance the progress of this initiative.[172]

14.136 Ms Janine Anderson, who manages a social recreation program for adults with a mental illness, considers that the screening process will aid holistic assessment and integrated treatment of all patient needs:

> The integration of services requires staff to undertake training so that each service has a better understanding of the other. Intake forms need to have questions that will indicate any other areas of the consumer's life [such as whether they have children] that may need expert attention, so that appropriate referrals and assistance can be given.[173]

14.137 To underpin the implementation of this approach, the National Drug and Alcohol Research Centre recommended that any services which receive government funding should be required to screen for co-morbid disorders and that accountability measures be put in place to ensure best practice is implemented for both single disorder and co-morbid conditions.[174]

Capacity building in the community

14.138 Service integration cannot occur without a robust network of interlinking agencies and service providers functioning at local and regional level.

14.139 Capacity for integrated service access should be grown from the ground up. Submissions emphasised the importance of involving both government and non-government agencies, along with consumers and carers, in treatment models offering a mix of options to address the range of dual disorder diagnoses. Dr Rolfe told the committee this is not just about access to psychiatrists and specialists:

> …it is a matter of having a whole-system approach where people can access the level of expertise that is required according to their needs. It is a matter of filtering people and building links between the various service elements so that people can get the highly specialised care that they might need—

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172   The Centre for Psychiatric Nursing Research and Practice, *Submission 217,* p. 14.

173   Ms Janine Anderson*, Submission 210*, pp. 2; 14.

174   National Drug and Alcohol Research Centre, *Submission 109*, p. 3.

from a psychiatrist, for example—quickly and expediently through a process of good communication through the network of agencies.[175]

14.140 An integrated approach to community mental health services also means more than breaking down the 'silos' of mental health and AOD services:

> Such an approach should address relationships between mental health services and the broader health service, as well as the links between mental health and other government agencies such as Housing, Education, Corrective Services, Juvenile Justice, Police and Transport.[176]

14.141 Carers wanted more involvement in, and more integrated, treatment regimes. Carers WA asked for opportunities to 'communicate between all parties, staff, psychiatrists, social workers, case workers or community nurses…and more integration with drug and alcohol services/psychologists for on going maintenance of care and treatment'.[177]

14.142 This vision is a giant step away from the acute care paradigm presently followed by mental health services. It places emphasis on early access and preventive care taking place in consumer friendly and interconnected treatment environments. This relies on well developed local referral systems and may be based on 'precinct' or accommodation based models. Tertiary level beds for detoxification may be collocated, along with GP services or support care by visiting or resident volunteers and professionals may be offered.

14.143 These models will require significant commitment at every level of service provision. Given the patient overload and under-funding of mental health services, which evidence suggests are compounding the 'service silo mentality', it is not to be assumed that top down initiatives will flower without sustained work at ground level.

Integrated community service models—the vision

14.144 Integrated community service models rely on having a developed methodology for agency referral, accountability mechanisms and incentives to encourage agency partnerships. Of paramount importance is the establishment of agreed treatment paradigms for the different disorders, so that access to appropriate services is streamlined and automatic. This will develop consumer, carer and service staff confidence, counteracting the sense of hopelessness which currently pervades the mental health sector.

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175   Dr Timothy Rolfe, Eastern Hume and South Hume Dual Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 23.

176   NCOSS, *Submission 274*, p. 5.

177   Carers WA, *Submission 297*, Attachment 2, p. 2.

Building regional and local partnerships

14.145 Eastern Hume Dual Diagnosis Service has recommended the implementation of the CCISC model adopted in the USA. As already mentioned, this model requires that governments recognise dual diagnosis as a mainstream mental health issue and set out ways in which existing services can provide better treatment.[178]

14.146 Eastern Hume submitted a template for improving the capacity of the system to address complex needs by consolidating local partnerships and regional links.[179] The model would provides both 'the carrot and the stick' necessary to secure change. It would also facilitate information gathering, service networking, education and leadership at a local level, by:

- establishment of Regional Implementation Groups;

- appointment of trained specialist co-occurring disorder field workers; and

- nomination of 'agency co-occurring champions'.

- *Regional Implementation Groups*—comprise mental health and drug treatment local management, consumers, carers, clinicians from each agency, specialist co-occurring disorders workers/portfolio holders. These groups would be policy advisers, repositories of management advice and local knowledge. They could act as coordinators of local partnership initiatives and generation of 'buy in' (local ownership) by service providers into an integrated service model. Specific tasks could include:

    - generation of Regional Profiles of co-occurring issues, to map the extent and nature of local needs and identify service gaps;

    - generation of Regional Integrated Treatment Plans, to identify specific local barriers to service, and generate statements identifying which agency will treat specific co-occurring disorder cohorts, interagency protocols, local education strategies, and plan review mechanisms; and

    - development of mechanisms for cross-agency treatment planning for complex clients.

- *Specialist co-occurring disorder fieldworkers*—deliver training and education, clinical supervisor, primary and secondary consultation (with orientation to co-occurring disorders), tertiary consultation, protocol development and development of worker competency standards. Eastern Dual Diagnosis Service considers that these field workers could be a potent force for building local capacity for integrated treatment as they will monitor and support implementation

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178   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 28.

179   Outline of the proposal drawn from Eastern Hume Dual Diagnosis Service, *Submission 374*, pp. 37–38.

of central policy directives to prioritise co-occurring disorders among middle management.

- *Agency co-occurring disorder champions*—each agency would nominate a 'portfolio holder' of information on co-occurring disorders accumulated in the agency to the Regional Implementation Group. The person would act as a repository of agency knowledge about co-occurring disorders, mentor other staff as well as evaluate the agency response to clients with co-occurring disorders.[180]

Community care 'hubs' —user friendly services

14.147 Another proposal was collocation of services in the same venue or area. This model was considered particularly effective for young people. Professor McGorry of ORYGEN told the committee that the ideal for young people was the development of youth 'precincts' offering a mix of services, including vocational recovery and drug and alcohol services, as well as medium stay beds.[181]

14.148 The Gold Coast Drug Council proposed the establishment of 'community-based hubs', some of which could target youth. These 'hubs' are basically small scale step-up step-down housing arrangements, with a focus on social integration and building of living skills rather than merely on psychiatric treatment.[182] An advanced integrated recovery model of this type may reduce the burden on the acute sector by enabling it to more adequately support the most complex clients. The model would be characterised by:

- development of psychiatric community-based hubs which would provide an holistic approach to the treatment and support of clients;

- holistic treatment for clients including: disorder specific clinical models for managing the symptoms of chemical dependence and of mental and personality disorders; cognitive therapy for changing irrational thoughts that drive the target problems; affective therapy for changing unmanageable feelings that drive the target problem; behavioural therapy for changing self-defeating behaviours that drive the target problem;

- early identification and assessment of clients with mental health problems through training of community organisations, public sector services and GPs;

- easy to access, prompt and accurate advice, and support services for clients, families and friends, other agencies;

- family support options for clients with families, to avoid family separation and homelessness as a result of unemployment;

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180   Eastern Hume Dual Diagnosis Service, *Submission 374*, pp. 37–38.

181   Professor Patrick McGorry, ORYGEN, *Committee Hansard*, 7 July 2005, pp. 19–20.

182   Ms Mary Alcorn, Executive Director, Gold Coast Drug Council, *Committee Hansard*, 2 February, 2006, p. 21.

- daily activity programs to address living skills, employment, nutrition, social networks and training;

- support officers to provide on-going support and contact with clients living with ongoing mental health problems to prevent relapse, these can be suitably skilled volunteers rather than specialist mental health staff;

- development of appropriate supported accommodation including 'step-down' support for those coming out of hospital;

- development of specialist residential units to provide holistic treatment and support for specific client groups—such as non-addicted dual youth, aged etc; and

- a career pathway for workers in the mental health sector which provides training and development as well as recognition for skills and experience.[183]

14.149 Bulk billing of doctors and psychiatrists would be essential and medical health services should be collocated with multidisciplinary care teams. The 'hub' would function as an access point to a range of other agencies including Centrelink and the departments for housing, and families, and for education and training.[184]

14.150 GCGC advises that an important role for federal and state governments would be to ensure that medical health professionals, especially doctors and psychiatrists find the model attractive. Options for alternative models of employment and funding for GPs to encourage them into the mental health sector, such as salaried positions, employment loadings and sessional contracts could be considered.[185]

Continuing care networks for dual diagnosis prisoners

14.151 The Australian Injecting and Illicit Drug Users League developed a plan of action to provide more equitable treatment, and follow up assistance, for people who have been in contact with the criminal justice system.[186] It recommended that workforce development plans be developed to integrate mental health and AOD services and other related services, and that:

- harm reduction strategies be recognised as valuable component of treatment for people living with co-morbidity;

- prisons develop assessment and referral models for when people leave prison and return to the community;

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183   Outline drawn from Gold Coast Drug Council, *Submission 533*, pp. 7–8.

184   Gold Coast Drug Council, *Submission 533*, p. 7.

185   *Submission 533,* p. 8.

186   See also Centre for Social Justice, Qld*, Submission 300*, Attachment 1: Tamara Walsh, *INCORRECTIONS: Investigating Prison Release Practice and Policy in Queensland and Its Impact on Community Safety*, Faculty of Law, Queensland University of Technology, 2004, p. 6.

- there be diversion to ethical and appropriate treatment programs as an alternative to custody for people living with co-morbidity;

- people living with co-morbidity be empowered to retain a stronger advocacy role within the various sectors;

- the role of peer education and support be expanded; and

- national initiatives such as the National Co-morbidity Taskforce which has been disbanded need to be reinstated with appropriate funding.[187]

14.152 The Centre for Social Justice, Queensland, also suggested proposals to address the special needs of Indigenous prisoners. It recommended:

- prison officers be given cross-cultural training;

- Aboriginal Liaison Officers be recruited with at least one in every prison. These officers should liaise between prisoners, their families and communities, the prison and the correctional department; and

- Indigenous prisoners be given access to prison release accommodation support which they are often denied on the basis that accommodation applied for does not meet scheme criteria.[188]

Leading by example —funding existing strengths

14.153 In the absence of a commitment to assist people with dual diagnosis in public mental health systems, non-government organisations have had to think and work hard to improve, adapt and expand their services. As a consequence of this, many of the most innovative and successful treatment models for people with dual diagnosis have been formulated by drug and alcohol service groups.

14.154 As discussed, people with dual diagnosis most commonly present at drug and alcohol services for their clinical needs.[189] These services are mainly provided by non-government organisations which overwhelming rely on government grants and project-based funding. This was not considered a good model for systemic capacity building of existing service strengths.[190]

14.155 Organisations that are the most innovative—offering the most effective comprehensive and integrated treatment—are under the most pressure. As mentioned, the Gold Coast Drug Council reported that it had expanded and transformed its services to meet the needs of clients, some 80 per cent of whom have dual diagnosis.[191] The GCDC provides a good case study of the challenges facing non-

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187   Australian Injecting and Illicit Drug Users League, *Submission 281,* p. 5.

188   Centre for Social Justice, Qld, *Submission 300,* Attachment 1, pp. 23; 146–47.

189   Charity organisations also provide assistance, including housing and other support.

190   NCOSS, *Submission 274*, p. 10.

191   *Committee Hansard*, 2 February 2006, pp. 15–16.

government organisations of its type. The Mirikai Residential Therapeutic Community Program is a prototype of the 'community hub' treatment model set out above. The goal of the program is to enhance the capacity and commitment of some 40 residential clients, aged 16 to 29, to achieve and maintain an optimal level of personal and social functioning free from harmful drug use. The program has four stages with each stage taking six to eight weeks.[192] Ms Alcorn, GCDC Executive Director, describes the process, citing a Mirikai success story:

> A young woman—let us call her Jane—comes in from Robina. She has been there for seven months, probably on an involuntary treatment order, having an amphetamine issue diagnosed with bipolar and a psychotic disorder…Her mental health worker comes and visits her once a week for 20 minutes…She would have gone through the whole rehabilitation program; learnt lots of cognitive behavioural therapy; learnt to swim; go for walks on the beach and do all the things that people need to do; learned to take responsibility for her actions to manage her disorder, her medication— and had education around medication. Most of all, she was with a whole group of other young people, and that is a really healthy thing to happen for you: to be able to mix again. From there, after six months of that, she went into a training scheme funded through DET for landscaping. She made a decision that she would like to go to TAFE, and she is currently doing a diploma. She is in the halfway house and is about to move out.[193]

14.156 The GCDC reported that, as result of the expertise developed, the service is now experiencing the referral of the most complex clients from mental health services as well as the wider community.[194] This organisation, like ORYGEN and equivalent service providers, is carrying the lion's share of the growing service burden of dual diagnosis, without adequate recognition of that role:

> The GCDC is supported by both State and Federal grants, but many of these do not provide for cost increases year on year and all are fixed term agreements. Recruiting and retaining staff in this environment is a continual challenge. For example, the Youth Dual Diagnosis Worker position has been filled by three different professionals since August 2004, as the salary available for this position is not sufficient to compete with similar roles in the public sector…In 2004/5 the Mirikai Residential Therapeutic Community Programme bed cost was @ $21 000 p.a. Other States such as Victoria and New South Wales have bench marked their costs for particular client beds, with the cost of an equivalent bed in New South Wales and Victoria running @ $30 000 per year, with this funding including a component related to complexity. Queensland Health have repeatedly confirmed that they do not intend to benchmark costs for specific services or to provide financial incentives for specific client groups. Without financial recognition for the complexity of clients supported, it may simply

192   GCDC, *Submission 533*, pp. 12–13.

193   Ms Mary Alcorn, GCDC, *Committee Hansard*, 2 February 2006, p. 18.

194   GCDC, *Submission 533*, p. 9.

not be possible to provide the environment and staff to deliver these services safely into the future.[195]

14.157 Consistent with arguments that overall expenditure on mental health services should reflect the extent of need, submissions maintained that as dual diagnosis has the highest disease burden, it should be funded accordingly. It was also considered that it is more cost effective to fund early prevention programs than to carry the significant burden of self and societal harms generated if these high needs are not met. ORYGEN made the point forcefully in its submission:

> Specialist interventions required by young people with serious mental illness are often unavailable or inappropriate. Most young people in Australia with serious mental illnesses will have access only to child or adult services that are not designed to meet all of the unique challenges faced by young people. Instead, they focus on the needs of younger children or chronically unwell adults. Due to resource restrictions, ORYGEN is able to treat only 40 per cent of the 2 000 young people referred to it each year. Even though research shows ORYGEN correctly targets those 'most in need', a substantial number of very unwell young people have to be turned away. Almost two thirds of those not admitted to ORYGEN have at least one mental illness and nearly one in four of this group have made a suicide attempt in the previous year.

> Consistent with the model those services which most efficiently service the cohort should be funded for continuous service; the expertise of non-government organisations needs to be 'mainstreamed' in the process of service integration, by being brought into core funding agreements.[196]

14.158 To extend this model, the federal government should also implement successful pilot programs nationally. Existing programs could be trialled for longer term implementation in specific regions:

> NCOSS supports the development of a number of funded trials on a range of service types across NSW (rural, remote and metropolitan) that would lead to an external evaluation of their effectiveness and the commitment to implementation and ongoing funding of the best 'models' for each area. For example, mental health peaks in discussion with NCOSS, raised an option of the establishment of a small number of residential treatment services for people with complex needs that would employ a number of different service models.[197]

14.159 With a national coordinating body in place, advanced models developed by state agencies for all dual diagnosis cohorts could also be identified, trialled and implemented nationally with federal support. The Public Advocate in South Australia reported that the state runs a very successful Exceptional Needs Program for dual

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195   GCDC, *Submission 533*, p. 9.

196   ORYGEN Research Centre, *Submission 98*, p. [3].

197   Council of Social Service of New South Wales (NCOSS), *Submission 274*, p. 9.

diagnosis clients. He regards the program as a model of multi-sectoral intervention and recommends it for wider implementation:

> South Australia is one of a small number of states that offers a holistic resource stream to clients deemed to live with exceptional needs. It provides a model of service delivery that is genuinely holistic, dedicating resources to the individual person, targeted to the key domains of their lives. Commonly, this combines issues of housing, daily support, case management and therapy. The success of this program is that it is well resourced, allows resources to follow needs rather than diagnostic or multiple eligibility criteria and it's commitment to clients is strong.

> This stands in stark contrast to the more typical picture, where housing, health and welfare services are discrete entities that create a degree of inertia that can mitigate against positive outcomes for clients.[198]

Acute care—community-based beds

14.160 Many operators of dual diagnosis services favoured collocation or close location of detoxification beds to avoid possible iatrogenic effects of hospitalisation and ensure consistent progression of a treatment plan. A view consistently held was that the consolidation of collaborative community-based care would reduce the need for dedicated acute care beds for people with dual diagnosis. Dr Andrew Chanen of ORYGEN told the committee:

> …an artefact of that coercive environment is, of course, that there is an increased need for beds. There is a kind of sentimental attachment to the old days when we had more beds, because we were more coercive and we could utilise those beds. In a collaborative environment the need for beds decreases, not increases.[199]

14.161 However, it was agreed that deinstitutionalisation has hit the dual diagnosis cohort particularly hard. The Health Services Union commented:

> Closure of tertiary alcohol and drug services intervention beds and competitive tendering has resulted in fragmentation of services as providers were forced to compete and cut cost rather than work together reaching cooperative benchmarks and industry service standards.[200]

14.162 As indicated, community-based support is not adequately funded to provide long stay detoxification beds. Consequently it was generally agreed that:

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198 Public Advocate, South Australia, *Submission 268,* p. 21.

199 Dr Andrew Chanen, Consultant Psychiatrist and Senior lecturer, ORYGEN Youth Health and ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 14.

200 Health Services Union, *Submission* 223, p. 22.

> There is an urgent need for more resourcing and coordination of services on the full continuum of drug prevention treatment, including medium intensive residential services for post detox treatment and support.[201]

14.163 As set out above, the policy of integrating people with dual diagnosis into mainstream emergency wards has proven spectacularly unsuccessful.[202] Evidence also suggested that integration of people with dual diagnosis into psychiatric wards reduces treatment outcomes for all patients, as well as being difficult for staff. Former psychiatric nurse Mr Jon Chesterson advised:

> Many vulnerable patients who are treated for other psychiatric or single disorders are frequently subjected to shared inpatient environments where they feel unsafe, unprotected and threatened by other patients, particularly by young males who may be acutely unwell during the initial phase of treatment or detoxification, whether vicariously or planned. It is not uncommon for patients with a dual diagnosis to continue using whilst receiving inpatient treatment, and despite clear policies and procedures, it can be extremely difficult and often compromises the therapeutic relationship and environment, when nursing staff are expected to police these situations.[203]

14.164 In recognition of this problem, the combined Queensland Gold Coast Mental Health and the Alcohol, Tobacco and Other Drugs Services (ATODS) has made a submission for the establishment of a 24 bed inpatient facility for management of people with dual diagnosis at the proposed new Gold Coast Health Services District Hospital. ATODS Director Dr Lynn Hawken advised:

> While patients with a mental illness are generally better managed in MH [mental health] wards during the acute stage of psychosis, those with co-occurring substance use problems who are non-acute, may often be better managed in a detoxification ward where staff have the necessary training and expertise, and where a safer and more secure environment can be provided for them.

> With respect to the intersection between GCHSD Mental Health Services and Alcohol, Tobacco and Other Drug Services, we feel the best way of supporting mental health services in its challenge to better manage co-occurring substance use problems among its patients would be to establish a specialised alcohol and other drugs detoxification ward here on the Gold Coast.[204]

14.165 There is also potential to build services for dual diagnosis in private settings, As discussed above, the model would require guaranteed government funding, perhaps through a bed buying arrangement as applied in Tasmania. Medical insurance

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201   Health Services Union, *Submission* 223, p. 23.

202   See quote: Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 8.

203   Mr Jon Chesterson, *Submission* 177, p. 15.

204   Background information provided to the committee, 18 January 2006.

and Medicare bulk billing options would also be required to make it affordable for this cohort.[205]

Concluding remarks

14.166 Governments appear to have difficulty engaging with the realities of dual diagnosis. This is reflected in the declaration in the National Mental Health Plan that 'drug and alcohol problems are primarily the responsibility of the drug and alcohol service system'. The evidence before the committee clearly indicates that it is counterproductive to separate out mental health and drug and alcohol services in such a definite way.

14.167 Progress overseas has been achieved by comprehensive review of both mental health and drug and alcohol policies. Suicide rates have dropped. This is credited to reduced access to drug supplies in combination with increased provision of integrated drug and alcohol and mental health services.

14.168 It is doubtful that being 'tough on drugs' without the existence of a robust well integrated service network to support this vulnerable group will yield the desired results. People with dual diagnosis—now the 'expectation rather than the exception' amongst those with mental health problems—will remain 'forgotten people', and continue to fall through the cracks, either into gaol or to their deaths.

14.169 The enormity of the problem suggests an immediate response from government. Federal government must grasp the 'burning brand' and lead the states on service integration. As potently argued in the evidence there is an urgent need to build bridges by taking what's best and developing on existing successful models.

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205   Healthscope, *Submission 82*, p. 1, and Australian Health Insurance, *Submission 292*, p. 6.