

Reflections on the evolution of dual diagnosis initiatives in an Australian state

Abstract

Purpose: The integration of health or social services is an enduring challenge and especially so in relation to the people experiencing 'dual diagnosis', the co-occurrence of mental health and substance use problems. The emergence of the 'dual diagnosis' concept has highlighted the tension between specialist treatment for single problems and complex, individualised care. This paper examines the evolving nature of dual diagnosis initiatives in an Australian state during recent decades.

Approach: Interpretive, case study analysis of policy documents and key informant interviews (19) illuminates the experience of dual diagnosis initiatives.

Findings: In the case of Victoria, dual diagnosis responsiveness has evolved slowly over the last 20 years, delayed by the inherent difficulty of practice change, a weak perception of need, interprofessional tensions and shortcomings in data collection, coordination and resources. Key enablers have been champions and leaders in policy, management and clinical practice, directive government policy and targeted funding. Achieving a wrap-around service system entails investment in interpersonal relationship-building and stigma reduction as well as technical or structural changes.

Value: A unique and independent view of a twenty year period indicates progress in attitudinal change that merits wider acknowledgement and application to other settings throughout health and social care.

Keywords:

Qualitative research; capacity-building; service provision

Introduction

This paper inquires into the implementation of 'dual diagnosis' initiatives in Victoria, Australia, which have adopted a 'no wrong door' approach. Identifying barriers and enablers to integration at a case study level highlights the relevance of the relative status of different health problems and importance of attitudinal change. Ideas tested in one of the more difficult fields for integration should be effective in any setting.

Australia is acknowledged as a leader in having national strategies for mental health (MH) and alcohol and other drug (AOD) problems (Fitzgerald and Swards, 2002, Meadows et al., 2007) In Victoria, dual diagnosis (DD) responsiveness in MH and AOD services is routinely expected and substantial locally developed resources and guidance are available (for example, Mills et al., 2012, Cementon, 2011, Lee and Jenner, 2010). The concept of DD is now arguably institutionalized in current health discourse, and consequently Victoria makes an ideal case for study of DD service integration.

International research on building DD responsiveness into routine practice emphasises the need to focus on systems and attitudes. Implementation can be lengthy and complex, requiring wider system support (Torrey et al., 2011, Carra and Clerici, 2006, Hintz and Mann, 2006, Todd et al., 2002) and MH and AOD treatment providers may have considerable difficulties with intersectoral liaison (Kavanagh et al., 2000). Integrated service models (for example, Minkoff, 1989) and tools for assessing progress on building DD capability (McGovern et al., 2007, Minkoff and Cline, 2001) suggest that 'wider system' support entails role clarification and change management at every level. Tiered frameworks can help to clarify roles (Rush, 2010, National Collaborating Centre for Mental Health, 2011) and support critically important personal relationships that avoid turf conflict (Brousselle et al., 2010, Roberts, 2012). Common success factors in the literature are leadership and system-wide support.

Victorian research on building DD pathways (Staiger et al., 2010, Edward et al., 2012) highlights continuing challenges, including the need for a 'cultural shift' in both MH and AOD sectors. Involving service users in improving DD treatment and systems is integral to a person-centred approach and a

number of Australian projects (MacDonald et al., 2002, Kenny et al., 2006, Holt and Treloar, 2008) have provided valuable insights into the way assumptions about professional status and the capacities of consumers can affect service integration.

A focus on DD may also have wider application by reminding specialist practitioners to consider the whole person. Glaser (1988) suggested (in the early years of DD discourse) that teaching consultation-liaison psychiatrists about AOD issues might encourage them to take a more welcoming and comprehensive approach to care in general. This idea of DD awareness among all MH and AOD practitioners leading to more holistic care is well developed by some authors (see for example, Minkoff and Cline, 2004). Other co-occurring issues are often present: for example, interviews with a sample of AOD service users in Victoria found that 60% reported chronic health conditions, with over one third taking medication for a physical condition on a regular basis (Staiger et al., 2011). Minkoff and Cline (2004) propose a process for reorienting services around *multiple* co-occurring needs of individuals and families, guided by values that reflect welcoming, empowered, helpful partnerships throughout the system. Similarly, Victorian MH strategy recognises the wider application of DD initiatives in these terms:

The 'no wrong door' approach ...is an important principle that should be extended to other combinations of mental, physical and social health issues. (DHS, 2009).

Extension of the principle is no *fait accompli*: the policy statement is aspirational, with no guarantee of translation into expenditure; the point was present in policies 20 years ago; and realising the vision is a long term project entailing intergovernmental and intersectoral commitment. Theories of change facilitation bear out the need for time and flexibility (Prochaska et al., 2001, Knightbridge et al., 2006, McLeroy et al., 1988, Hawe et al., 2009). The overarching point in these literatures is that providing welcoming and effective services for people with dual diagnosis is a system-wide project. Hendrikson (2006) draws usefully on General Systems Theory to emphasise the conditions under which capacity building endeavours inevitably operate: organisations have mutual and conflicting needs; interactions are formal and informal; the nature of interactions is based on inter-organisational history; traditions and certain mutually accepted ways of communicating within this system must be followed; power within the system is based on a mixture of hierarchical structure, funding flow, community support and personal charisma; and the system will resist any substantial change.

This paper brings multiple sources of information together under an interpretive lens to examine Victoria's experience with building DD capacity. Analysis of policy texts and interviews explores initiatives through the period and illuminates lessons for ensuring more holistic care across the health system.

Methodology and method

This qualitative study, draws on a review of the literature on DD service integration, analysis of policy documents, and the perspectives of key informants in a case study of policy in Victoria, Australia. The methodology recognizes the situated knowledge of researcher and informants. As a single case study its primary focus is the realities of the particular landscape, describing it in enough detail for the reader to make good comparisons (Stake, 2005).

The 19 informants were purposively selected to offer insights into threads in the discourse. The author conducted the interviews during 2010 and 2011, with senior policy executives(3), service providers (14) and consumer researchers (2) with expert knowledge and experience of relevant developments in the field of dual diagnosis in Victoria throughout recent decades. Interviews were semi-structured, focusing on experiences of DD discourse and perceptions of its function in service provision. They were conducted at the informant's choice of venue (their workplace or the researcher's workplace). One was conducted by telephone. Thirteen informants later chose to respond to an online questionnaire based on analysis of validated interview transcripts. Multiple-choice and open questions included a series on benefits and concerns in relation to dual diagnosis discourse in Victoria.

National and State MH and AOD policies, strategies and evaluation publications were reviewed.

Qualitative analysis was both manual and aided by a computer software package (QSR International

NVivo). Thematic, discourse and narrative analysis (Perakyla, 2005, Riessman, 1993, Silverman, 2001) proved useful in iterative study of the texts and relevant literature. The study was approved by Monash University Human Research Ethics Committee.

Findings

Drawing on a review of relevant policy and related literatures, as well as analysis of key informant perspectives, this section describes the evolution of initiatives over the last 20 years and examines recurring or strongly stated barriers and enablers. Where particular key informants' insights are referred to they are numerically coded ('KI 1, 2, 3', etc.) with an indication of their position.

Evolving initiatives

Policy document analysis and key informants' accounts show a gradual coalescing of effort around dual diagnosis in Victoria. Isolated activities in the early 1990s included a two-year action research project on building dual diagnosis capacity (McDermott and Pyett, 1993). In the later 1990s interested MH and AOD organisations developed local dual diagnosis projects using small-scale, time-limited grants and shared their learning through two major local conferences and a dedicated network. The 1998 National Drug Strategic Framework (NDSF) urged 'specific strategies to meet the needs of individuals with co-existing mental health and drug problems' (Ministerial Council on Drug Strategy, 1998: 7) and in 2000 the National Comorbidity Project (Teesson and Burns, 2001, Teesson and Proudfoot, 2003) launched a program of capacity building. National mental health strategy began to include dual diagnosis concerns after a review (Thornicroft and Betts, 2002) recommended the elimination of barriers between MH and AOD services and ultimate 'full integration of these two health services [in a] seamless system for consumers' (Thornicroft and Betts, 2002: 12). In parallel with national work, the Victorian Dual Diagnosis Initiative (VDDI) entailed from 2001 a statewide system of capacity-building teams, strengthened after a 2004 evaluation (Roberts, et al., 2004) by additional funds and a 2007 state government policy 'Dual diagnosis: key directions and priorities for service development' (hereafter 'the Key Directions policy'). This directive policy required service providers to apply a 'No Wrong Door' approach, improve screening, assessment and treatment, and measure outcomes. From 2007 and under the banner of the National Comorbidity Project, 'Improved Services Initiative' (ISI) grants were awarded competitively to AOD services to develop DD capacity over a three-year period, with funds also provided for supportive resources such as screening tools and clinical treatment guidelines. Victorian MH strategy articulated a tiered framework for the health and social care system (DHS, 2009) clarifying who should be treated by whom and for what conditions. Evaluations (Australian Healthcare Associates (AHA), 2011; Australian State and Territory Peak AOD NGOs, 2011), however, noted the slow pace of change, the need for stronger governance and further clarification of roles in the fragmented service system.

Thus a narrative of dual diagnosis capacity-building can be traced, emerging from the concern and work of early champions, challenged by siloed mental health and drug strategies but slowly accruing support in a variety of forms: specialist workers in the role of change agents, training, policy directives, research and dissemination of screening tools and clinical guidelines, outcome measurement and program or strategy evaluations. This narrative reflects the capacity-building theory of the period and arguably demonstrates the tendency for a greater emphasis on worker knowledge and skills than on organisational, system and socio-cultural factors (Allsop and Stevens, 2009; Hawe, King, et al., 1999).

Barriers

Informants highlighted several longstanding structural and professional barriers to integration along with 'process' obstacles concerning resources and planning. The barriers are outlined below.

Difficulty of practice change

Several informants dwelt on the intrinsic difficulty of changing practice that has been established early in a career with a particular focus. People are considered 'too set in their ways' (KI 12, KI 17) and services seem to become 'sheltered workshops' (KI 18) where 'whatever has been going on in that location and in

that service tends to be perpetuated' (KI 1). In this respect many informants chose to reflect on their own early experiences as practitioners and the ways in which these remained influential.

In relation to clinical MH services, informants recognised the pressures in a crisis-oriented system, identifying the workforce as 'change weary and change wary' (KI 2) and describing the challenge of facilitating a cultural and discursive shift as 'like turning round the Queen Mary'. . The AHA evaluation (2011, p47) and this study's informants (KI 5,6) highlighted independent stories of conflicts between acute MH services staff and staff in withdrawal units (residential detoxification facilities), where clients were exhibiting signs of acute mental illness and MH services were unresponsive.

Weak perception of need to collaborate

A weak perception of the need for DD capacity-building was seen as a further barrier to change.

Informants (particularly from the MH services perspective) thought the need to share the care of the people needing both MH and AOD services was minor, given the low number of people with severe mental illnesses presenting to AOD services (KI 14). A contrasting view pointed to undetected psychoses and a clear need to collaborate, as 'a big problem is that mental health services don't provide a service to a lot of people who need it' (KI 5).

Interprofessional issues

The Key Directions policy refers to tensions between the 'differing professional, consumer and carer conceptions of mental health and wellbeing' (DHS, 2007). Informants, however, emphasised underlying attitudes: fear of 'the other', social stigma and protectiveness of professional status. One noted that attitudes in MH were 'based on myths and assumptions without really understanding the perspective of a substance user and hearing their story... Fear and ignorance are huge psychological factors in any health profession' (KI 14). This informant added, 'If you say you are working in that field [MH, AOD or DD], those societal stigmas have a professional connotation as well' (KI 14). On status, there were references to 'professional snobbery' on the part of MH clinicians (KI 11) and a need for a 'maturing' of interprofessional relationships (KI 12). A psychiatrist commented:

I would argue that the No Wrong Door policy hasn't really shifted things along any faster. There are still plenty of wrong doors..... not so much for someone like me, because I have the kudos of being a psychiatrist and an addiction specialist. But when you've got a vulnerable family member, or a lower level drug and alcohol worker contacting psychiatric services, then the No Wrong Door policy is often disappointingly not applied (KI 5).

These views highlight the power of historical beliefs, hierarchies and service specialisation to affect decisions on mental health and wellbeing.

Resources

A leading manager of an AOD service recalled incredulity concerning the lack of resources accompanying the Key Directions policy:

There was no consideration to the differences in the service systems and the capacity of the different service systems to be responsive. I thought it was some sort of weird joke. The intention is absolutely fine, but both service systems are probably under-resourced, and AOD more so (KI 4).

On this theme of over-ambition, a senior policy executive acknowledged the small scale of investment in dual diagnosis capacity-building:

Drug and alcohol has had virtually no new money for the last decade!...I think the VDDI was a good idea but it's very small and so you're really sending a boy on a man's errand if you think it's going to change rapidly (KI 16).

These informants reflect a general consensus that the espoused goals of integrating care had not been matched by serious investment.

Lack of data

The inadequacy of data collection systems has been noted in all evaluations from 1993 onwards (Australian Healthcare Associates (AHA), 2011, McDermott and Pyett, 1993, Roberts et al., 2004, Australian State and Territory Peak AOD NGOs, 2011). Government continues to search for data to inform meaningful targets and ways of monitoring who is treated, how often, in what ways, for how long and with what effect (KI 3, KI 4, KI 16). DD projects struggle to provide evidence of change:

I think our work has certainly benefited services and clinicians and hopefully benefited consumers. The tangible measure of that is really hard to do. We just don't know. (KI 11)

This barrier indicates a need for more sophisticated technical solutions and health data linking but also, crucially, the need to resolve debates about what constitutes adequate evidence.

Planning and coordination

There was a view that the VDDI should have been launched with policy-level direction to ensure DD was promptly built into core business, particularly in MH:

They put the cart before the horse. You had all these dual diagnosis workers working in silos and isolation either supported by a manager who felt it was important, or not -and in most cases not supported by management, just a bit of an add-on, tokenistic (KI 14).

A lack of coordination was seen as a factor causing some delay and confusion, particularly in the matter of choice of screening tools and in the coexistence of state and national initiatives.

You had the national initiative and the state initiatives run out at the same time and there's confusion between the two....: different labels, different tools, agendas, staffing. I don't think that helped (KI 12).

The 2011 AHA evaluation found that achieving dual diagnosis capability through the VDDI was hampered not only by unwillingness in some organisations, the delayed use of a policy lever and reluctance to mandate specific screening and assessment tools but by an ineffective governance structure and an undefined scope of practice for each sector. These observations indicate an incremental quality in the building of dual diagnosis capacity that was recognised by a senior policy executive in describing the process as a 'cobbling together' of divergent systems and workforces.

Enablers Champions

When asked about significant factors in the development of DD responsiveness, informants named champions of the cause: international researcher-practitioners, others with a national public profile, particular policy executives in state government departments, and long-serving clinicians in DD initiatives, all of whom were generally seen as providing leadership and a focus for achievement amid complexity. Champions were considered important at every level – as 'it's only people within who actually change practice' (KI 1).

Policy direction

A second enabling factor was the Key Directions policy (DHS, 2007) requiring that people be seen as 'clients of the whole system rather than one type of service' (p28). Between 2007 and 2011, AOD and MH services were expected to build DD into core business by becoming 'dual diagnosis capable', establishing effective partnerships and mechanisms to support integrated practice, monitoring progress and involving consumers and carers in planning and evaluation. Key informants were somewhat divided in their responses to this policy (as indicated above) although none classed it as a barrier. DD clinicians thought it lent considerable weight to their capacity-building efforts:

It's a great policy. Before then we had nothing to lean on (KI 17)

Change has to be deployed motivationally or you never get anywhere, but there had to be the iron fist in the velvet glove. We had spent so much time knocking on doors ...and there were determinedly pre-contemplative agencies and managers who slammed the door in our face (KI 2)

Evaluators agreed, describing the policy as a 'critical turning point for change' (AHA, 2011).

Injections of funding

Independent, government-funded evaluation of the VDDI was 'a real trigger point' (KI 3) for later developments. The 2011 evaluation found that the additional funding prompted by the first evaluation in 2003-2004 had been effective, notably a statewide education and training unit and greater psychiatrist involvement. National capacity-building funding for AOD agencies, although only for those who won grants, is reported to have had significant outcomes. Outcomes reported at a national evaluative forum (Australian State and Territory Peak AOD NGOs, 2011) include generic quality improvements: complete

policy and procedure reviews, service accreditation, stronger linkages not only with MH but with other health and community welfare services, greater diversity awareness, access to clinical supervision, mentoring and networking, and better data collection systems. National and state funding was sometimes combined, through an integrated DD protocol that overcame some of the disadvantages of separate funding streams and priorities (AHA, 2011).

The 2011 evaluators, however, warn that 'the remaining window for change is narrowing as the change agenda for organisations becomes increasingly crowded, by seemingly competing interests.'

Discussion

As we have seen, the Victorian public health system's responsiveness to the concurrence of MH and AOD problems is considered to have developed slowly and incrementally. Challenges affecting DD initiatives have included the intrinsic difficulty of practice change, varying views on the need for integration, longstanding beliefs, hierarchies and specialisms, inadequate funding and a lack of data to argue for more. Nevertheless, the commitment of DD champions and the eventual provision of policy direction and targeted funding for workforce and organisational development are understood, according to our analysis, as key factors in the building of DD capacity. Closing intersectoral gaps in services has required work at every level from individual workers to government, in order to achieve role clarity and overcome the history of separation and cultural clashes between the services. These findings resonate with Hendrickson's (2006) comparison of DD change agency with a number of system traits, in particular the role of hierarchical structure, funding flow, and personal charisma. (ref page) Achievement of welcoming and effective services for people with DD is a complex project that goes well beyond basic training and formal protocols. Victorian developments may be typical: like those reviewed by Torrey and colleagues (2011), they have taken many years to begin to change attitudes, skills and processes, and the strengths and weaknesses of leadership and systemic support have been critical factors.

What are the insights from this study that may be of general use for health system integration? DD work is perceived as deeply connected with dominant issues in health: individualised care, workforce development in its multidimensional sense and the sustainability of change. Projects aimed at upskilling AOD services to manage DD have been recognised as extending to generic quality improvement for *all* clients whatever their co-occurring conditions. While funding is never the only answer, ongoing resourcing for sustainably integrated treatment and care may be hard to come by when new funding has to have a specific label and a time limit. Many of the improvements we have mentioned depended on a selective grants process. Further improvement may come from the next new initiative – perhaps family-sensitive practice. This process calls upon services providers to take a positive view of the latest quality improvement initiatives, seeing them as building on rather than subsuming or competing with the previous initiative. A major contribution of the years of DD work is the hope that when champions offer vision and leadership and collaborative personal relationships are a central focus, integrated, inclusive policy and structures must follow.

This unique study is valuable in considering a twenty year period and engaging key players and observers in personal, confidential reflection that is independent of current initiatives and their evaluation. Further study of the history of DD could build on the work of Russell (2009), Schulte and colleagues (2011) and others who privilege the voices of consumers. Related avenues of inquiry should address the shortcomings in data to inform decision-making that have been noted throughout DD research and evaluation; this may entail challenges to the limitations of traditional outcome measurement in matters of the mind.

Conclusion

A final observation from this study is the extent and complexity of efforts to improve services in a single jurisdiction over a period of twenty years. This longer view highlights the persistence of stigma and a (related) lack of resources. Yet DD work has arguably pulled above its weight, real progress in changing attitudes is claimed and merits wider acknowledgement. Status issues and moralistic attitudes bring

particular challenges to the task of integrating MH and AOD services: if methods of bringing services into harmony are effective in the contested context of dual diagnosis, then they should be effective in any setting throughout health and social care.

'Client complexities expose our limitations, not theirs.' (From the noticeboard of an AOD hospital liaison team, Victoria, 2011)

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Qld – appreciated the hands-off role of government – NGOs were free within certain boundaries and goals.

‘there are few examples

nationally or at a state level where the investment by government has yielded such widespread change in a group of funded agencies. The project governance has resulted in a leverage effect on the overall quality of service and capacity of the recipient agencies and not merely resulted in ‘improved services for people with co-morbidity’. (ConNetica Consulting, 2011, p. 14)

there are clear tensions for the mental illness sector, associated with social control and constraint supported by legislation (i.e., compulsory treatment orders), adopting mental health promotion goals of empowerment and structural change, especially when it has been noted that the institutional end of mental health services has become harsher and more focused on security and risk management in some countries such as Australia (Hazelton, 2005). Mental health promotion for people with mental illness needs to go beyond the recovery and rehabilitation workforce - and beyond the ‘treatment and maintenance’ sectors of the mental health promotion wheel (Barry, 2001) - and foster responsibility within ‘other sectors’. Maintaining people who have been previously diagnosed with an illness (but may not be currently managed by public mental health services) in public housing, employment, and education should entail workforces in ‘other sectors’. p2(Battams, 2009)

Allsop and Stevens – workforce and org development frameworks, adding environmental change (Allsop & Stevens, 2009)...see also (Knightbridge, King, & Rolfe, 2006)

Policy design and policy tools, eg information, grants, training. Schneider & Ingram 1988, 1990, 1997 – direction and regulation vs capacity building

The VDDI workers have increasingly identified themselves as change agents (24), using the Transtheoretical Model(28) as applied to organisational change rather than (as is the bread and butter of AOD work), to individual behaviour change. In this model, a large amount of 'resistance to change' is not only expected but understood as a stage of change from which progress can be facilitated. The problem is that what works for a self-determining individual takes on a different hue when applied to an organisation or system where the powers-that-be want staff to convert to their mission.(Prochaska, Prochaska, & Levesque, 2001)

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