vaada

Dual Diagnosis

VDDI

INTEGRATION OF CARE IN PRACTICE

VICTORIAN EXAMPLES OF MODELS OF CARE, TOOLS AND ACTIVITIES THAT PROMOTE INTEGRATED TREATMENT, CARE AND SUPPORT FOR PEOPLE EXPERIENCING MENTAL ILLNESS AND SUBSTANCE USE OR ADDICTION

Prepared by the Victorian Dual Diagnosis Initiative Leadership Group Working Group on Dual Diagnosis Integrated Treatment and the Victorian Alcohol and Drug Association (VAADA).

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Special thanks to the following people for their contributions to this document:

- Gabby Cohen on behalf of South City Clinic
- Westside Lodge Dual Diagnosis Unit
- Patrick Lawrence First Step and roject Team for the CCISC Pilot Project
- Simon Kroes Nexus Dual Diagnosis Consultation Service
- Associate Professor Melissa Petrakis, Social Work, Monash University
- Julia Daly, Administrator, VAADA Victorian Alcohol and Drug Association

We also wish to acknowledge Sam Biondo's contribution to the Victorian alcohol and other drug sector as Executive Officer of VAADA for the past 16 years.

Nexus Dual Diagnosis Consultation Service

Eastern Health

Eastern DDx Service

Southern Dual Diagnosis

The Royal Melbourne Hospital

S+ sumitt SUBSTANCE USE & MENTAL ILLNESS TREATMENT TEAM

Vision Statement

The Victorian Alcohol and Drug Association (VAADA) and the Victorian Dual Diagnosis Initiative Leadership Group (VDDI LG) acknowledge the significant existing Mental Health and Alcohol and Other Drugs cross-sector work that has occurred over many years regarding integrated treatment, care and support models to improve the outcomes for those with co-occurring mental health and Alcohol and Other Drug's needs.

Together, VAADA and the VDDI envision a system that enables the delivery of high-quality treatment, care and support for all that are identified with co-occurring substance use and mental health concerns. We support a principled care system that is welcoming, person-centred and allows the individual, and their families and supporters, to experience seamless responses to their multiple issues, whatever the circumstances, wherever they present.

Further, we envision a system in which mental health and AOD workforces are empowered and supported and have a mutual commitment to provide integrated treatment, care and support via organisational policy, workforce development and collaborative systems that are developed and reflected collectively across both AOD and MH systems and other allied systems.

Background

Over the last two decades, internationally and across Australia, mental health and drug treatment systems have strived to develop effective responses to people experiencing co-occurring mental health and substance use concerns. This has been driven by their recognition that, in people receiving treatment for either concern,

- Co-occurring mental health and substance use concerns are highly prevalent, the " expectation not the exception"
- There are significant harms and unwanted outcomes associated with experiencing both concerns compared to experiencing only one.
- There is potential for both mental health and substance treatment systems to be more effective in treating their 'target' disorders if they can develop the effectiveness of their response to co-occurring mental health and substance use disorders

For some time, people with lived experience expertise have expressed a preference for the provision of seamless, integrated treatment care and support for both mental health and substance use issues, wherever a person presents for treatment. Further, since 2002, Victoria has devoted considerable investment and effort developing improved systems of integrated care. In 2007, the Victorian Department of Health published the seminal Key Directions document, which outlined that the prevalence and complexity of dual diagnosis requires an integrated approach to assessment and treatment delivered as 'core business within specialist mental health and alcohol and other drug services. This document enabled the establishment of some foundational elements towards integrated treatment.

In 2021 the final report of the Royal Commission into Victoria's Mental Health System recommended that by the end of 2022, all mental health and wellbeing systems, across all age-based systems, including crisis services, community-based services and bed-based services provide integrated treatment care and support to people living with mental illness and substance use or addiction. The Royal Commission proposed three models for implementing integrated treatment in Mental Health and Wellbeing (MHWB) services, which were included in the Department of Health "Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction Guidance for Victorian mental health and wellbeing and alcohol and other drug services" (Department of Health 2022)

Figure 4: How Local and Area Services can configure themselves to develop capability in and deliver integrated treatment, care and support [1]

Multidisciplinary teams	Workers of different disciplines provide integrated treatment, care and support in a single service setting. There is a high degree of collaboration and coordination to deliver person-centred care.
Co-location and care coordination partnerships	A Local or Area Service physically co-locates with an AOD service to deliver coordinated treatment, care and support. Through care coordination and single care planning, they deliver integrated treatment, care and support needed to meet the person's co-occurring needs. Regular case conferencing and shared records and information enable seamless and coordinated care, where both providers work towards joint care goals. Care coordination and shared information systems are critical components in this model.
Service delivery partnerships	A Local or Area Service partners with an AOD service to deliver some aspects of a person's treatment, care and support within the mental health and wellbeing service.

(Department of Health, 2022, P19)

When considering the appropriate model of care for a service, factors such as consumer needs, funding and resources, environment of treatment and purpose of treatment provided are important. Some models will require greater systems and structural considerations, while others rely on inter-organisational/ professional relationships. For example, as described in Croton (2007), some may require shared screening and assessment and integrated treatment planning tools.

Since the Royal Commission report, the priority of developing integrated treatment care and support has been reflected in all Victorian mental health policy documents – notably in:

- Integrated treatment, care & support for people with co-occurring mental illness with substance use or addiction - Guidance for Victorian MHWB & AOD services
- Local Adult and Older Adult Mental Health and Wellbeing Service – Service Framework (note especially the detailed features of integrated substance treatment that is expected that the Local MHWB services will provide - pp 38-40)
- Victorian Mental Health and Wellbeing Workforce Capability Framework

Since 2002 the Victorian Dual Diagnosis Initiative (VDDI) has been responsible for supporting Clinical Mental Health Services (Adult and Youth), Mental Health Community Support Services (MHCSS), Alcohol and other Drug Services (AOD) and the youth homelessness sector across Victoria in the delivery of a model of care that embraces comorbidity in all interventions for consumers and their families/carers experiencing mental health and alcohol and drug problems.

The VDDI has particular expertise in the implementation of evidenced based tools, approaches and models of care within practice environments which have had a significant impact on service delivery.

Purpose of the document

The VDDI provides guidance and oversight for a broad range of integrated mental health and alcohol and other drug activities. In support of the notion that integrated treatment is possible within mental health services, the VDDI would like to highlight a number of models, tools and activities that capture the integration of alcohol and drug activities into the mental health community and bed-based services. This does not provide a definitive list of AOD MH activities and models but reflects current practice examples developed and utilised within Victorian AOD and MH services.

To illustrate the integrated treatment practice examples this document borrows from the template used by Deady et al.

(2014), Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Mental Health and Drug and Alcohol Office. The Sax Institute Model employs a rating system for the evidence base of each model. We have chosen to use the same rating system which is outlined below:

- STRONG – Systematic review of multiple randomised controlled trials (RCT) or multiple RCTs with consistent findings
- GOOD – At least one RCT or multiple comparative (non-randomised) studies with consistent findings
- MODERATE – Any form of comparative (non-randomised) study
- SOME – Case series (single treatment group)
- NO RATING – No experimental studies. Any statements are based on single case reports or clinical opinion/expertise.

Definition of co-ocurring mental health and substance use

Within the Royal Commission into mental health services and the subsequent Integrated Treatment Guidance, there is a shift from using the term Dual Diagnosis to a recent descriptor of Mental Health and Substance Use and Addiction. However, there continues to be a discussion on this change in language.

Recent advice from the Eastern Metropolitan Region Dual Diagnosis Consumer and Carer Advisory Council (DDCCAC) suggests the phrase 'Co-occurring Mental Health and Substance Use Concerns' as more accessible language to those who use mental health and alcohol and other drug services.

The working group reviewing the integrated treatment practice examples recognise the importance of language in supporting change which may continue to evolve.

Different words/terms/descriptions can mean different things to people with lived and living experience, clinicians and practitioners and may be contested now and into the future.

For this reason, the working group recognises that different definitions may be more suitable for different settings, groups and individuals.

Whilst a range of terms are used within this document, following consideration, the working group has chosen to use the phrase Mental Health and Substance Use Issues/ Concerns. The intent of this phrase is be inclusive of mental health problems, trauma, psychological distress, disorders/diagnosis and substance use, misuse and addiction.

Principles of integrated treatment

Another key element of the Royal Commission findings relates to reframing the MH sector to foremost reflect the voices and experiences of people accessing the system and ensure person-centred care.

As one means of achieving this, all reform policy work incorporates a principled care concept that aims to frame the work undertaken around core principles. In the case of the provision of integrated care,

it is asserted that despite the model of care that is utilised, if it aligns well with core integrated treatment principles it is likely that an individual or their family and supporters will feel that they have received an integrated treatment response.

The development of the Integrated Treatment Guidance document referenced earlier saw wide cross-sector consultation around shared principles of care and, as a result, suggested the following four broad principles were integral for integrated treatment.

PRINCIPLES	DEFINITION	CORE EXPECTATIONS OF SERVICES
1. Inclusion	All MHWB and AOD services welcome people with co-occurring needs and their families and supporters.	· Welcome · Hope · Respect · Non-Judgemental
2. Access	People with co-occurring needs and their families have equitable access to treatment, care and support.	· No wrong door · Maximise Accessibility · Ensure Aboriginal cultural safety and self-determination
3. Capability	Services and workers have skills, knowledge and attitudes to meet people co-occurring needs, the needs of their families and supporters – enabled by individual, practice, organisational and system level supports	· Meet both co-occurring needs · Take a person-led approach · Promote and support harm reduction · Support and involve families and supporters · Collaborate and learn
4. Participation	People with co-occurring needs and their families and supporters feel empowered to influence and improve the services that work to support them.	· Create meaningful participation and leadership opportunities

Adapted from Integrated Treatment Guidance (2022)

Multiple other integrated treatment frameworks have developed their own set of principles that generally align with those listed above, but may be helpful when considering the model of integrated care that is most suitable to your service. Where possible, and as best practice, principles for integrated treatment and care should be co-designed, produced and written in language developed with people with lived and living experiences of mental illness and substance use.

FRAMEWORK	RESOURCES
CCISC	http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc/
National Comorbidity Guidelines	https://comorbidityguidelines.org.au/pdf/comorbidity-guideline.pdf
UK	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

Examples of Models, Tools and Activities that Support Integrated Treatment and Care

The working group on Integrated Treatment and Practice Examples would also like to acknowledge that there may be other examples of integrated treatment and care not highlighted with this review and hope that this publication supports other models to be identified and discussed.

All of the models, tools and activities described can be linked to the Integrated Treatment Models previously described and as outlined in the Final Report of the Royal Commission into Victoria's Mental Health System 2021 (page 332, Volume 3, Table 22.1). Eeach example has been grouped in this document according to each of the three models. It is of note that some examples have elements of more than one model. Further, some tools and activities are designed to be used across both the AOD and MH systems of care - these shared activities enable integrated treatment.

The Principles of Integrated Treatment (Inclusion, Access, Capability and Participation) described earlier within the Integrated Treatment Guidance document are in each example where there is a match in the description of each mode.

Model 1:

Multidisciplinary Teams

"Practitioners and clinicians, as well as peer workers, provide integrated care in a single service setting. There is a high degree of collaboration and coordination to deliver consumer care. For example, in an acute bed-based service, multidisciplinary teams such as mental health nurses, addiction medicine specialists, psychiatrists, lived experience workers, social workers and other allied health workers work together in an integrated way to deliver treatment, care and support."

(Department of Health, 2022)

Example 1

Eastern Health Mental Health Program Dual Diagnosis Clinician Shared Care Model

Developed in 2018 and designed for clinical mental health community and rehabilitation services to address Mental Health and Substance Use Issues. The model is supported by the locally developed Eastern Dual Diagnosis Service Dual Diagnosis Integrated Treatment Framework (Foster et al, 2022).

SETTING/SAMPLE	The Dual Diagnosis Clinician Shared Care Model (Foster et al, 2022) is now in its fourth year of operation and is well embedded in mental health continuing care and rehabilitation services. Dual Diagnosis clinicians (possessing both mental health and AOD expertise) are co-located with community mental health teams and deliver a shared-care, modified case management role via primary consultation to consumers and/or their carers; as well as providing secondary consultation and capacity-building focused activities to clinical mental health staff. Referral to the DD clinicians relies on the identification of an alcohol and drug issue by the mental health team. All mental health consumers can access the service, regardless of status under the Mental Health Act (2014). Referral and re-referral to the DD clinician is simplified as much as possible and in most instances is simply a verbal request from a mental health staff member; often occurring during the course of a multidisciplinary team case review. There is no limit to the number of times a consumer can be re-referred during their care episode with the mental health team. The length of engagement with the DD Shared Care Clinicians is variable, depending on need, but averages three months. It does not extend beyond the duration of engagement with the clinical mental health service.
COMPONENTS	Shared care involving dual diagnosis clinicians with a high level of alcohol and drug capability working with multidisciplinary, intensive case management teams providing: Stage-appropriate treatment; Integration of mental health and substance use treatment; Harm reduction: . Collaborative recovery model . Individual and family work.
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS AND CAPABILITY**	Meeting consumers where they are at by providing 'in-house' dual diagnosis recovery focused treatment.
ASSESSMENT	University led evaluation of HONOs as a measure and consumer, clinician evaluation of the model. Publication pending.
OUTCOMES	Early work found the program was associated with significant engagement in alcohol and drug interventions leading to reductions in consumer drug and alcohol use, improvement in symptom severity and life functioning and successful engagement with inpatient withdrawal admissions. It is a continuing operational model generating a significant amount of previously unavailable data on substance use and mental health connections. Independent evaluation has demonstrated a reduction in HONOs scores.
EVIDENCE TYPE	Ethics approved research on HONOS scores and the, evaluation of consumer and clinician feedback. The Dual Diagnosis Clinician Shared Care Model has been discussed in two published journal articles including Croton and Foster (2018). Foster, G., Robertson, J., Pallis, S., Segal, J. (2022)" The dual diagnosis clinician shared care model – a clinical mental health dual diagnosis integrated treatment initiative", Advances in Dual Diagnosis: Volume 15 Issue 3 ISSN: 1757-0972 Croton, G. and Foster, G. (2018), "Victoria's strategies towards integrated service delivery for people with mental health-substance use concerns", The Australian Journal on Psychosocial Rehabilitation,pp. 28-33
LEVEL OF EVIDENCE	Moderate
RESOURCES	This model can be tailored to needs of the service. Four full time clinicians can provide shared care support to approximately two hundred referrals per year. Senior medical leadership is required to support and oversee clinical work.
CONTACT FOR FURTHER INFORMATION	Dual Diagnosis and Service Development Administration EDDS@easternhealth.org.au

Example 2

NEXUS Dual Diagnosis Consultation Service Integrated Treatment Evidence for Activities Addressing Mental Health and Substance Use Concerns.

Carers Can Ask (CCA) - A collaborative engagement tool for families, carers and clinicians

Created by Simon Kroes of Nexus as a co designed North East Dual Diagnosis Youth twork project utilising input from carers, consumers and staff across Victoria. Designed to assist communication between carers and health services.

"What a terrific resource you have created!" Carer Consultant South Australia

Web link: https://www.svhm.org.au/ourservices/departments-and-services/n/nexus/carers-can-ask

SETTING/SAMPLE	The CCA was launched in 2013 and has been locally and globally distributed via the Caring Together and St Vincent's Hospital websites. It has been distributed via the Independent Mental Health Advocacy Service (IMHA) and the Mental Health Complaints Commission (MHCC). It has been used in practice extensively by carer consultant at Austin Hospital. Numerous hospitals across Victoria have modified it for their own geographical areas.
COMPONENTS	The CCA was designed to assist carers to have an informed conversation with a service about treatment, discharge planning and post discharge support. The resource provides questions that may assist carers to find out about treatment and discharge planning. This resource is also useful to services to assist them to understand the information needs of carers and to encourage carer engagement in treatment and discharge planning. It has also been used by staff and consumers to aid in communication.
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS, CAPABILITY AND PARTICIPATION.**	Empowering carers to have effective communication with treatment providers. 
ASSESSMENT	Survey instruments and focus groups across numerous sites.
OUTCOMES	Carer Consultants and carers who have used the CCA found that it enhanced knowledge and confidence in communicating successfully with treatment providers in relation to the person they care for.
EVIDENCE TYPE	CCA project officer evaluation report (NB: project officer was a Carer Consultant with lived experience). Services where CCA has been used (some with local modifications regarding service contact information) · St Vincent's Hospital · Royal Melbourne Hospital · Austin Hospital · Family Drug Help · Bendigo Dual Diagnosis Rehabilitation Unit · Alfred Hospital · Eastern Health · North Eastern Hume Mental Health Service · Goulbourn Valley Hospital · Orygen · Monash Health · Mercy Health · North West Area Mental Health
LEVEL OF EVIDENCE	Moderate
RESOURCES REQUIRED TO DELIVER THIS MODEL	Implementation Support from Management. Staff Training in how to use the CCA is 2 hours plus mentoring. Carer training in the CCA 90 minutes.
CONTACT FOR FURTHER INFORMATION	Simon Kroes nexus@svha.org.au

Example 3

REASONS FOR USE PACKAGE (RFUP)

Developed in 2012 by Simon Kroes and Kevan Myers of Nexus Dual Diagnosis Consultation Service. Successful pilots led to the awarding of a St Vincent's Hospital Catalyst Innovation fund of $50K which was used to collaboratively build the online version with the Faculty of Monash Art Design and Architecture. The website was launched in 2018 - https://reasonsforusepackage.com (Rose et al, 2018)

SETTING/SAMPLE	This integrated treatment tool has been in use for nearly ten years and is well embedded in St Vincent's Mental Health, Neami National, Mind Australia and Wellways. So far services in Victoria, Western Australia and Queensland have been introduced to the RFUP.
COMPONENTS/ PHILOSOPHY **INCLUSION, ACCESS AND CAPABILITY**	The RFUP combines the Reasons For Use Scale, Treatment Options for Consideration and Staff training and mentoring. "The RFUP increased insight for me, the consumer and for our workplace" Training participant Key philosophical underpinnings include: consumer and carer centred, harm reduction, strengths based and recovery orientated practice. **CASE EXAMPLE** Young women with depression who uses alcohol and occasionally heroin Time and Setting: First Prevention and Recovery Centre stay. The consumer approached a staff member and expressed cravings for heroin at day 3 of stay. Staff member offered RFUP. Consumer explored reasons for use and identified coping with unpleasant affect. Consumer selected grounding strategies from options and staff member used these with her the same evening. Strategies for longer term support were developed during remainder of PARC stay **RESULT** Improved DD Knowledge and confidence of both consumer and staff member The consumer stayed in the programme thus avoided heroin overdose risk. (Office of the Chief Psychiatrist (2012) Chief Psychiatrist's investigation of inpatient deaths 2008-2010 Victorian Government, Department of Health, Melbourne, Victoria).
ASSESSMENT	A National two state comparison trial was conducted with staff from Neami National in an ethics approved collaborative research project with Monash University and Nexus. Staff and Consumer data was collected via survey instruments, focus groups and mentoring notes. Further research data has been collected and analysed across a number of different organisations which support the findings. There is a current co- designed research project with Neami National expanding our knowledge of the youth consumer experience of the RFUP which is showing positive results.
OUTCOMES	The Reasons For Use Package was found to increase and sustain knowledge and confidence in dual diagnosis interventions. Furthermore Consumers find the resource improves their therapeutic relationship with staff and improves their ability to develop collaborative treatment goals.
EVIDENCE TYPE	Evaluation of consumer and clinician feedback. Four published articles to date. Including Kroes et al (2019) and Myers et al (2020) "Simple, meaningful and related to work practice" Training participant Myers, K., Kroes, S., O'Connor, S. & Petrakis, M. (2020). Reasons for Use Package: Outcomes From a Case Comparison Evaluation. Research on Social Work Practice, 1049731520915636. Kroes, S., Myers, K., Officer, S., O'Connor, S. & Petrakis, M. (2019). Dual Diagnosis Assessment: A Case Study Implementing the Reasons for Use Package to Engage a Marginalised Service User. Cogent Medicine (2019), 6: 1630097.
LEVEL OF EVIDENCE	Good.
RESOURCES REQUIRED TO DELIVER THIS MODEL	Implementation Plan includes an Organisation Agreement covering fidelity of use of the RFUP, Four hours staff training and two x 90 minutes mentoring sessions following use with consumers.
CONTACT FOR FURTHER INFORMATION	Kevan Myers and Simon Kroes nexus@svha.org.au

Example 4

BEFORE DURING AFTER (BDA) HARM REDUCTION PACKAGE

Simon Kroes developed the concept in 1995 prior to working at Nexus Dual Diagnosis Consultation Service. After commencing employment with Nexus Simon ran an initial multi-site pilot run across 5 MHCSS sites in 2016. Since then the BDA has been fully implemented at St Vincent's Community Care Unit and North Fitzroy Prevention And Recovery Centre (PARC), (St Vincent's and Wellways partnership), where it is now part of everyday practice.

St Vincent's Hospital Fitzroy Victoria, Australia.

Web link: https://www.svhm.org.au/our-services/departments-and-services/n/nexus/bda

SETTING/SAMPLE	This integrated treatment tool has been in use for nearly ten years and is well embedded in St Vincent's Mental Health, Neami National, Mind Australia and Wellways. So far services in Victoria, Western Australia and Queensland have been introduced to the RFUP.
COMPONENTS	The BDA provides a practical, user friendly and comprehensive approach to doing harm reduction work with consumers. It aims to provide staff with a structure and approach for conversations to explore harm reduction issues with consumers in a non-judgemental, engaging and systematic manner. The BDA package consists of a range of resources, training and mentoring, consultation and evaluation measures to aid implementation of the tool.
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS AND CAPABILITY**	Integrated dual diagnosis approach based on harm reduction and including consumer centred strengths and recovery orientated practice. User friendly and staff actually use it.
ASSESSMENT	A Quality Assurance Project was conducted at St Vincent's Mental Health Community Care Unit in 2016 after staff had used the BDA with their consumers.
OUTCOMES	The BDA Package was found to increase staff knowledge and confidence about how to explore harm reduction issues with their consumers. Consumers find the resource improves their therapeutic relationship with staff and improves their ability to develop collaborative treatment goals. It provides the organisation with a clear structure that can be measured. The BDA provides staff with specific skills and a tool they can use to engage consumers in meaningful conversations about harm reduction. Importantly the initial evidence demonstrates the ease of application and usefulness of the package. It has been used effectively with consumers aged 12 and up including at Austin Hospital Child Adolescent Mental Health Service.
EVIDENCE TYPE	St Vincent's Hospital and Monash University ethics approved collaborative research project and a Quality Assurance project focussing on clinician feedback. Presented to TheMHS conference 2017 and written up as independently referenced conference paper (Morrison et al 2017) Morrison, B., Kroes, S., Owens, C., Fairclough, F., Myers, K. and Petrakis, M. (2017). Before During After: A Harm Reduction Tool. 27th TheMHS Conference, 'EmbracingChange: Through Innovation and Lived Experience' 29 August-1 September (2017), Sydney, Australia
LEVEL OF EVIDENCE	Moderate
RESOURCES REQUIRED TO DELIVER THIS MODEL	Implementation Plan with Organisation re fidelity and use. Staff receive two hours training and 2 x one hour mentoring sessions.
CONTACT FOR FURTHER INFORMATION	Simon Kroes nexus@svha.org.au

Example 5

Westside Lodge (WSL) Dual Diagnosis Rehabilitation Centre

WSL was developed in 2018 as a residential rehabilitation program for people with dual diagnoses

SETTING/ SAMPLE	Westside Lodge is a 20 (planned for 30) bed specialist 3 month residential rehabilitation program designed for persons over 18 years of age who present with drug and alcohol problems and mental health issues. Mental health symptoms must be stable, and the person must have completed a substance detoxification prior to admission. Westside Lodge is appropriate for people who are beyond the acute phase of their illness. Mental health symptoms that need active treatment may include overnight support for issues such as anxiety or depression, or low-level psychosis. It is not suitable for people who: · Have a history of extreme antisocial behaviours; · Experience active suicidal thoughts; · Present with acute positive symptoms of psychosis; · Are undergoing acute withdrawal from substances; · Have a low body mass index that requires medical care; · Have a moderate to severe intellectual disability. Westside Lodge provides individually tailored three-month treatment programs. The programs are voluntary and best suited to people who are motivated to work towards their recovery. Individualised client care plans are developed with the client by a multidisciplinary team. This may include support for preparing for job interviews and seeking employment.
COMPONENTS	Westside Lodge provides tailored, individualised care plans, including group therapy and one-on-one treatment in a structured and therapeutic environment. The multidisciplinary team comprises Addiction Medicine consultants, and frontline staff including nurses, social workers, psychologists and dual diagnosis clinicians.
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS AND CAPABILITY**	Westside Lodge operates from a clinically-led, holistic, person-centred, recovery focused model driven by clients' Individualised Treatment Plans in an environment of support, mutual participation and harm reduction. The aim of Westside Lodge is to facilitate the health and wellbeing of clients experiencing co-occurring alcohol and other drugs and mental health issues who require a more specialised care.
ASSESSMENT	Qualitative evaluation of consumer experience.
OUTCOMES	WSL utilise data related to client post-discharge connections with AOD supports, mental health supports, such as, ongoing psychology and community interventions, as well as maintenance of a connection with their GP. HONOS is also utilised to inform client well-being at 3 and 6 months post-discharge.
EVIDENCE TYPE	WSL facilitate an Exit Interview with all clients who complete the program – qualitative evaluation emerges from this. WSL also utilise quantitative data which provides an overview of referral numbers, waitlist times, area of referral, substance use, mental health issues, physical health issues and a range of psychosocial considerations (for example, housing, family reunification if appropriate, community supports).
LEVEL OF EVIDENCE	Currently the level of evidence is moderate; however, WSL is building into our program research which will better evaluate our outcomes
RESOURCES REQUIRED TO DELIVER THIS MODEL	WSL operates with a multidisciplinary team approach. In order to deliver our model of care, WSL staff includes Dual Diagnosis clinicians (from nursing, social work, welfare and community development backgrounds). An AOD specific knowledge base as well as an established mental health understanding are crucial to delivering this model of care. WSL is currently establishing links with Dual Diagnosis specific services, which will add to our already established access to reciprocal specialist mental health services. WSL staff are encouraged to further develop their understanding of AOD and mental health issues through professional development. WSL facilitates a therapeutic Program which works to further establish a broader understanding of the 3 key pillars which underpin WSL. These are: a Harm Minimisation Approach; A Person-Centred Approach; and A Recovery Approach.
CONTACT FOR FURTHER INFORMATION	westsidelodgereferrals@wh.org.au

Example 6

Southcity Clinic

Southcity Clinic consists of an AOD/specialist addiction team embedded in an Area Mental Health Service.

SETTING/SAMPLE	It provides primary, secondary and tertiary consults and shared care in the CCT, CCU, PARC, Inpatient Unit (IPU) and Secure Unit (SECU) as well as community AOD and primary care. All mental health consumers are offered stage matched AOD interventions. These include referral to AOD treatment, supported and advocated referral into AOD treatment, case management to address requirements for AOD treatment, motivational enhancement, and harm reduction
COMPONENTS	• Individual staff work across inpatient and community addictions settings • Combined daily handover attended by inpatient & community addictions teams • Southcity linkage worker: works alongside consultation-liaison addictions team, links inpatient consumers to community programs • DD nurse practitioner: physical health and addiction treatment for community MH & addictions program • Addictions registrar: located in consultation liaison addictions, sessions in community addictions • Medical registrar: located in consultation liaison addictions and HARP • Southcity: shared case management of community MH, 'inreach' to inpatient psychiatric (low dependency & high dependency units), inreach to Dandenong secure extended care unit • Addiction psychiatrist in inpatient psych and consultation liaison addictions • Addiction psychiatrist for primary and secondary consultations in community psychiatric program
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS AND CAPABILITY**	A one-stop shop in an integrated setting that is client-centred. There is combined operational and clinical oversight of the addictions team (community mental health program and consultation, liaison and emergency psychiatry). Clinical risk management is combined, including a mental and addiction health high risk panel.
ASSESSMENT	Both assessment and treatment offered is integrated: • Joint &/or collaborative assessments of community MH and addiction referrals • Shared care of community MH & AOD consumers, mutual attendance at clinical reviews & care team meetings • Shared care of MH consumers attending residential AOD treatment, remote reviews • Collaborative case management and stepped care between inpatient & community AOD teams • Stage matched AOD interventions for all MH service consumers and families • Pre contemplation: harm reduction, rapport building, behavioural support, staff education • Contemplation: harm reduction, rapport building, motivational enhancement, staff education • Preparation: recovery coaching, orientation to AOD treatment options, staff education • Action: AOD goal setting, supported referral into AOD treatment, staff education • Maintenance: recovery coaching, staff education
OUTCOMES	HoNOS (Health of the Nation Outcome Scales) LSP-16 – an abbreviated version of the Life Skills Profile Basis- 32 - is used for adults and older people to rate their own mental health. Phase of Care - prospective description of the primary goal of care for a consumer at a point in time.
EVIDENCE TYPE	Qualitative: staff satisfaction, consumer engagement Quantitative: number of addiction referrals
LEVEL OF EVIDENCE	Case series, case reports
RESOURCES REQUIRED TO DELIVER THIS MODEL	In addition to the components and multidisciplinary staff team, staff participate in specialist addiction training delivered by addictions staff across inpatient medical, psychiatric and community programs, including: alcohol and opioid use, methamphetamine use disorders and psychosis, withdrawal management, prescribing for addictions, harm reduction and AOD treatment options.
CONTACT FOR FURTHER INFORMATION	southcityclinic@alfred.org.au

Example 7

The Substance Use and Mental Illness Treatment Team (SUMITT) Model

Established in 1998, SUMITT is funded by the Department of Health to provide direct care to people with co-occurring substance use and mental health issues, and to strengthen the dual diagnosis capacity of staff in mental health services.

SETTING/SAMPLE	SUMITT's current reach extends to 8 metropolitan Area Mental Health Services (AMHS) in Melbourne, including 5 adult services (i.e. Inner West Mental Health Service, Northern Area Mental Health Service, North West Area Mental Health Service, Mid-West Area Mental Health Service, and Mercy Mental Health), a child and adolescent service (i.e. Royal Children's Hospital Mental Health), a youth service (i.e. Orygen Youth Health), and an aged service (i.e. North West and Inner West Aged Psychiatry Assessment & Treatment Team). SUMITT covers community mental health and inpatient units within the above AMHS catchment. SUMITT also provides similar service to youth homelessness services including Melbourne City Mission and Hope St Youth and Family Services in north-western metropolitan Melbourne. SUMITT is a unique specialist dual diagnosis program in that it has the capacity to continue to provide services to consumers moving from one AMHS to another within its catchment area. In doing this, it covers about a third of the population of metropolitan Melbourne.
COMPONENTS	SUMITT provides highly specialised, integrated treatment, care and support to individuals as well as secondary consultation to professionals working in mental health services or alcohol and other drug services. Specifically for shared care consumers, SUMITT provides: • Assessment • Case formulation • Brief interventions • Harm reduction strategies • Motivational Interviewing • Counselling e.g. Cognitive Behavioural Therapy (CBT), supportive psychotherapy • Problem solving • Assertive outreach • Relapse prevention • Pharmacotherapy recommendations & support • Referral and liaison e.g. for detoxification or rehabilitation treatments • Capacity building
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS AND CAPABILITY**	SUMITT places value on multidisciplinary collaboration for developing patient centred and recovery focused care. This is demonstrated through close collaboration and consultation the AMHS SUMITT is involved with. SUMITT also recognises the value of working collaboratively with treating teams to deliver holistic care that meet consumers' needs. In doing so, it co- locates its services in partnership with AMHS taking a collaborative care approach. This approach has been beneficial for providing highly specialised, integrated treatment, care and support to patients and for strengthening the capacity of mental health practitioners to respond to co-occurring mental health and substance use and addiction. **To be eligible for SUMITT:** The consumer must be registered with an AMHS in the SUMITT catchment area and be experiencing: a. High Alcohol and other Drugs (AOD) issues b. High mental health needs c. Significant psychosocial complexity d. Poor capacity to engage with AOD services / previous unsuccessful attempts to engage with AOD services The consumer must be registered with a youth homelessness service in the SUMITT catchment area. a. The threshold for youth homelessness consumers is more flexible due to the nature of the consumer group.
ASSESSMENT	REDCap surveys (3) have been designed for quality improvement and to obtain feedback from consumers SUMITT is working with, and the services referring to SUMITT. The first two surveys are designed for feedback obtained from the consumer. First survey is completed whilst working with clients (i.e. client service mid-treatment survey), and the second survey is completed at the point of discharge (i.e. client service end of treatment survey). The third survey is designed for feedback obtained from the referrer and/or treating team. This survey is designed to be given at the end of treatment for the clinicians/teams referring to known as SUMITT 'Service' Survey (End of Treatment).
OUTCOMES	Preliminary results from the quality improvement surveys indicate very positive experiences from consumers and services referring to SUMITT.
EVIDENCE TYPE	Qualitative and quantitative
LEVEL OF EVIDENCE	SUMITT consists of 14.2 Full Time Equivalent (FTE) multidisciplinary senior clinicians, 0.4 consultant addiction psychiatrist, 0.4 FTE psychiatry registrar and 1.0 FTE administration assistant. All clinical staff have a minimum of 5 years' experience in mental health and/or AOD services.
RESOURCES REQUERIED TO DELIVER THIS MODEL	westsidelodgereferrals@wh.org.au
CONTACT FOR FURTHER INFORMATION	https://www.nwmh.org.au/contact

Model 2:

Co-location and Care Co-ordination Partnerships

"DIFFERENT SERVICES PHYSICALLY COLOCATE AND DELIVER COORDINATED CARE"

For example, in a community mental health service, a mental health service and a non-government provider of alcohol and other drug services physically co-locate. Through care coordination and single care planning, they deliver the integrated services needed to meet the consumer's needs.

Example 1

The Integrated Care Pilot (funded by the Victorian Department of Health), a collaboration of service providers in Southern Metropolitan Melbourne in the implementation of Comprehensive continuous integrated system of care model (CCISC)

CCISC is a model for integrated SYSTEM design, rather than a model of integrated clinical care. Based on the recognition that co-occurring conditions are an expectation, CCISC offers a process by which systems with diverse programs and staff can organize themselves within their available resources to provide appropriately matched integrated services to the diverse individuals and families with co-occurring needs who present in all types of settings and programs.

SETTING/ SAMPLE	Built with the understanding that most service users have co-occurring needs, the CCISC is a practical, whole-of-organisation process for improving services' ability to meet the needs of those individuals and their families. The pilot involved 9 organisation (First Step as lead) from the Southern Melbourne Area. It was completed at the end of 2022, and the final report from the evaluators was provided to the Department of Health in early May.
COMPONENTS	The CCISC has been developed over decades and includes a comprehensive array of resources: 1. A set of underlying principles 2. A comprehensive set of 'tools' designed to facilitate implementation of welcoming, person and family-centred, recovery and resiliency-oriented, integrated systems of care into existing real-world systems. 3. A stepped approach for organisations through the process of implementation 4. A self-evaluation process for organisations and programs to assess themselves against the principle, and develop an action plan for change. The ZiaTools are designed to be used by systems in transformation to help system partners learn how to apply CCISC principles as they move towards complexity capability in all areas of practice, programming and design. They include tools that can be used for systems, programs, primary or behavioural health, staff competency and practice health.
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS AND CAPABILITY**	The CCISC is an integrated recovery philosophy that makes sense from the perspective of both the MH and the AOD treatment system.The following 8 principles guide the model: 1. Co-occurring issues and complexity are an expectation NOT an exception. 2. The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship 3. All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring-capable services for different populations. 4. When co-occurring issues and conditions are present, each issue or condition is considered to be primary 5. Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue. 6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue. 7. Recovery plans, interventions, and outcomes must be individualized. There is no one correct dual-diagnosis program or intervention for everyone. 8. CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring-capable.
ASSESSMENT	The CCISC has been assessed by the Substance Abuse and Mental Health Services Administration (US department of Health and Human Services) as being a model of best practice. There have been many papers written in assessment of this model and its efficacy in the delivery of integrated service responses for people who have complex co-occurring conditions. See references representing some of the available publications. First Step expects the final evaluation report of the pilot to be made publicly available soon
OUTCOMES	The final report includes the following observations: 1. The principles align strongly with the mandates of the Royal Commission into Victoria's Mental Health System (and to other reports including the Productivity Commission Report into Australia's Mental Health System among others) 2. CCISC transforms culture by bringing awareness to language, attitude and unconscious biases towards people living with complexity and building a common language about those issues. In this way it transforms not only approaches to clients to but to colleagues, to the way we approach challenges at work etcAll continuing partners have successfully engaged and empowered staff to improve integration in their pilot programs 3. The principles of the model resonated strongly with the ICP Lived Experience consultation group 4. All continuing partners have successfully engaged and empowered staff to improve integration in their pilot programs 5. Organisations discovered that they are doing far more integrated work than they realised, and identified how the siloed systems in AOD and MH fail to acknowledge and account for this. 6. Most partners have sought to expand the initiative into other parts of their organisations 7. Programs have discovered that they are doing far more integrated work than they realised, than is recognised or funded 8. Enabled organisations to recognise the importance of addressing internal gaps and reinforcing, organising and consolidating through policy and procedures.
EVIDENCE TYPE	See references
LEVEL OF EVIDENCE	Moderate
RESOURCES REQUIRED TO DELIVER THIS MODEL	This model utilises the existing resources of participating services, alongside a commitment to develop dual diagnosis capability across the system.
CONTACT FOR FURTHER INFORMATION	info@firststep.org.au

Model 3:

Service Delivery Partnerships

"A mental health service partners with another care provider, such as a non-government organisation, to deliver some aspects of the consumer's care within the mental health service.

For example, in a community bed-based service, the mental health service could partner with a non-government organisation to provide peer-support workers or counselling for consumers with substance use issues or addiction, delivered in the mental health service."

(Department of Health, 2022)

Example 1

Dual Diagnosis Peer Led Group Program

Commencing in 2018 and designed for people living with mental health and alcohol and drug concerns receiving support from mental health and alcohol and other drug services.

The development of this 'Peer Led' model has been significantly informed by the Dual Diagnosis Consumer and Carer Advisory Council and the Dual Diagnosis Working Group (Mental Health and AOD Clinicians and practitioner from form across the Eastern metropolitan region). This partnership is referred to as the In Tandem Dual Diagnosis model (ITDDM).

"It is the Mission of the Eastern Metropolitan Region Dual Diagnosis Consumer and Carer Advisory Council and the Dual Diagnosis Working Group to ensure that residents of Eastern Metropolitan Region of Melbourne are provided the highest quality hospital and community-based mental health and substance use treatment services to adults, youth, children and their families.

We envision a community where co-occurring mental health concerns and substance misuse, dependency and addiction are recognized as health issues of equal concern and where stigma and other barriers to recovery are eliminated."(DD 'In tandem' Model Terms of reference, 2022)

SETTING/SAMPLE	This group program is delivered by people with a lived or living experience as consumers and carers of co-occurring mental health and substance use concerns. The Dual Diagnosis Peer-Led Group Programme is for consumers receiving care at clinical community mental health or bed based services and alcohol and drug residential services and living with co-occurring mental health and substance use concerns. Peer facilitators are supported by a member of the clinical team in each group. The Dual Diagnosis Peer-Led Discussion Groups aim to support positive outcomes for individuals experiencing co-occurring mental health and substance use concerns. Facilitators of the group program are those with a lived experience of dual diagnosis, meaning the groups are peer-led, acknowledging a mutual experience, strengths-based and consumer-focused. The EH Dual Diagnosis Peer-Led group program runs weekly across multiple sites including Inpatient Units (IPUs), Adult Prevention and Recovery Care (PARC), and Community Care Unit (CCU). **The program aims to:** Provide participants with an opportunity for connection, skill building, and learning about the relationship between substance use and mental health; Enable participants to explore autonomy, resilience, their own personal values and develop their own goals and needs; Support positive outcomes for participants by providing a non-judgmental environment, one that is flexible to the stages of individual recovery journeys.
COMPONENTS	The Dual Diagnosis Peer-led groups are a brief intervention for consumers experiencing both mental health and alcohol and drug concerns that promote trust, connection, belonging and understanding (Croton & Foster 2018). Peer-led groups "plant the seed" for further recovery possibilities and can lead to "light bulb" moments. Topics are flexible, informal, relaxed, and conversational, providing an opportunity for growth and understanding. Peer facilitators can easily 'steer' conversations. Their shared experience, adaptability and flexibility are strengths of the role: sessions are "based on the interests and needs of the group that day". Program content and delivery is tailored for different settings.
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS, CAPABILITY AND PARTICIPATION**	Recovery modelling via lived experience leadership.
ASSESSMENT	An evaluation template has been developed and will measure Participants' experience/satisfaction of the program process; perceived engagement in the program content; perception of connectedness to the group program; and facilitators' observations of participant's engagement in group process and content.
OUTCOMES	Anecdotal reports from participating consumers and clinicians note evidence of change talk inspired by the Lived Experience led discussion.
EVIDENCE TYPE	Ethics approved evaluation has commenced and includes quantitative and qualitative assessment using questionnaire specifically designed for this activity.
LEVEL OF EVIDENCE	Low but promising based on anecdotal reports Has been profiled in the Dual Diagnosis 'In Tandem Model' documentary, as per the attached link The Dual Diagnosis Service (easternhealth.org.au).
RESOURCES REQUIRED TO DELIVER THIS MODEL	8 -10 paid facilitators with a lived experience of dual diagnosis capable of delivering six groups weekly. 4 clinician (existing staff) mentors with dual diagnosis capability to provide support and debriefing. Organisational capacity to train lived experience facilitators.
CONTACT FOR FURTHER INFORMATION	Dual Diagnosis and Service Development Administration EDDS@easternhealth.org.au

Example 2

Eastern Health Mental Health Program and Anglicare Victoria Inpatient Psychiatric Unit Dual Diagnosis 'In reach' Model developed in 2016. Also known as Dual Diagnosis Program.

SETTING/SAMPLE	The model is now in its six year of operation and is well embedded in Adult Inpatient Psychiatric Units and is now being replicated in the Adolescent Inpatient Unit with Youth Substance Advisory Service (YSAS). The Dual Diagnosis (DD) Program is a specialist program, which offers one to one short and long term therapy to individuals experiencing problematic substance who also have a formal diagnosis or self-reported mental health condition. The Dual Diagnosis Program aims to support individuals and their families to address both substance use and mental health simultaneously. Working from a harm reduction and trauma informed model of therapy, the program offers intake and assessment for individuals in the community who have been in- patients at Maroondah Inpatient Psychiatric Units 1 & 2 and Upton House. In addition, the program completes comprehensive biopsychosocial assessments and delivers intensive one to one counselling. Working from a step up step down approach the program will also support referrals to additional support programs for case v, primary health, pharmacotherapy and family support.
COMPONENTS	Anglicare Alcohol and Drug workers (identified as Dual Diagnosis Counsellors) provide 'in reach' into IPUs to engage with AOD services post discharge. Referrals identified by IPU multidisciplinary teams; and includes: · Stage-appropriate treatment; · Integration of mental health and substance use treatment; · Individual and group modalities; · Provision of brief interventions, · Harm reduction and · Time-unlimited services; · Assertive engagement and support for families/carers.
KEY PHILOSOPHICAL UNDERPINNINGS **INCLUSION, ACCESS AND CAPABILITY**	Welcoming approach to dual diagnosis supported by interagency collaboration.
ASSESSMENT	Measured against 28 day IPU readmission, impact on AOD identification by IPU staff and engagement with AOD services post discharge (Croton and Foster 2018)
OUTCOMES	Early work found the program was associated with increased identification of AOD problems in IPUs (from 6 - 30% improvement within 12 months), increased engagement in alcohol and drug interventions and a halving of 28 day re-admissions in this group as per the benchmark of 14%. Client Outcomes of the comparable K10 data gathered, 70% of clients had an improvement in their K10 scores during the time they were engaged in counselling. This was recorded over the 2020-2022 financial years. Readmission rates for the period Jan – Jun 2022 identified that 84.94% of consumers referred from inpatient units were not readmitted at any time during or at the conclusion of an episode of care after referral and engagement with Anglicare Dual Diagnosis services. For the 2021-2022 financial year 87.41% of consumers referred from inpatient units were not readmitted at any time during or at the conclusion of an episode of care after referral and engagement with Anglicare Dual Diagnosis services.
EVIDENCE TYPE	Partnership evaluation of 28 day readmission data, referral and follow up with service data.
LEVEL OF EVIDENCE	Moderate
RESOURCES REQUIRED TO DELIVER THIS MODEL	Alcohol and drug counsellors (identified as Dual Diagnosis capable) delivering 'in reach' two sessions a week with capacity to deliver follow up services. Access to reciprocal specialist mental health and alcohol and other drug training.
CONTACT FOR FURTHER INFORMATION	Dual Diagnosis and Service Development Administration EDDS@easternhealth.org.au

Conclusion

This paper is only the starting point in describing different ways in which integrated treatment can be implemented within mental health services. We acknowledge that other services may have developed their own activities, tools and practices and extend the invitation to share your initiatives with VAADA or the VDDI to continue to generate innovative solutions to the complex issue of co-occurring mental health and substance use.

As a foundation, following the principles of integrated treatment and aligning these with one of the 3 configurations as prescribed by the Royal Commission will be helpful in ensuring that any model meets the needs of those accessing support. Considering successful existing tools, activities and models as described will also help you in considering the best approach.

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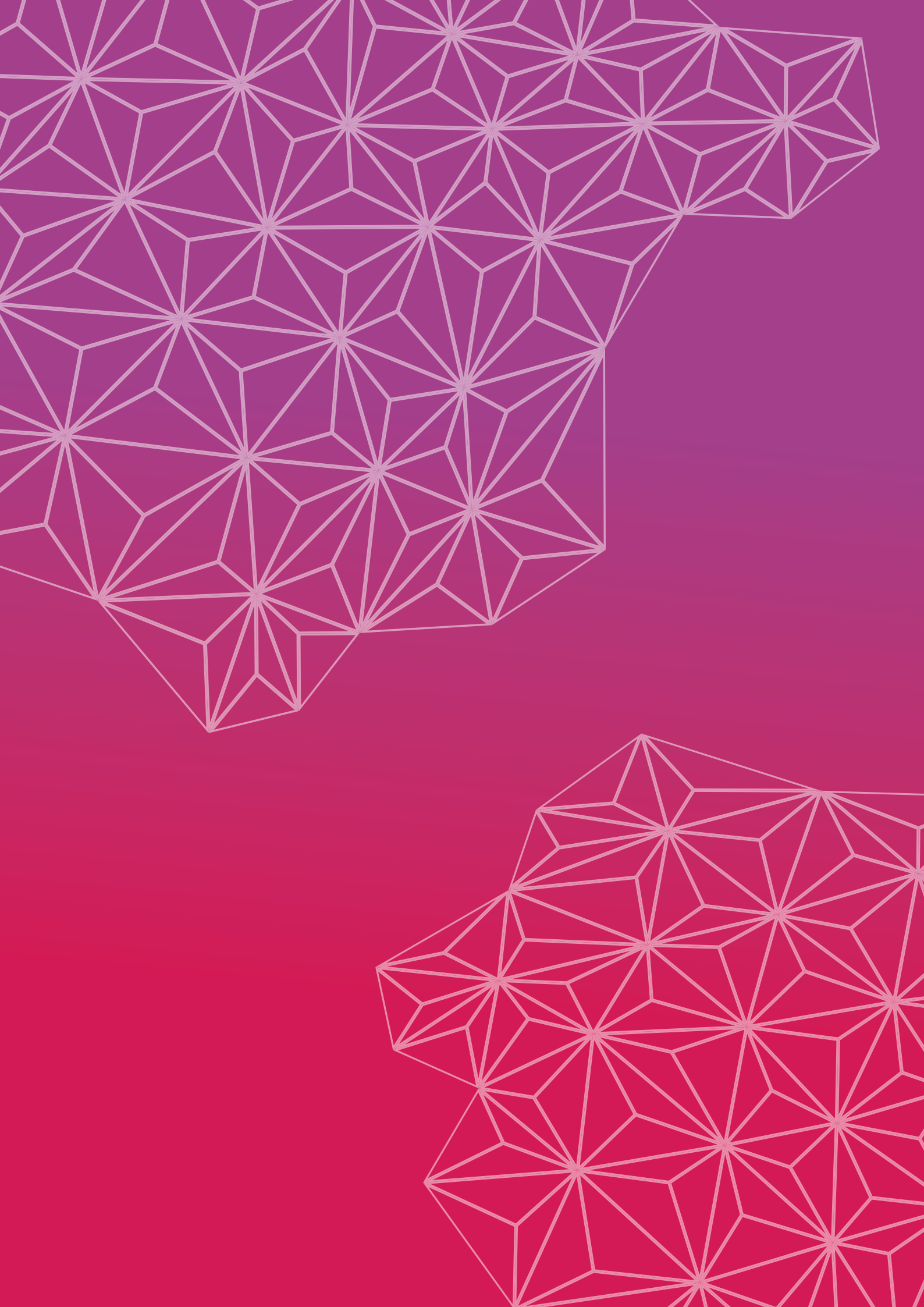

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