

**Victorian Travelling Fellowship Program
2006-2008**

Final report

Caroline Byrne

November 2007

1. Project information

Fellow's name: Caroline Byrne

Title of project: *Dual Diagnosis: from early intervention to residential rehabilitation*

Fellow's study area: The integration of mental health and substance use services, utilising the *Comprehensive, Continuous, Integrated System of Care (CCISC)*, developed by Dr's Cline and Minkoff.

Fellow's organisation: South West Healthcare Psychiatric Services Division

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Date of report: November 2007

2. Project summary

Top three outcomes

- Establishment of international professional relationships and networks with others interested in the same areas of service development.
- Inspiration and provision of tools for undertaking change within our service on the topic of interest. Consolidation of project plans.
- Reinforcement of the positive achievements of our service system.

Main activities undertaken

- Attendance at the International Initiative for Mental Health Leadership Conference in Ottawa, Canada.
- Matched to an Inuit health service, and partnered with a psychiatrist with the First Nations and Inuit Health Branch.
- Studied application of the Comprehensive, Continuous, Integrated System of Care (CCISC) at a system and service level in San Francisco, United States of America.
- Attended workshop with CCISC change agents and consultants Dr K Minkoff and Dr C Cline.
- Attended American Psychiatric Association 59th Institute on Psychiatric Services 'Recovery: Patients, Families, Communities', New Orleans, United States of America.

Major learnings

- Comprehensive understanding of system wide and service application of the *Comprehensive, Continuous, Integrated System of Care (CCISC)*, developed by Dr's Cline and Minkoff. Including the strengths and difficulties of applying the various components in services, and implications for application within our service.
- Group based programs remain highly regarded and effective, including:
 - Psychotherapeutic groups for trauma recovery for indigenous groups, mentally ill, and dually diagnosed.
 - Multifamily groups to improve family management of conflict.
- Issues for various indigenous groups are common across different nations; however approaches to resolve same vary considerably.
- Specific understanding developed of Inuit culture and problems related to relocation.
- The effects of a major disaster on service system recovery.

Overview of lessons for the Victorian healthcare system

- The importance of influential leadership at all levels of change – from funder to service provider.
- The importance of appropriate housing options for the dually diagnosed.
- The value of accessible employment and vocational opportunities for the mentally ill and dually diagnosed.

3. Description of the study itinerary

Background

As outlined above, my travelling program included attendance at two conferences, in addition to visiting an extensive range of services. Fortuitously, the first conference had a focus on my topic of interest, dual diagnosis (mostly referred to overseas as co-occurring disorders). The second conference also contained significant presentations on this issue.

The term dual diagnosis refers to those people who experience serious mental illness concurrently with a substance use problem. My particular interest, supported through extensive service visits, was in the integration project being undertaken in San Francisco.

In mid 2004 the San Francisco Department of Public Health Community Behavioural Health Services entered its second phase of integrating mental health and substance use services. They have utilised the expertise of Dr's Chris Cline and Ken Minkoff (recognised as leading experts in dual diagnosis) to develop quality improvement at the system, program, clinical practice, and clinician competency levels. Utilising the model developed by Dr's Cline and Minkoff, known as Comprehensive, Continuous, Integrated System of Care (CCISC), they have developed strategies leading to action at multiple levels to enhance service integration and collaboration.

The San Francisco Department of Public Health first undertook to transform mental health and substance use services into an integrated and dual diagnosis capable system in 2004. They developed a three year plan for change, and originally planned to conclude the project in 2007, however much work remains to be done. The CCISC model has significant support from the United States of America (USA) federal government. It has been implemented in many states across the USA, and is regarded as best practice for systems implementation for treatment of individuals with co-occurring psychiatric and substance disorders (ICOPSD). An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus based best practices for the treatment of all types of ICOPSD throughout the service system.

The CCISC model for organising services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or countries, networks of agencies, individual complex agencies, or even programs within agencies.

The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives. All programs are designed to become dual diagnosis capable (or enhanced) programs, generally within the context of existing resources, with a specific assignment to provide services to a particular cohort of individuals with co-occurring disorders. Implementation of the model integrates the use of system change technology with clinical practice technology at the system level, program level, clinical practice level, and clinician competency level to create comprehensive system change.

The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilises a common language that makes sense from the perspective of both mental health and substance disorder providers. This model can be used to develop a protocol for individualised treatment matching that in turn permits matching of particular cohorts of individuals to the comprehensive array of dual diagnosis capable services within the system.

Dr Minkoff is well known for his work on integrated treatment for clients with co-occurring disorders, and is recognised as one of the leading experts on integrated treatment for clients with dual diagnosis in the USA. Dr. Minkoff and his consulting partner, Dr Christie A. Cline, Medical Director, Behavioural Health Services Division, New Mexico Department of Health, have provided consultation for CCISC implementation in over 15 states of the USA. Dr's. Minkoff and Cline have and continue to develop a range of system, clinical and training tools.

I was particularly interested in understanding why and what constituted the resistance and barriers to service integration, and establishing a workforce that is 'dual diagnosis capable'; also, in understanding and reviewing the broad system, organisational structure and policy obstacles. As clients with dual diagnosis often fall through service gaps, continuity of care was an important system issue to review.

Other matters of interest included:

- The processes used to develop policy, and the action plans used for implementing change.
- How the 'change agents' used were established, and how effective they have been.

Study itinerary

A. 2007 International Initiative for Mental Health Leadership Exchange (IIMHL) and Conference

Originally a joint endeavour between national mental health bodies of England, USA, and New Zealand, established in 2003. Other participating countries now include Australia, Scotland, Ireland, and Northern Ireland. The partnership intends to facilitate the sharing of best practices, and to provide support and collaboration for leaders of mental health services to develop robust managerial and operational evidence based practices.

It aims to provide mental health leaders with an electronic network of international mental health professionals that assist one another to maintain awareness of advances in recovery focused, best practice models, on managerial, operational, clinical, cultural, and consumer issues. It also has a focus on dual diagnosis, as an important international issue in the mental health field.

In supporting leadership development for the next generation of mental health leaders, specific leadership competencies that have been identified include:

- personal skills and knowledge
- interpersonal (people) skills
- transactional (execution, management) skills
- transformational skills
- policy and program knowledge.

The theme for the 2007 IIMHL, held in Ottawa, was *Indigenous, Ethnic and Cultural Diversity*. The conference was fully subscribed, indicating its continued expansion and popularity with members.

The structure of the event entails matching leaders with services, undertaking service visits over two days, prior to a two day conference. I was very fortunate and was matched with an indigenous service, complementing the conference theme.

Healthcare organisation

Tungasuvvingat Inuit ('a place where Inuit are welcome') is a cultural and community support organisation established in 1987 to meet the growing needs of Inuit living in Ontario. The various service components I visited included:

- Mamisarvik Healing Centre
- Community Support Program
- Employment Resource Centre
- Inuit Family Resource Centre
- Diabetes Awareness Program

- Food Pantry.

I was provided with an orientation to the Inuit culture, and the difficulties they experience, including:

- High suicide rate (especially males) 11 times the national average, 83 per cent under 30.
- Rapid population growth and change.
- High rates of homelessness.
- High rates of substance use (alcohol, crack, marijuana).
- Transience and mobility are common.
- Past and recent history of highly involved children's protection agencies in metropolitan areas, actively removing children from families.

Other significant considerations follow:

- Urban Inuit make up 25 per cent of the total Inuit population of Canada.
- Many Inuit travel to urban areas for medical services, education and employment.
- Globally, the most recent indigenous culture to integrate into a western civilisation (last 50 years).
- The above factor results in poor availability of current data for better understanding their issues, and planning services to respond to these.
- They require discreet and specific services, as they are distinct from First Nations groups, and have their own unique culture and language.
- They have experienced significant marginalisation until recent times.
- Low rates of non recurrent funding sources, affecting service and staff continuity.

Key approaches observed

Inuit, Tapiriit Kanatami defined mental wellness as 'self esteem and personal dignity flowing from the presence of a harmonious physical, emotional, mental and spiritual wellness and cultural identity'. Staff firmly believe a blend of traditional, cultural and western approaches work best when designing and delivering services.

Community connections are acknowledged and strengthened by actively including Inuit community members in programs, and training them to also deliver services. Eighty per cent of staff are Inuit, a strong emphasis on Inuit human resource development is also undertaken. A two-year certificate level course is provided, staff study part time whilst working.

The Inuit Youth Program for 13-30 year olds focuses on providing education, cultural, and recreational opportunities. Programs are designed to promote language, life skills and positive social interaction.

The Mamisarvik Healing Centre provides a treatment program for those experiencing addiction and trauma, resulting from residential schools, physical and sexual abuse, and forced relocation from traditional lands. They provide:

- intake, pre treatment and assessment services for addictions and trauma
- an eight week residential and day treatment program, conducted four times per year
- average 12 clients per cycle
- stabilisation and case management services
- addictions treatment
- trauma therapy
- individual and group counselling
- therapeutic Inuit cultural and history programming
- healing work with Elders (paid for their contribution)
- wilderness trips, with use of a labyrinth – with very positive results
- therapeutic recreational and life skills programming
- services provided in Inuktitut and English.

Key lessons learned

Considering the difficulties faced by the Inuit, staff at all services were very warm and welcoming, keen to talk about their service, and expressed a very positive outlook for their people.



I quickly understood there are many different cultural clans, like most indigenous peoples they are not a homogenous group, with many different languages, in Inuktitut the same words can have a completely different meaning.

They are used to small communities, making integration into cities stressful. Unlike the First Nation and other

indigenous groups, they do not possess many rituals, and don't identify with rituals used by First Nation tribes. Therefore, the lighting of the Quillic lamp (oil lamp pictured above) was a very special way of learning about and understanding the Inuit culture for me.

There is not an extended family system as with many Australian Aboriginal tribes. Inuit are very clear about parental and nuclear family boundaries, with strong networks and relationships with kin. Children are the centre of the family and extremely important to the family unit and culture.

The process of becoming an Elder was described as a bit of a mystery, knowing them by 'how they look'; by 'wisdom and leadership', was the way it was described to me. It is not an automatic thing done by age as the only criteria, as in some Australian Aboriginal communities.

The newness of integration is creating numerous health problems, their bodies have not adjusted to new diets for example. High rates of cardiac problems and diabetes exist.

The service staff were very collaborative and respectful of self determination and group decisions.

Healthcare organisation

First Nations and Inuit Health Branch, Community Programs Directorate, Medical Specialist in Mental Health.

Key approaches observed

The staff I met were very conscious of the need to respect and acknowledge the Inuit perception and experience of marginalisation, with relevance to strategies developed for First Nation and other aboriginal groups, who have much larger numbers.

First Nations people suffer a disproportionately higher rate of morbidity across many diseases and mortality compared with the rest of Canadians. This disparity is a reflection of systemic, societal and individual factors that influence their health. The majority of these factors do not necessarily lend themselves to simple intervention as they generally are beyond the control of individual First Nations. These influences are considered the broader determinants of health. They consider them influences of their own circle of life. This tacit belief system goes beyond the physical and emotional dimensions of life and includes the spiritual aspect of who they are as peoples of their land. This system is rooted in a harmonious and sustainable relationship with the world around them. They do not necessarily separate themselves from the world, but see themselves integral to it.

As wealth decreases people become less healthy and, unfortunately, many First Nations people live in poverty. For First Nations, when considering a framework for improving health, it is necessary to include a spiritual component. Approaches must reflect and respect First Nations autonomy, values and practices.

There has been a recent shift by the Canadian Government to refocus efforts in the areas of preventative medicine. These efforts are driven almost exclusively by the alarming fiscal reality that a treatment-focused approach to health in Canada is not sustainable. The arrival of SARS (Severe Acute Respiratory Syndrome) also raised the awareness of the need to not only promote good health, but also the need to protect it.

The high rates of unemployment, lower education opportunities, poor housing, overcrowding and lack of basic amenities such as running water and indoor toilets are but a few social issues that contribute to the poor health of First Nations. First Nations believe that true community healing and well-being will only be achieved through the path of self government and self-determination.

A broad range of services exist that provide specific services for First Nation peoples.

2007 International Initiative Mental Health Leadership Conference (IIMHL)

The key issues raised by the presentations I attended are summarised below.

- When considering the matter of indigenous leadership, environments where trauma is experienced reduces the potential and capacity for the elements that create and support leadership.
- Potential indigenous leaders need to be identified and nurtured. Good examples of policy and local development of such programs are evident in New Zealand, United Kingdom and Alaska.
- Service and funding agreements should include key performance indicators for matters of culturally and linguistically diverse (CALD) and indigenous outcomes.
- Presentation of the Alaskan Indigenous Model of Evidence-Based Effective Practice was very helpful. The term indigenous included black and ethnic minority groups. The model integrates indigenous forms of knowledge, with intent to provide government and other funding agencies with an empirical basis for acquiring indigenous evidence of the effectiveness of local practices. Programs that include congruence with cultural life ways, and active participation by local communities in program development and validation, are developed. The model contains three levels of evidence:
 - Level 1 – client based evidence
 - Level 2 – practice based evidence

- o Level 3 – research based evidence.

Key lessons for Victoria

Lessons to consider are:

- The cultural appropriateness and positive regard for trauma recovery groups supported by indigenous populations.
- The importance of developing strategies for establishing indigenous and CALD workforces.
- The long term benefits of identifying and nurturing indigenous leaders.

The next IIMHL conference is in Australia; service matches across Australia and New Zealand are available prior to the conference in Brisbane, March 2009. This will be a great opportunity for colleagues from Australia and New Zealand to showcase our services and reacquaint ourselves with other leaders.

B. San Francisco Integration Project

Healthcare organisation

City and County San Francisco Department of Public Health, Community Behavioural Health Services Administration Office
Dr Bob Cabaj, Director of Community Behavioural Health Services
Dr Alice Gleghorn, Deputy Director of Community Behavioural Health Services
Lucy Arellano, Quality Management Consumer Specialist
Edwin Batongbacal, Director Adult and Older Adult Services, Systems of Care

I met with several senior staff responsible for the implementation of the Integration Project in San Francisco, as listed above.

Key lessons learned

System level

- The Integration Project was less successful when involvement was voluntary, issues of leadership skill and associated authority also arose. When involvement was made compulsory and meetings became more focused and attendance and more active participation began.
- Overall, many services are at different levels and stages of integration. Partner selection is important; services need to find others that match their culture and values.
- The 'change agent' model has been the strength and success behind service change and integration.

- State legislation governing the ability to compel clients into treatment (called 51/50 'danger to self and others' such as involuntary status) is significantly restricted in California, comparative to Australian states. Coercion of clients into treatment occurs either through the judicial system or from the community into limited residential rehabilitation programs, or for crisis admissions into short term acute beds (in emergency departments for assessment, stay is a maximum 72 hours and must be substance free, often brought in by police), or acute psychiatric units where the average stay is two to three days.
- Many dual diagnosis services are residential in nature, with a secure environment; clients are often required to complete rehabilitation to avoid incarceration.
- The diversion of mentally ill from incarceration into community programs is outlined further in this report.
- Increasingly the process is being driven by the funding body (City and County San Francisco Department of Public Health, Community Behavioural Health Services). The use of the term 'behavioural' is used purposefully to reflect both the mental health and substance use service sectors.
- Funding agreements contain specific expectations that mental health services will identify a substance use agency partner, and that a minimum number of six hours of joint staff training is conducted annually.
- The disparity that sometimes exists between state and federal policies creates some conflict for service providers. For example, the 'zero tolerance' policy expectation at federal level regarding substance use does not fit well with a 'harm reduction' approach, favoured by most services.
- Increasingly federal funding is sought by states and their services to support service delivery and expansion. This adds to difficulty in creating a coherent and consistent policy approach.
- Similar to the Australian experience, substance use services are not funded at the same levels as mental health services. This is a source of tension between services and staff and does not assist the integration process. Many substance use services expressed a fear of 'being taken over' by mental health services.
- Funding bodies focus on outcomes of investment, utilising contract performance indicators and measures rather than clinical ones. Some measures include: client turnover; employment/training hours; stable housing; criminal activity; and contact hours.
- For some substance use services, being involved in the Integration Project and now delivering mental health services has enabled them to access funding sources previously unavailable to them. Services can be 'certified' as 'dual diagnosis capable'.
- The Department Community Behavioural Health Services have implemented the Zialogic approach in ways that suit their system. The

use of simple checklists and brief summarised information makes it more readily accessible to staff. A focus on pragmatic solutions is the desired way of reaching goals.

- Of significance is the lack of involvement of psychiatrists in the process. Of the current 140 change agents, no psychiatrists have offered to take on this role.
- Policies driven by politicians at local, state, and federal levels are often uncoordinated and unable to be enacted for pragmatic and resource reasons.
- Outcome measures are not routinely used in services, some attempts to use some consumer rating tools as a quality improvement activity was attempted in a limited way some years ago. Plans are underway to incorporate them into the development of a pilot of electronic medical records over the next five years. Clinical outcome measure tools linked with individual service plans will be trialled.
- The system separates issues of compliance and quality improvement. The accreditation process is much simpler than in Australia. Services conduct their own audits against 12 standards and report these to the accreditation authority. This process of self reporting is less burdensome, but naturally raises the question of validity.
- Incident reporting systems focus on deaths (accidental, suicides, and murders).
- Client satisfaction surveys are conducted regularly. Consumers are involved in various committees and consumer participation is fairly active in most services, a tax has provided \$1b to pay consumers for involvement.
- New legislation is before parliament to provide free health care for underprivileged children, and increase their access to health insurance.

Healthcare organisations

Centre for Recovery, Haight Ashbury Free Clinic
Integrated Service Centre South of Market - Mental Health Services
Family Service Agency Community Aftercare Program
Asian American Recovery Services
Infant Parent Program
Community Substance Abuse Services
Bayview Hunters Point Foundation
Walden House Adult Day Rehab Program and Adult Residential Services
Monterey Adult Behavioural Services

In this section of service visits, I have collated and summarised key lessons that were significant to my project. Many services and individuals reported similar issues and experiences. I have focused on outlining the learning and

ideas that are relevant, generated through many observations and discussions.

To aid alignment of the content of this section of the report with the intended aims of this component of my Travelling Fellowship, it is necessary to state that my observations, experiences, and information provided to me, did not completely match the expectations of what I hoped to learn. However, this is not a significant matter, as in the overall context of what I gained it is only a small perception gap.

The area I was ambitious to review related to staff's resistance to working with dually diagnosed clients, and service barriers to integration. I found our services and staff shared very similar issues and attitudes, helping me to appreciate common international experiences, and reduced my idealistic expectations a little.

I regard these differences as a positive outcome, firstly effective and efficient strategies for service change can be designed upon realistic expectations and accurate information. Secondly, the service Integration Project I studied intends that the comprehensive framework or model used in the USA can be modified for application in other systems and settings. Therefore, these differences do not affect the outcomes or benefits of applying such a model.

Key approaches observed

Service level

- Staff in both service sectors still experienced difficulties in accessing respective services for dual diagnosis clients in a timely and responsive manner.
- Most services and staff were in support of the Integration Project, and agreed that the dually diagnosed traditionally 'fell through the gaps'. Although in practice, many aspects of integration remain a struggle; the commitment remains to continue to reach the goals of integration.
- Most who had been exposed to the Integration Project agreed with the concepts proposed by Dr Minkoff, especially the under detection of either mental health or substance use problems by the respective agencies and the 'every door is the right door' approach.
- A general perception existed that mental health services were more reluctant to participate in the project than substance use services.
- The ability of services to respond to the presenting issues of the dually diagnosed, as suggested in the 'no wrong door' approach, actually varied considerably from service to service. Many felt even after training that it remained a specialist area, requiring specific expertise they did not possess, and it was time consuming trying to match clients to more appropriate services.

- Again, a similar experience to the Australian situation is the issue of qualifications of staff in substance use services. Staff are being provided with competency based training to increase their skill and knowledge.
- Concern also exists on the ratio of recovered substance users working in substance use services. Many, including those in substance use services, expressed a view that the ratio was too high. Although regarded as a group with much to offer, 'they should be used like salt and pepper, not as a main meal', was one way the issue was described to me.
- Some services believed they had been successfully working with one another prior to the implementation of the Integration Project. In some isolated cases staff felt the project had interfered with their ability to continue to progress in this area.
- Although mental health staff almost universally acknowledged the existence of dual diagnosis, I was surprised that some wished to 'see the data' regarding substance users 'with mental health problems'.
- Most agreed that group based formats were very successful for dually diagnosed, and this in combination with intensive 1:1 case management was regarded as best practice.
- Many services conducted their own psychotherapeutic groups and PDRSS (psychiatric disability rehabilitation and support services) type day programs as well. They found this provided better continuity of care and enabled tailoring of programs to suit individual consumers.
- Those services well linked to, and able to access a range of housing types, had better outcomes for their clients.
- Most mental health services support those with an Axis 1 diagnosis. Many clients also experience post traumatic stress disorder, often from trauma experienced on the street. This is particularly important for homeless women.
- Clients with 'high prevalence' disorders (mostly anxiety and depression) struggle to access affordable services (similar to the Australian experience).
- A strong service system exists that supports educational and vocational opportunities for mentally ill consumers and the dually diagnosed. This was a particularly interesting as in discussion with consumers their eagerness to find work (even a few hours per week) and obvious pride and improvement in self esteem after doing so, contributed to an expressed willingness to reduce drug use. Helpfully, consumers receive additional social security benefits for being enrolled in training programs.
- Staff often reported, however, that greater access to funds resulted in relapse into substance use for some consumers. In such circumstances administration orders and guardians may be used to restrict access to funds.

- The Haight Ashbury Free Clinic service delivery model that provides mental health, substance use, and primary care services all in one location has many benefits and good outcomes for consumers. The integration with primary care is well in advance of other service integration attempts that are focusing on mental health and substance use service.
- Most services struggled with the pressures of meeting funding targets balanced with providing adequate periods of support and care. Case management provision for longer than one year could be provided by applying for extensions to treatment, and meeting specific criteria.
- The history of San Francisco culture, having a long tradition of promoting itself as a 'fun' city, where there has been some tolerance in the past for drug use, was not supported by many in the field. Some staff felt this created conflicting expectations for the community.
- One clinic had a café attached to their waiting room, managed by consumers, and was very popular. This clinic also had a policeman in situ daily due to the level of violence experienced, however he was very engaged with consumers, lots of laughter and humour was used to defuse difficult situations.
- Use of depot medications is common; medications requiring regular pathology testing less used due to difficulties tracking clients for testing. All medication is free for clients in public services, including Buprenorphine.
- Interestingly, many staff expressed the difficulty encouraging clients to be forthright about their substance use. Concern about legal consequences seemed to be the main barrier; for some it was concern about involvement of child protection services.
- Difficulties in providing a coordinated service system for young people were expressed by some staff.

Key lessons learned

A brief overview of my learning about the Integration Project follows:

- Commenced in 2004, it is now regarded as an indefinite quality project, with no end date; this was not the original intention.
- The first year was spent in extensive consultation with community services, letting staff express negative comments and concerns. Residential services (acute units, rehabilitation services) are not currently included in the project, but may be eventually.
- The Integration Project intends services to partner with primary care agencies as well as substance use services, however this is not broadly understood in the field, or by change agents.
- Overall support and direction comes from the most senior department position, Director of Community Behavioural Health Services, this has helped influence agencies to take up the project.

- They commenced with 40 volunteer change agents, and now have 140. Policy directives provided initial direction and more recently (2006-07) funding incentives and requirements have also influenced this growth.
- Funding agreements contain seven to eight specifications on integration, including services having a change agent and attending 50 per cent of meetings annually. A checklist with requirements and time lines outlined clarifies service responsibilities.
- There is now an acknowledged 'top down and bottom up change process' occurring.
- The change agents are currently forming a leadership group, to assist communication and coordination issues.
- The integration tools (for example CODECAT) are still being rolled out across services. Some change agents reported many services regarded it as an unpopular tool.
- Change agents meet monthly for two hours and for six hours every quarter. Their training program and workshops every quarter have Dr's Minkoff and Cline supporting their role.
- Some change agents represent more than one service. Change agents provide leadership both within their service and to partner agencies.
- They push their service at a local level to improve and it is planned to then set benchmarks for services to meet.
- The first conference of change agents is scheduled for 2008.
- The major changes noticed are the range of new policies and procedures that support the project and shifts in attitudes and behaviours of staff to one another.
- One of the most important principles of the CCISC, and still a challenge for the project, is that both service sectors have to be 'welcoming'. This concept is fundamental to achieving 'every door is the right door' policy. In implementing integration, an emphasis was placed on the importance of developing the capability of all programs and staff to be welcoming and engaging toward all individuals and families. The goal is empathic, hopeful relationships that facilitate appropriate identification of needs, access to appropriate assessment and properly matched services. It is the first step of engagement.

This in itself may seem like a simple goal, but in my experience it is one of the most difficult things for staff to translate into practice, especially if they do not feel equipped or confident to deal with the issues they are being presented with. So, for staff:

- working in substance use services to be screening or assessing someone who may be presenting in an acute psychotic state; or
- mental health service staff presented with someone in a state of toxicity or withdrawal; the

- o experience from the consumer's perspective is either one of rejection and a poor referral process to a 'more appropriate service', or an initial attempt to engage them and acknowledge their attempt to seek assistance with their problem, and the ability to respond to their situation.
- Agencies have begun the process of addressing welcoming practice and reduction of access barriers in their own programs. There is not yet a process in place to evaluate welcoming, or to quantify instances where individuals have either been unable to access services due to co-morbidity or have been excluded from services due to co-morbidity.
- The issue of professional differences and rivalries has not been addressed specifically, but through the joint meeting process where positive working relationships are developed. These meetings are regarded as one of the most successful strategies to date. As more clinical staff participate in integration it is hoped this will influence more psychiatrists to also become engaged. Specific training programs for psychiatrists are being considered.
- Strong relationships underpin the approach at all levels. Ultimately aiming to aid the client referral process between agencies.

Other key lessons and reflections

- Consumer involvement in mental health services has increased through influence from substance use services. Employment of recovered clients in these services enabled them to advance consumer participation many years prior to the mental health sector.
- 12 step programs remain very popular in many agencies, including those treating dually diagnosed and substance use services. Many felt they were 'moving towards abstinence' with clients.
- In mainstream mental health services, medical models usually dominate, creating some tension with agencies that are comfortable with 12 step programs.
- The simplicity of the concept that services are able to adequately respond to the presenting issues of the dually diagnosed clients 'walking through the door' is very attractive and appealing. In reality, most tried to match clients to suitable services.
- Suitable housing options are a particularly vexed yet highly important and relevant matter for the dually diagnosed. Finding accommodation that matches the client's stage of change in relation to substance use (such as from completely 'wet' through to thoroughly 'dry') did not exist in San Francisco. Yet this was identified by all as a matter of priority.
- Group based programs for dually diagnosed are uniformly regarded as best practice, with the best outcomes. In some services, case managers run groups with only their own clients, regarded as both efficient and effective by most.

- A significant difference to the Australian experience is the drugs used by clients; crystal methamphetamine is the drug of preference for most clients, with alcohol second, heroin third and cannabis fourth.
- The service system is complex with many small agencies with specific roles (for example, mental health or substance use services for gay men only). This affects their capability with the Integration Project and the implementation of the policy of 'welcoming' more challenging.
- Information and communication technology requires further development to support clinical work. Staff did not have access to laptops or electronic clinical forms. A database that could provide information on what services had been attended by clients over defined periods of time and electronic records were the two priority areas.
- Common assessment tools are not supported or possible, but shared components or domains are.
- Some of the positive initiatives that could contribute to my project need to be adjusted to suit our context. Consideration of issues including workforce (issues of experience and turnover will affect capacity for adhering to CCISC principles of continuity for example); service role/s allocation; service capability for change. Some may need to be implemented incrementally.
- Our service has very successfully developed a protocol with emergency services; systematic staff training and service responsiveness have improved. A similar approach could be used for establishing agreements with housing providers and the employment and vocational sectors. This could be integrated with the Mental Health First Aid training provided by our PDRSS.
- Reviewing services that are fairly 'organic' in nature, and only loosely evidence based, reinforced learning about the importance of clear operational systems that can support a service achieve its aims and responsibilities. Small services that depend on their leader to define their purpose, and are influenced by personal preferences, are at risk of instability, inconsistent standards and rapid change when personnel changes occur.
- The importance of well established clinical service systems and structures, ensuring service standards and service levels are maintained, irrespective of personnel changes within services.

Healthcare organisation

Mental Health Court
Citywide Case Management Forensic Program
Office of the Public Defender

Key approaches observed

I attended a Behavioural Health Court session and discussed the Collaborative Justice Program with staff from the Office of the Public Defender and the Citywide Case Management Forensic Program. The program has been operating since 2003 and is highly regarded by staff and consumers alike. The three main goals of the program, as outlined by the judge, are:

- release prisoners with serious mental illness from jails
- enhance access to medical and other services in the community
- link clients to mental health services and assertive treatment.

I observed approximately 30 program participants presented to the court, most were complying with the program, remaining drug free (or reduced use) and willing to continue with community based treatment. The judge was very encouraging of those doing well and firm with those not. Some offenders had to wait in prison until either a bed in a suitable facility was available or a case manager could be appointed.

Those who successfully complete the program are provided with a formal graduation celebration at the court.

Evidence supporting approaches

D. McNiel and R. Binder (AMJ Psychiatry 2007) conducted a retrospective observational study, comparing the occurrence of new criminal charges for 170 people who entered a mental health court after arrest and 8,067 other adults with mental disorders who were booked into an urban county jail after arrest during the same interval.

The results showed that participation in the mental health court program was associated with longer time without any new criminal charges or new charges for violent crimes. Successful completion of the mental health court program was associated with maintenance of reductions in recidivism and violence under supervision of the mental health court.

They conclude from the results 'that a mental health court can reduce recidivism and violence by people with mental disorders who are involved in the criminal justice system'.

Anecdotally, I observed a mother and son in court presenting to the judge together. The son had been charged with serious assault of his mother but had elected to enter the court program, rather than proceed with the court case and possible custodial sentence. The son was living with his mother, now compliant with medication, his aggression was under control, and his mother willingly agreed to drop all charges (which also meant no ability to access victim of crime compensation for medical bills, an indication of her

support for the process). Both felt that the program had been highly successful, both in terms of controlling the son's symptoms and their relationship.

Key lessons learned

Although not an ideal approach (as the system is an adversarial one due to the Californian state legislation for the mentally ill), it is the main way of creating treatment compliance for seriously mentally ill offenders.

Suitability to our practice and Victorian healthcare system

Similar programs exist in Victoria through Forensicare, their capacity however for supporting more mentally ill offenders requires expansion.

C. American Psychiatric Association 59th Institute Psychiatric Services Conference – 'Recovery: Patients, Families, Communities', New Orleans, USA

The key issues raised by the presentations I attended are summarised below.

- The use of the term 'recovery' is increasingly popular and therefore it is necessary to define it, to ensure consistent meaning and shared understanding occurs.
- The consumer participation movement is refining itself, shifting from employing consumers to undertake operational work within the service, to performing a peer support role.
- Services in New Haven, Connecticut employ staff that focus on vocational and employment opportunities for clients. All staff are encouraged to take responsibility for providing advice and support to consumers on options for work and training. They have posters stating 'Work is Everyone's Business'.
- The new work presented by Professor William McFarlane (received the APA/PPF Alexander Gralnick Award for Research in Schizophrenia) on biosocial treatment in schizophrenia, proposes the 'biosocial theory'- that 'major psychiatric disorders, such as schizophrenia, are the result, both at onset and throughout their course, of the continual interaction of specific brain abnormalities and specific social factors or processes'. Advancing on previous theories, emphasising the effect of continual and minor stressors, and specific social phenomena interacting with biological dysfunction, resulting in illness relapse.

Based on considerable research and a significant body of work, Professor McFarlane has attempted to translate his theory into effective treatments that can be tested. Suggestions for highly structured (yet low key) programs for families, with a focus on

multifamily groups for improving general functioning and specific communication styles (expressed emotion) were presented, and enthusiastically received. This work is particularly interesting and relevant to prodromal phases, where young people and families experience negative cycles of internal conflict. Family relationships and functioning is often damaged, prior to parents recognising a mental illness is present.

- The recovery process for New Orleans post hurricane Katrina has been slow and painful for its citizens. Ninety per cent of 'first responders' (emergency services personnel) lost their homes, had their families evacuated (could not communicate with them), yet had much traumatic work to perform. Many remain in need of ongoing assistance with post traumatic stress disorder.
 - Many others have also experienced significant mental health difficulty; mental health staff have begun to understand and expand the concept of 'attachment theory' beyond usual meaning, to now include loss of family, homes, and way of life. Examples of hardship were extreme, including stories of first responder suicide, parents having to quickly decide which child to evacuate on the one place left on the helicopter, and children still traumatised by decisions they made during the hurricane.
 - There were many examples of continuing community hardship, such as only a third of schools being reopened, increased drug use, and lack of medical personnel. Pressure on suitable and affordable housing is extreme, and affects the mentally ill. Clients living in trailers provided for families create a 'hothouse' effect, with rapid escalation of tension and conflict. For the purpose of this report however, I will focus on issues relevant to my project.
 - Mental health services have not returned to their former status; they have acquired some bed-based services (50 now, previously 300 before Katrina) but have very few community services. This is the opposite of the model they had and want. They have 120 psychiatrists, 300 previously.
 - The workforce has not returned and they cannot recruit and cannot open all the beds. McDonalds offers a higher hourly pay rate for staff than services can provide. Sick leave for current staff has increased by 200 per cent, as they struggle to look after themselves and their families. Many are not performing at the same practice standard level as before the disaster, they affectionately refer to this as 'Katrina brain'. Staff retention is low.
 - In the newly opened acute beds in general medical and surgical hospitals, 18/23 beds admit patients with mental illness. The amount of substances used by individuals has increased, more than the percentage of the population using them. Increases in drug induced psychosis and dual diagnosis is very noticeable.

- In the rebuilding process psychiatric services were not supported or considered a priority, planning came after other services were established. Similarly, services for substance users came after psychiatry, services for children and adolescents last.
- One benefit in rebuilding services is that they are able to redesign services in ways that overcome previous system problems. These include new service partnerships and integration models.
- Many inspirational stories and examples of positive service development were provided. A leadership program for children was established matching them with older adults, some children who had not been coping were now doing well, and were back at school.
- Redefining 'normal' reactions to trauma in disaster situations is an area of review.
- Vicarious trauma for health professionals is underestimated in disaster situations.
- In the USA there is growing evidence and concern for children of prisoners. They are a high risk group, with few services available to them. Most services are only available whilst parent(s) are in jail.
 - Rates of incarceration are very high comparative to other developed countries. In the 1990's 25 per cent of USA adults had a criminal record.
 - Incarceration statistics from 2004 revealed:
 - USA = 724:100,000
 - United Kingdom = 145:100,000
 - Australia = 120:100,000.
 - On any day in the USA, 2.3 million people are incarcerated, one in 32 adults under some type of correctional supervision, most drug related offences.
 - More mothers in jail than fathers (since 1980 the ratio is now two women: one man in jail) 60 per cent women are mothers.

Key lessons/reflections learned

- People (especially children) can be remarkably resilient in emergency situations and the motto 'Recover; Rebuild; Re New Orleans' has mobilised many people in very positive ways.
- Some of the lessons learned from the disaster outlined at the conference included:
 - Government emergency management plans are usually inadequate for major disasters and do not foresee many of the practical but important issues (for example, how emergency staff sent money to their family).
 - Needs of children and the elderly are often not considered in plans.
 - National plans must be designed to be implemented in a detailed way at a local level.

- Accreditation standards that refer to 'disaster preparedness' need to be redesigned to incorporate their learnings.
- The influx of volunteers added stress to a stretched system, many did not know what to do and when they left the community often felt abandoned again.
- A slow recovery process re-traumatizes the community and makes recovery very difficult.
- Redesign government grants to suit the situation, for example, federal grants could only be used for capital redevelopment, so they had the building but needed funding for recruiting staff and did not fit the funding criteria.
- Collaborative strategic planning with key stakeholders may help strengthen partnerships and the development of common goals for service development.
- A pilot employing staff skilled in local employment and vocational opportunities for clients, working with community based adult teams would create and evaluate a new model of rehabilitation and recovery, and enable linkages between different parts of the service system to respond to those with serious mental illness in more effective ways. If this was proved to be successful, major system change could be considered, restructuring clinical services and the PDRSS sector to clarify roles and responsibilities.
- Application of the biosocial theory and related multifamily groups to the work of early intervention teams deserves consideration and development. The interventions have broader application for any family with similar conflict.
- Again, the value of trauma recovery groups was reinforced as a valuable clinical tool. Much focus has been on recovery groups from mental illness, perhaps a broader approach is more beneficial.
- The development of screening tools to assess family readiness for change, when introducing multifamily groups, would be a useful way of determining which families might benefit most from such programs.

4. Improving the Victorian healthcare system

The lessons learned during my travel, and the ability to reflect whilst away, have assisted consolidation of project planning ideas and implementation strategies.

In brief the project is one of integration, between our clinical mental health service, and our regional substance use treatment services. I anticipate we will use similar approaches to those I observed overseas, adapting approaches to suit our context.

A steering committee will be formed, with representatives of all partner agencies. Our primary goal will be to develop a comprehensive set of actions to meet the *Dual Diagnosis - Key Directions and Priorities for Service Development* document recently launched by the Mental Health Branch of the Department of Human Services. The outcomes we are expected to achieve are set out below:

1. Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as core business in both mental health and alcohol and other drug services.
2. Staff in mental health and alcohol and other drug services are 'dual diagnosis capable', that is, they have the knowledge and skills necessary to identify and provide integrated assessment, treatment and recovery.
3. Specialist mental health and alcohol and other drug services establish effective partnerships and agreed mechanisms that support integrated care and collaborative practice.
4. Outcomes and service quality for dual diagnosis clients are monitored and regularly reviewed.
5. Consumers and carers are involved in the planning and evaluation of service responses.

We have identified our own 'change agents', they are our Early Intervention/Dual Diagnosis 'champions'. We will work with partnering agencies to identify 'champions' in their services also. Better understanding of the service options for consumers with specific presenting dual diagnosis types requires exploration and understanding by both service sectors. This issue can be assisted through studying the appropriate matching of treatment for each of the sub-groups of individuals with combined mental health and substance abuse disorders (the 4 Quadrants model used by Minkoff and Cline).

We have staff exchanges, joint staff training programs, and dual diagnosis capable training plans underway. We believe we can improve client continuity of care, and referral pathways through focused development of clinical processes and the formalisation of these with a memo of understanding and support from Regional Department of Human Services.

Longer term issues that may also be addressed through these forums include:

- suitable housing for dually diagnosed
- access to adult residential rehabilitation in the region
- development of psychotherapeutic groups for dually diagnosed, we are currently running Collaborative Therapy groups
- clarity and role definition for our adult PDRSS in:
 - supporting dual diagnosis clients in the community with rehab and recovery

- o employment/vocation options.

The steering committee will establish a range of methods and strategies to monitor and evaluate progress, and use available tools to measure success. The *Compass* tool currently approved for use in Victoria assists services to evaluate themselves against set criteria. It is possible for this tool to be used by service partners, to measure internal service progress and benchmark against other services.

5. Sharing and promoting the project

I would be pleased to make my report publicly available. In addition I am scheduled to deliver a presentation to our Board of Directors in mid December 2007. I have offered to also present to a number of local services and committees, including the Regional Alliance of Mental Health Promotion. I will be opportunistic and also make myself available to present at regional forums, Mental Health Branch, Mental Health Training Clusters, Primary Care Partnership, local agencies, consumer and carer networks and agencies, and Koori health services.