MONASH University

Dual diagnosis interventions in mental health community support services: outcomes from a national trial to enhance skills in direct practice staff

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Abstract

Brief Dual Diagnosis Background: There is a large body of literature going back over 30 years which explores "dual diagnosis"(Roberts,2013). Seminal texts in Australia include McDermott and Pyett (1993) 'Not Welcome Anywhere: People who Have Both a Serious Psychiatric Disorder and Problematic Drug Or Alcohol Use' which highlighted the negative impacts of service design on this consumer group. International literature has explored the extent of co-morbidity experienced by people suffering from mental illness and using alcohol and other drugs, and the problems with parallel and sequential treatment approaches (Drake, Mercer-McFadden, Mueser, McHugo and Bond, 1998). Nexus Dual Diagnosis Consultation Service, where this candidate works is a component part of the Victorian Dual Diagnosis Initiative (VDDI) (Roberts, 2013; Allsop, 2008), which commenced in 2000. Similar initiatives were developed in other states in Australia (NSW Health 2000, Pennebaker, Robinson, Gomes, Quigley, Bennetts and Browton 2001; Groenkjaer et al 2017). More recently in Australia both the Royal Commission into Victorian Mental Health System Final Report 2021 and the Federal Government Productivity Commission into Mental Health 2020, strongly endorsed the need to address the co-occurrence of mental health and substance use.

Reasons For Use Package: The Victorian State government policy document Dual Diagnosis Key Directions for Service Outcomes (Department of Human Services, 2007) called for staff in mental health and Alcohol and Other Drug services to develop their capacity to provide evidence-based dual diagnosis treatment. The Reasons For Use Package was designed by Simon Kroes and Kevan Myers (the candidate) to address this issue. It combines the Reasons for Use Scale with optional intervention strategies, training and mentoring. An initial pilot of the RFUP in 2012, which included staff from Neami National, led to a partnership between Nexus, Neami National and Monash University Department of Social Work to pursue this research project.

The research question was: What is the perceived efficacy of a dual diagnosis intervention strategies package, namely the Reasons For Use Package (RFUP)?

A subsidiary research question was: What is the Consumer experience of using the RFUP with mental health support workers?

Methods: A case-comparison trial was conducted with staff employed by Neami National in Victoria who received training and mentoring in the Reasons For Use Package compared to a matched sample of staff respondents from the same organisation in N.S.W. A mixed methods approach including staff and consumer surveys, focus groups and a case study was used to collect data for the study.

Results: Self-reported improvements in perceived knowledge and confidence for the group receiving the RFUP training and mentoring Victorian Cohort. Focus group feedback indicated staff benefitted from a package providing a framework for implementing strategies with service users where substance use relates to positive symptoms and medication side effects, social situations, peer pressure, managing unpleasant affect and enhancement. Consumer respondents also gave positive feedback on their experience of using the RFUP.

Conclusions: The Reasons For Use Package shows promise as an aid to dual diagnosis capacity building and can have a positive impact for consumers.

Publications during enrolment

Myers, K., Kroes, S., O'Connor, S. and Petrakis, M., 2017. The reasons for use package: Development research and implementation lessons for the field. In *26th Contemporary TheMHS in Mental Health Services,'People: Authenticity starts in the heart': 2016 TheMHS Conference Proceedings, Australia* (pp. 1-10).

Myers, K., Kroes, S. and Petrakis, M., 2018. A foundation for dual diagnosis practice: Wisdom, tools and resources. In *Social Work Practice In Health* (pp. 135-152). Allen and Unwin.

Myers, K., Kroes, S., O'Connor, S. and Petrakis, M., 2018. The reasons for use package: How mentoring aids implementation of dual diagnosis practice. *New Paradigm*, pp.25-29.

Petrakis, M., Robinson, R., **Myers, K.,** Kroes, S. and O'Connor, S., 2018. Dual diagnosis competencies: A systematic review of staff training literature. *Addictive Behaviors Reports*, *7*, pp.53-57.

Kroes, S., **Myers, K.,** Officer, S., O'Connor, S. and Petrakis, M., 2019. Dual diagnosis assessment: A case study implementing the reasons for use package to engage a marginalised service user. *Cogent Medicine*, *6*(1), p.1630097.

Myers, K., Kroes, S., O'Connor, S. and Petrakis, M., 2020. Reasons for use package: Outcomes from a case comparison evaluation. *Research on Social Work Practice*, *30*(7), pp.783-790.

Thesis including published works declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes *five* original papers published in peer reviewed journals, an industry journal, a chapter in a Social Work text book and a conference proceedings paper. The core theme of the thesis is exploring the perceived impact of the Reasons For Use Package on dual diagnosis capacity of staff from a Mental Health Community Support Service with a subsidiary exploration of the consumer experience of the RFUP. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the Department of Social Work under the supervision of *Associate Professor Melissa Petrakis*.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of this Thesis my contribution to the work involved the following:

Thesis Chapter	Publication Title	Status *(published, in press, accepted or returned for revision, submitted)*	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution*	Co-author(s), Monash student Y/N*
Chapter 1	A Foundation for Dual Diagnosis Practice: Wisdom, Tools and Resources	Published	50% Reviewed literature, conducted analysis, prepared and revised manuscript.	Kroes, S. 40% input into manuscript. Petrakis, M. 10% input into manuscript.	Yes No
Chapter 2	Dual diagnosis competencies: A systematic review of staff training literature	Published	35% Reviewed literature, conducted analysis, prepared and revised manuscript.	Petrakis, M. 30% input into manuscript. Robinson, R. 15% input into manuscript. Kroes, S. 15% input into manuscript. O'Connor, S. 5% input into manuscript.	No Yes Yes No
Chapter 4	The reasons for use package: development research and implementation: lessons for the field	Published	50% Reviewed literature, developed instruments, collected data conducted analysis, prepared and revised manuscript.	Petrakis, M. 10% input into manuscript. Kroes, S. 30% input into manuscript. O'Connor, S. 10% input into manuscript.	No Yes No
Chapter 4	The Reasons For Use Package: how mentoring aids implementation of dual diagnosis practice	Published	55% Reviewed literature, developed instruments, collected data, conducted analysis, prepared and revised manuscript.	Petrakis, M. 10% input into manuscript. Kroes, S. 30% input into manuscript. O'Connor, S 5% input into manuscript.	No Yes No
Chapter 4	Reasons for Use Package: Outcomes From a Case Comparison Evaluation	Published	55% Reviewed literature, developed instruments, collected data conducted analysis, prepared and revised manuscript.	Petrakis, M 10% input into manuscript. Kroes, S. 30% input into manuscript. O'Connor, S 5% input into manuscript.	No Yes No

I have not renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.
Student name: Kevan Myers

Student signature: **Date: 14/9/2022**

I hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.
Main Supervisor name: Associate Professor Melissa Petrakis

Main Supervisor signature: **Date: 14/9/2022**

Acknowledgements

I would like to dedicate this thesis to my father, John Myers who passed away in late 2021 after a short illness and my mother Shirley Myers who has been his partner in life since they met over 60 years ago. Both my parents were a constant source of support and encouragement for all my endeavours over the years, in particular with respect to taking on a PhD. It is worth noting that my mum left school at 15 despite being a bright student to begin work. The short pathway from school and home to wife and mother was historically common and ultimately fulfilling to a large degree, but mum often remarked on how opportunities where lost due to her gender. In particular she remembers being earmarked for a management course which was then whisked away when she fell pregnant. My Dad worked as a draughtsman for many years and studied at night school until at the age of 37 he went to University and seven years later became an Architect. He remembered being mistaken as a lecturer on his first day!

I mention these events from the past as they aptly illustrate how education is not a level playing field, but that nevertheless with support and hard work it can be a fruitful area of endeavour. This reminds me as a social worker that there is a responsibility to look at how any research ultimately impacts on those participating in research and those who may be a beneficiary of the research rather than seeing research solely as a formulaic process.

Simon Kroes of Nexus Dual Diagnosis Consultation Service has been a friend, colleague and collaborator of mine for the past decade. His contribution to the field has been highly significant particularly through the development of Dual Diagnosis tools and resources such as the Reasons For Use Package. Simon is a co-author on all five papers included in this thesis and lead author in a separate related article referred to in the appendices that reports on a case study and consumer feedback (Kroes et al, 2019) that will be included in his own thesis.

Associate Professor Melissa Petrakis has been a key contributor to supporting the development of and research into the Reasons For Use Package. Her early support for the initial pilots of the package and consequent encouragement for further research through an academic process has been sustained for over ten years. I am particularly grateful for her ongoing support as main supervisor during my candidature and guiding me through numerous learnings. Associate Professor Petrakis is the Director of Social Work, Innovation, Transformation and Collaboration in Health (SWITCH) Research Group at the Department of Social Work Monash University.
I'd also like to acknowledge Associate Professor Cameron Duff of Royal Melbourne Institute of Technology (RMIT), formerly of Monash University as an associate supervisor for his role in supporting the research.

Neami National staff and consumers who have contributed their time and thoughts for this research project. The spirit of generosity and sharing ideas from a number of key staff include Sarah O'Connor who supported and facilitated the research internally at Neami National and subsequently has contributed to four of papers in this Thesis. Sarah Officer who was employed at Neami National at the time, contributed her thoughts and ideas through a case study in the paper referred to in the appendices which explores the consumer experience of the RFUP (Kroes et al 2019)

Professor David Castle and his team at the Mental Health Research Collaborative Therapy Unit developed and validated the Reasons For Use Scale (Spencer et al 2002). Professor Castle has encouraged the development of the Reasons For Use Package and subsequent research through his chairing of the St Vincent's Mental health and Addiction Medicine Research Advisory Group which oversees research projects at St Vincent's. Professor Castle has been engaged to begin a

new role at the Centre for Addiction and Mental Health in Toronto and has expressed keen interest in continuing to collaborate in a research trial of the RFUP in Canada.

Chris Hynan Manager is the Nexus Dual Diagnosis Consultation Service and Department of Addiction Medicine at St Vincent's Hospital Melbourne. Chris is also the current chair of the Victorian Dual Diagnosis Initiative (VDDI) Leadership Group whose membership includes; Victorian Department of Health, Families where a Parent has a Mental Illness (FAPMI), Victorian Alcohol and Drug Association (VAADA), Centre For Mental Health Learning (CMHL), Dual Diagnosis Consumer Carer Advisory Committee (DDCCAC) and representatives from the VDDI Metro Teams and Rural Dual Diagnosis Forum. Chris has been a key supporter of the RFUP development and has encouraged research and implementation of this resource.

Finally I would like to thank my wife Meggie who has supported me through the trials and tribulations of doing higher degree research. Without her encouragement it would have been impossible to complete this undertaking. I'd also like to thank my three children, Juanita, Alkina and Keelin who have also supported this endeavour and importantly have been part of my self-care process allowing me to maintain a steady perspective even during the Covid-19 pandemic.

Glossary including Acronyms

ASSIST.3 W.H.O	Alcohol Smoking and Substance Involvement Screening Test Version 3 World. Health. Organisation https://www.who.int/publications/i/item/978924159938-2
AOD	Alcohol and Other Drug
AMHS	Area Mental Health Service
Carer	A person who has a care relationship with a consumer
Collaborative Recovery Model (CRM)	A model of practice developed at Neami National with Wollongong University
Consumer	Service user: sometimes referred to as a client of the service
Consumer and carer centred Practice	Provision of Service is tailored to meet the needs of the individual and their Carer
Dual Diagnosis	The co-occurrence of a mental health and substance use issue
IPS	Intentional Peer Support
MHCSS	Mental Health Community Support Service
Mentor	A person who provides mentoring
Mentee	A person who receives mentoring
Motivational Interviewing	A Collaborative conversation approach Introduced by Dr William Miller and Dr Stephen Rollnick. References 2012
Neami National	An Australian based mental health provider
PDRSS	Psychosocial Disability Rehabilitation Support Service
RFUP	Reasons For Use Package

RFUS	Reasons For Use Scale survey questionnaire a component of the RFUP
Recovery Focused	An approach which seeks to aid individual consumer recovery journeys see Rapp et al 2011
Service user	sometimes used in preference to consumer or client particularly in the Australian AOD sector
Social work	A profession engaged in Social Work practice
Staff member	A person employed by an agency to provide service to consumers
Strengths Model	An approach that was popularised as a counter position to deficit based approaches see references Rapp et al 2011
Substance use	The use of any substance which effects the mind or body

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Chapter 1

Introduction to Thesis

Thesis Outline

This thesis inclusive of published works comprises of five chapters and includes five published works. The choice of thesis inclusive of published works was deliberate in that the research partnership, which is described below, supporting the project was keen to create a published and accessible evidence base in an mental health industry sector where, practice based research was developing in earnest around 2013-15 when this candidature was first envisaged. With the changes brought in due to the National Disability Insurance Scheme (Foster, Henman, Tilse, Fleming, Allen, and Harrington, 2016.), community mental health providers were keenly aware of the need to capture what they did and what impact this had for service users. In part this was a reaction to the challenge presented by the NDIS model, which was built on the concept of enduring impairment as opposed to the recovery model which recognised the fluctuating nature of mental health. This candidate, who is employed in a state-wide initiative, which aimed to improve outcomes for service users who experienced mental health and alcohol and other drug issues, also felt that published works could enhance cross sector capacity building.

Outline of Chapters

Chapter One

The first chapter is the introduction, which gives a broad outline of the thesis including a background to the issues surrounding the mental health service sector's response to consumers and carers who experience "dual diagnosis" co-occurring mental health and substance use. This chapter includes the first published work, which is a book chapter entitled 'A Foundation for Dual Diagnosis Practice: Wisdom, Tools and Resources'. The chapter is part of a Social Work textbook edited by Associate Professor Melissa Petrakis titled Social Work Practice in Health: An introduction to contexts, theories and skills. The book's editor "draws on the experience and

expertise of leading researchers and practitioners to provide a guide to the disparate settings in which social workers are engaged and the conceptual frameworks and skills needed for effective practice"(Petrakis, 2018 Back Cover). The dual diagnosis chapter begins by exploring the literature with respect to the context, prevalence and impacts of dual diagnosis and outlines a number of tools and approaches, which aim to enhance practice including the Reasons For Use Package.

Chapter Two

The second chapter explores the literature with respect to dual diagnosis. This chapter begins by exploring the literature with respect to the key conceptual models of mental health and substance use historically and then explores the case for an integrated treatment approach as opposed to sequential or parallel approaches to mental health and substance use. The second part of the literature chapter, is primarily focussed, on exploring dual diagnosis capacity buil ding. The second published work in this thesis appears in this chapter which is a systematic literature review titled "Dual diagnosis competencies: A systematic review of staff training literature" which identified gaps in the literature. This chapter clearly establishes the link between the existing literature and the rationale for this study.

Chapter Three

The third chapter begins with a more detailed explanation of the RFUP with particular attention to how this package relates to previous methods of dual diagnosis capacity building. It then covers methodology and ontology and discusses the rationale and methods used to explore the research questions. This chapter also explains the intervention timelines for the two state comparison trial.

Chapter Four

The fourth chapter covers results and as well as including three published papers, also has two sections which reports on consumer feedback and focus group findings. The first published paper in the results chapter is titled "The Reasons for Use Package: deve lopment research and implementation: lessons for the field".

This paper was presented at the TheMHS (The Mental Health Services) conference, Auckland, New Zealand in 2016.

The second published works in the results chapter is titled "The Reasons For Use Package: how mentoring aids implementation of dual diagnosis practice.'

This paper was published in New Paradigm: The Australian Journal of Psychosocial Rehabilitation, which is produced by a coalition of Australian Mental Health Peak bodies including Vicserv the Victorian Peak Mental Health Service Body. This particular edition of New Paradigm, was dedicated to practice based research with the cover title "Research into Practice" and included two other papers, which have been included in a Monash University thesis inclusive of published works in the Medicine, Nursing and Health Sciences Faculty.

The third results paper was published in a Q1 peer reviewed journal, Research on Social Work Practice and is titled "Reasons for Use Package: Outcomes From a Case Comparison Evaluation". The paper reports on the quantitative data comparing results from the control cohort, New South Wales (NSW), with the intervention cohort of matched staff from Victoria.

Chapter Five

The fifth chapter integrates discussion of the results from this study with respect to the research questions, methodology and the unique knowledge claims that can be drawn with appropriate limitations. It explores implications for the State of Victoria, the Australian Nation and International jurisdictions. This includes discussion of implications for practice and policy. The chapter discusses future areas for research including discussion of a current co designed and produced research aimed at delving deeper in the service user experience of the RFUP.

Background to the study

Stigma and Discrimination

People who use drugs face both stigma and discrimination (Livingston, Milne, Fang, and Amari, 2012), which inhibits their ability to either ask for or receive treatment. Drug users are often

denied access or face early discharge from health services because of their substance use history. A systematic review by Van Boekel et al. (2015) showed how negative attitudes of health professionals decreases feelings of empowerment and subsequently treatment outcomes for patients who have a substance use background. This in turn can lead to chronic health conditions such as diabetes and kidney disease being under treated. Furthermore as discussed below the lack of integrated health and welfare responses actually causes new issues as service users and their carers have to navigate several service systems. Although not the focus for this study it is worth noting that there has been consistent concern that separate data collection and storage systems in clinical mental health, community mental health and the alcohol and other drug sectors is inefficient and ultimately has a negative impact on service user outcomes (Coffey et al 2008).

It is a sad reality that a large percentage of prison populations (Miller, and Najavits, 2012; Sung, Mellow, and Mahoney, 2010) have high levels of trauma, substance use and or mental health issues. Furthermore people of colour are more likely to be incarcerated (Schoenfeld, 2012) for drug offences.

One of the more obvious effects of stigma towards people who use drugs can be seen in the comparison between funding of law enforcement compared to drug treatment. In most jurisdictions, more is spent on drug law enforcement than treatment. A 2009 paper looking at Canadian Government Drug strategy funding found that despite the pro treatment language used in the strategy documentation, law enforcement continued to receive the most funding.

"Specifically, law enforcement initiatives continue to receive the overwhelming majority of drug strategy funding (70%) while prevention (4%), treatment (17%) and harm reduction (2%) combined continue to receive less than a quarter of the overall funding (DeBeck et al 2009)".

A notable exception to this approach is Portugal, which decriminalised substance use in 2001 with a deliberate policy of diverting enforcement budget towards treatment. The Portuguese have not found that this policy shift caused drug use harm to increase, rather that harm from use and the

related burden of care actually reduced as people with drug issues were steered towards treatment rather than prison (Cabral, 2017).

With respect to mental health stigma and discrimination are common themes in the literature (Martin and Johnston, 2007) and are often related to particular diagnosis as well as particular cultural and historical settings (Ye, Chen, Paul, McCahon, Shankar, Rosen, and O'Reilly, 2016; Thornicroft, Mehta, Brohan, and Kassam, 2010). Whilst attitudes towards depression and suicidal ideation may have improved in places like Australia over the past twenty years since the introduction of bodies such as Beyond Blue (Corrigan, 2012), people with other diagnosis such as borderline personality disorder are still likely to face discrimination.

Conceptual models of substance use.

The historical discourse around alcohol and other drugs or substance use has shown how competing conceptual models impact on treatment and critically the individual's role in treatment planning (Martin, Chung, and Langenbucher, 2016). To illustrate the issue it is necessary to explore some of the key models as they have bearing on the design of the Reasons For Use Package, the approach used in training and mentoring staff and the choice of research methods used in this thesis.

In an article on treatment for alcohol problems, Miller and Hestor (1995) looked at a number of different perspectives regarding the nature and aetiology, of alcohol problems.

The Moral model according to Miller and Hestor emphasises personal choice, i.e, it is the individual, who makes the choice to drink to excess and in the process violates the norms of society. This in turn leads to the use of law enforcement and deterrent approaches aimed at steering the person back to acceptable social norms. One of the direct results of this way of thinking is that whole groups of people who already don't fit in with the said norms of a society

can end up over represented in prison populations. In this model though the person who uses a substance is seen as having control of their actions.

Miller and Hestor argue that the Temperance model starts from the view of alcohol being such a powerful substance that no-one could maintain moderate drinking and that therefore there was an inevitable drift towards alcoholism. This is still a very pernicious view of substances generally. Heroin and methamphetamines for example are seen as having such a powerful effect on the user that the only reasonable course of action is to pressure them to be abstinent. In this model, the user of the substance has limited capacity to make decisions in the face of the powerful substance. It is only when the person has sobered up or got "clean" that they can return to active choices.

A related model here is the spiritual model, which is central to Alcoholics Anonymous (AA) where the individual is encouraged to appeal for help from their higher power rather than relying on their own agency. It is worth noting here that people find attending AA can be helpful in maintaining abstinence, whether this is a result of having a structured support system or by following a more spiritual path to recovery (Kaskutas, 2009; Humphreys, Blodgett, and Wagner, 2014).

Biological models as the title suggests focusses on a combination of the unique hereditary and changes to brain physiology of the substance user in the face of continued use of a substance. In its earlier incantations this model, was prone to genetic determinism, i.e. Indigenous peoples couldn't control their drinking. Both Frank (2000) and Langton (1992) make the case that rather than being a result of genetics, problem drinking in many indigenous communities reflected both a lack developed social norms for alcohol use combined with the rapid destabilisation of indigenous society through colonisation. Another variant of this model suggests that alcoholism is impacted by genetic background (Edenberg and Foroud, 2006; Enoch, and Goldman, 2001). Modern science of course with MRI scans for example gives us the ability to see how substance use effects people physically and show how a person can become physically dependent on a substance such as

heroin, with consequent changes to the brain. Some addiction specialists see people who are substance dependent as suffering from a brain disease (Leshner, 2001). Service users therefore need to be actively treated for the disease until they have recovered, but even then, they would be vulnerable to the dependence if they returned to use. The design and funding of many withdrawal units are focussed primarily on dealing with the physical aspects of dependence. Thus bed stays of 5-7 days to assist people to deal with the physical symptoms of withdrawal are the norm (Sacks, and Ries, 2005). Although this approach does help people return to homeostasis, pre substance use state, it often means that the person leaves without building up the necessary skills and resources to deal with their underlying trauma or other reasons for use. Whilst there are longer term rehabilitation programs which can assist to build new skills, there has been consistent complaints about demand out stripping supply (Lubman et al 2014).

The Impact of Trauma

One of the developing themes in the literature with respect to both mental health and substance use is the high degree of lifetime trauma (Ouimette, and Brown, 2003; Marsh, Coholic, Cote-Meek, and Najavits, 2015). Furthermore there is evidence that ongoing Post Traumatic Stress Disorder has an impact on likely substance use relapse (Read, Brown, and Kahler, 2004). It is a sad reality that a large percentage of prison populations (Miller, and Najavits, 2012; Sung, Mellow, and Mahoney, 2010)) have high levels trauma, substance use and or mental health issues.

The push for trauma informed approaches (Butler, Critelli, and Rinfrette, 2011) to service users with mental health and substance use has gained momentum with a consequent call to redefine substance use as a health rather than a primarily law enforcement issue.

Substance use and mental health interaction.

Substance use and mental health issues are bi-directional, that is changes in one has an impact on the other. This has a direct bearing on how service users need to be engaged in developing their own treatment plans to the largest extent possible. Only by engaging with the service user

and their significant supports can services truly develop effective treatment plans. Although it is tempting to try and short cut this process and develop treatment plans in isolation in practice the plans are likely to fail when some of the key contexts are missing. Shared decision making (Drake, and Deegan, 2009) is now gaining support even though at the time of writing the long term outcomes of this approach are yet to be established. It seems obvious as a basic starting point that like in other areas of health care, the service user has a human right to be involved in their own treatment. It is conceivable that a plan which is developed with a service user taking into account their own personal circumstances and intrinsic motivations (Miller and Rollnick, 2012), is much more likely to be effective compared to a treatment plan developed by the health professional alone.

An Eclectic approach to substance use

The move towards a more eclectic understanding of the eitology of substance use issues began to gain wider acceptance during the mid-1980's and 90's with ground breaking work by Prochaska and Diclemente (1992), who developed the "transtheoretical model" better known as stages of change and Miller and Rollnick (1991) who developed Motivational Interviewing. The central tenant of both these approaches was that understanding the perspective of the substance user and engaging with them when developing treatment interventions was a critical step. These developments should be seen against the prevailing back drop in the proceeding period, that the substance user couldn't be trusted as they were generally seen as being in denial (White, and Miller, 2007). The movement towards a wider concept of addiction combines both an understanding of biological, genetic and social factors, physical changes to the brain and the ability of the person with an addiction to respond to intrinsic motivators for change (Satel and Lilienfeld, 2014; Ouzir and Errami ,2016).

Lived and Living Experience

Over the past thirty years there has been an increasingly influential peer movement of people with Lived and Living experience, which championed the perspectives of people experiencing mental health and substance use issues (Gagne, Finch, Myrick, and Davis, 2018). Although co design and co-production (Boyle and Harris, 2009) brings certain challenges it has been seen as the most effective way to develop policies and interventions that work. With respect to substance use it is generally accepted, that the major impetus for this was the A.I.D.S crisis in the mid 80's to early 90's (Des Jarlais, 1993). This saw active collaboration between substance users, health providers and government agencies in developing harm reduction approaches (Wodak, 1995; Marlatt 1996). This also extended to the involvement of peers as active participants in treatment provision (Reif et al. 2014; Daniels et al., 2014).

Although stigma and discrimination against people who use drugs has improved over all, this is not universal, but is dependent on the actual substance used. Crack and intravenous users (Kulesza, 2013) are generally more likely to face stigma and discrimination compared to people who use cannabis. This extends into mental health treatment settings as well as the wider health sector where attitudes can mirror that of the general public. Substance use, although recognised as having an impact on mental health symptoms (Volkow, 2001), is often cited as a reason for withdrawing mental health support rather than the mental health issue being seen as a contributor to the substance use itself.

As will be discussed further in the methodology chapter the RFUP was designed to reflect harm reduction (Rhodes, 2009.) which recognises that not all people who use substances have problems and that people who have mental health and substance use issues can and do recover if given the opportunity. Harm reduction sees abstinence as part of a continuum not as an alternative option. Suddenly stopping alcohol use for example could cause fatal seizures. By considering harm reduction across both mental health and substance use staff provide a broader

threshold for treatment engagement compared to one which begins with abstinence as a starting point for treatment (Vakharia & Little, 2017. The latter approach is unrealistic because service users don't always turn up ready for a change of this magnitude. They may for example be admitted to hospital for another issue which may be related to substance use such as accident and emergency settings or acute mental health units. The act of offering harm reduction interventions in these situations can reduce risk to both the individual and the wider community. In a study of chronically homeless individuals with mental health and substance use it was found that offering housing with a harm reduction approach rather than offering housing contingent on abstinence improved outcomes (Tsemberis et al., 2004). This was despite the fact that participants in the abstinence program used substance use treatment services more often.

Where service users in mental health and or substance use treatment services are encouraged to play an active role in decision making regarding their own treatment, they are much more likely to successfully move towards recovery when compared to more paternalistic approaches (Drake et al 2009).

The Reasons For Use Package which will be discussed further below was designed to enhance the capacity of staff to respond more effectively with service users. The RFUP actively encourages the service user to consider the reasons for substance use and how this interacts with other aspects of their life including mental health issues. The staff member is encouraged to collaborate with the service user to develop a treatment plan with the aid of a brainstorming component with a menu of treatment options.

The literature review chapter of this thesis will discuss the high prevalence of dual diagnosis and the consequent burden on service users and service providers who are still primarily orientated towards either mental health or substance use despite evidence which clearly shows that clients with both issues are in fact the majority. The chapter will also explore the case for integrated treatment models and dual diagnosis capacity building, to which the RFUP may contribute. The

perceived efficacy of this RFUP is therefore not a minor issue. Whether one looks at the burden of health for individuals or the wider society successful integrated treatment models are a worthy area for research. If staff perceive that the RFUP helps to build their dual diagnosis capacity and at the same time it assists service users to develop treatment goals, it can also counter therapeutic nihilism which is often underscored by stigma. Whilst no one approach will guarantee improved outcomes for all service users, establishing whether there is an evidence base for the RFUP is a valuable pursuit.

Introduction

Preamble to published paper 1

Published Paper 1

Title: **Myers, K**, Kroes, S and Petrakis, M 2018, 'A Foundation for Dual Diagnosis Practice: Wisdom, Tools and Resources' chapter 9, pp 135-152 In Petrakis, M. (Ed) *Social Work Practice in Health: An Introduction to Contexts, Theories and Skills*, Sydney: Allen & Unwin.

Answering subsidiary research question:

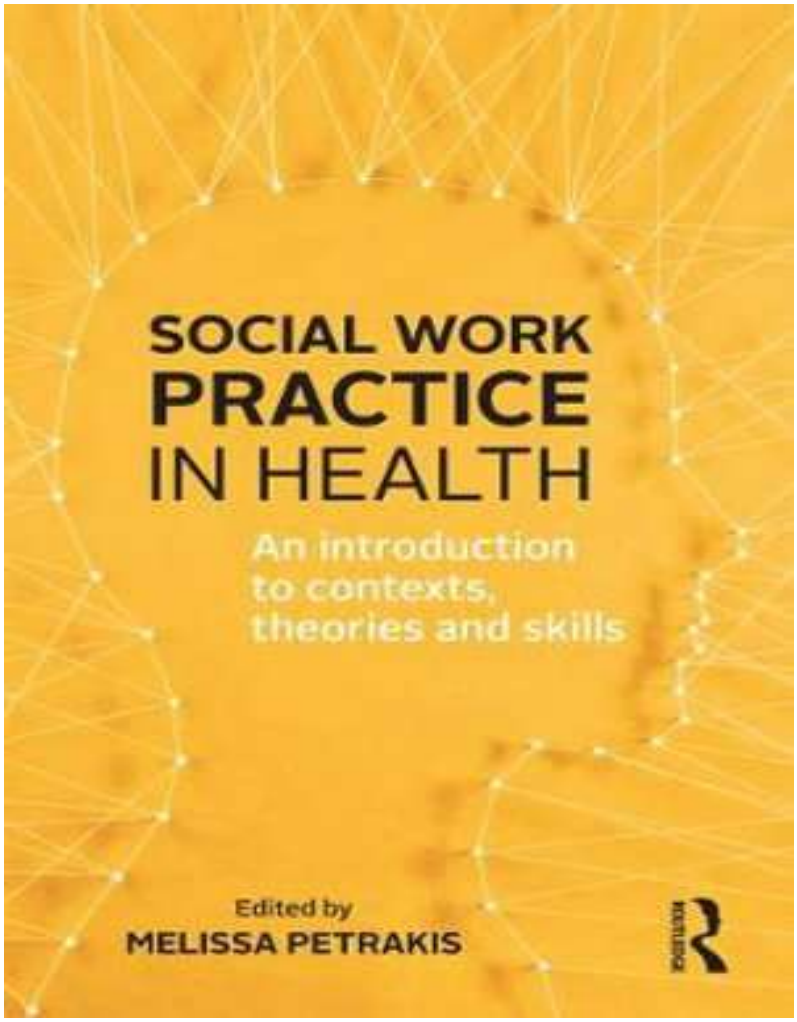
What is dual diagnosis, why does it matter, and are there models for approaching this issue?

Background: The candidate had been a regular honorary lecturer at Monash University, Master of Social Work (MSW) since 2014 and is recognised as having expertise in this area. He is a member of the Victorian Dual Diagnosis Initiative Leadership Group which meets regularly with the Victorian Government Department of Health on a fortnightly basis. It was on the basis of this reputation that he was invited to contribute to this textbook for Social Work students by Associate Professor Melissa Petrakis in 2017.

This book is a core text for MSW students at both Monash University Melbourne, Victoria and Queensland University, Brisbane, Queensland. It can be found in over 100 libraries across Oceania, North America, Africa and Europe, including prestigious universities such as Cornell and Columbia. The book has been positively reviewed from New Zealand to the Czech Republic. A second edition of this book including the Dual Diagnosis chapter has been commissioned by Routledge which is expected to be published in 2022.

A Foundation for Dual Diagnosis Practice Chapter 9

This peer reviewed chapter explores the national and international literature including prevalence data and impact of dual diagnosis for consumers, carers and service providers. It also sets out the key dual diagnosis approaches and emerging evidence base for achieving better outcomes. The chapter also introduces the reader to tools and resources including those that have been developed by Simon Kroes and Kevan Myers such as the Reasons For Use Package (RFUP) which is the subject of this thesis. Since this book was published the evidence base for RFUP and other resources has expanded. This updated material will be added to the 2nd Edition.



9

A foundation for dual diagnosis practice: wisdom, tools and resources

Kevan Myers, Simon Kroes & Melissa Petrakis

Introduction

As a social worker a large percentage of the people you work with are likely to have a dual diagnosis. Social workers entering practice need to develop knowledge and skills in this area so that consumer (service user) and carer needs may be adequately addressed. Many of the basic principles of a dual diagnosis approach can be grasped early in practice. Some basic skills and knowledge can then build on firm foundations. Dual diagnosis practice aligns with social work practice principles. Social work practice engages with the most marginalised populations within society. Substance use and mental health issues regularly occur within populations who have faced degrees of trauma, social isolation and economic disadvantage. There may be a level of complexity when working with people with substance use and mental health issues, with stigma compounding both areas. Dual diagnosis practice is therefore fundamental for all social workers.

The aim of this chapter is to both outline a dual diagnosis approach and give some examples based on practice wisdom from the field over many decades.

What is 'dual diagnosis'?

It's easy to assume that dual diagnosis only refers to consumers who have severe mental health and substance use issues. In practice, however, a range of dual diagnosis presentations exist.

Both nationally and internationally, a variety of terms, including 'comorbid mental health and substance use' and 'co-occurring mental health and substance use', have been used to describe the common scenario of a person having both a mental health and substance use problem (Allsop 2008; Minkoff & Cline 2004; Roberts 2013; Schulte et al. 2010). While recognising each of these terms brings a range of possible interpretations, this chapter will predominately use the term 'dual diagnosis' to describe the co-occurrence of mental health and substance use problems, as at the time of writing this is the commonly used term by government-funded initiatives, such as the Victorian Dual Diagnosis Initiative where the authors are currently employed.

It's easy to assume that dual diagnosis only refers to consumers who have severe mental health and substance use issues. In practice, however, a range of dual diagnosis presentations exist. For example, some people may find that:

- caffeine increases anxiety
- alcohol reduces auditory hallucinations
- opiates numb trauma.

Given these (and many other) all-too-common interactions, all consumers should be individually assessed around the interaction between their mental health and substance use to collaboratively determine the best way to improve their quality of life.

Prevalence: why dual diagnosis is the expectation

The significance of dual diagnosis has had growing recognition over the past twenty years, both internationally and within Australia. For example:

> There is a high prevalence of substance use disorders (SUDs; including alcohol and drug abuse and dependence) among people with psychotic disorders and other serious mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, and major depression. Although the lifetime prevalence of SUDs in the general population is approximately 15%, about 50% of people with a psychotic disorder develop a drug or alcohol use disorder at some point in their lives.
>
> (Mueser & Gingerich 2013: 424–39)

> The US Epidemiological Catchment Area study . . . on comorbidity (1980–84). Highest levels of comorbidity were found in those with

> a lifetime history of any drug history other than alcohol; with 53% with comorbid mental disorders and 47% with comorbid alcohol disorders.
>
> (Teeson & Proudfoot 2003: 1–2).

More recently, Hartz et al. (2014) found that:

- The odds of smoking, alcohol and other substance use were dramatically higher in severe mental illness than estimates in mild mental illness;
- 30 per cent of people with severe mental illness engaged in binge drinking, compared to 8 per cent in the general population;
- 75 per cent of people with severe mental illness are regular smokers compared to 33 per cent in a control group;
- 50 per cent of people with psychotic disorders used marijuana regularly, compared to 18 per cent in the general population;
- Half of those with mental illness also used other illicit drugs, versus 12 per cent in the general population.

The early mortality in people with severe mental illness (25 years earlier than individuals in the general population) is largely attributable to medical illnesses associated with substance use disorders.

Australia's response

In the late 1990s the National Drug Strategy and National Mental Health Strategy developed the National Comorbidity Project (Teeson & Burns 2001). These initiatives were informed by international literature regarding the extent of comorbidity experienced by people suffering from mental illness and using alcohol and other drugs, and the problems with parallel treatment systems (Drake et al. 1998), and have continued to note findings from overseas (Substance Abuse and Mental Health Services Administration 2002). The Victorian Dual Diagnosis Initiative (VDDI), of which Nexus Dual Diagnosis Service is a component, commenced in 2000. Similar initiatives were developed in other states in Australia (NSW Health 2000; Pennebaker et al. 2001).

Leadership in meeting the challenge: the Victorian Dual Diagnosis Initiative

Across Australia and New Zealand, in the late 1990s and early 2000s, an open door to working with comorbidities was not a reality. The state of Victoria in Australia has shown considerable leadership in this area. Indeed,

Dual Diagnosis Australia and New Zealand is a project of Eastern Hume Dual Diagnosis Service, Mental Health Services and Northeast Health, Wangaratta, sharing a resource repository created by and for people with an interest in co-occurring substance use–mental health concerns. (The web link follows later in the chapter.)

In many services funded by the Victorian Department of Health, dual diagnosis policy is stated as core business. The purpose of the VDDI (Allsop 2008), for example, is to promote development of a systematic and integrated approach to service provision, so that people of any age experiencing dual diagnosis have prompt access to quality treatment and support, focused on recovery and optimising individual outcomes. VDDI services provide a balance of direct care, and consultation and support to primary care and other sectors working with people experiencing dual diagnosis (which would include housing, employment, education and community organisations). The priorities included that consumers and families/carers were to be involved in policy and service development both centrally and locally to enable services to be easier to use, and seen as useful and aligned with their needs.

In 2007 the state government released a seminal document: Key Directions and Priorities for Service Development. There are five key directions/priorities identified in this document:

1. Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as core business in both mental health and drug and alcohol services.
2. Staff in mental health and alcohol and other drug services are 'dual diagnosis capable' (DDC), that is, they have the knowledge and skills necessary to identify and respond appropriately to dual diagnosis consumers and advanced practitioners can provide integrated treatment and care.
3. Specialist mental health and alcohol and other drug services establish effective partnerships and agreed mechanisms that support integrated treatment and care.Working with dual diagnosis as core business within each sector will ensure that people of all ages are not excluded from a service. Their needs will be addressed within the most appropriate service setting by suitably trained staff and treatment and care that they receive is of high quality.
4. Outcomes and service responsiveness for dual diagnosis consumers are monitored and regularly reviewed.
5. Consumers and carers are involved in the planning and evaluation of service responses to dual diagnosis.

(Department of Human Services 2007)

A multilayered response

Achieving good dual diagnosis practice relies on seven key elements.

1. Core business

The prevalence of dual diagnosis is such that social workers should approach all consumers as if dual diagnosis is core business no matter where you are working. While you are likely to have a range of different capacities in terms of interventions and roles depending on your position, you should consider dual diagnosis as being 'the expectation not the exception' (Minkoff & Cline 2004). In practical terms this means that when working with consumers, you should be looking for emerging or existing mental health and substance use issues and have at least a basic understanding of how to screen and assess for these issues and interventions that may be offered.

An example from the field may be a young man who is seeking assistance from a housing agency who has a history of homelessness stemming from childhood abuse is highly at risk of developing mental health and substance use issues. While the primary presenting need is around housing, unmet need around substance use and mental health are likely to impact on the sustainability of any housing options. Thus this provides an opportunity to explore and where possible offer interventions or referral advice.

2. 'No wrong door'

The myriad and complex service systems that consumers with a dual diagnosis could look to for assistance are difficult to navigate, for health and welfare workers as well as individuals with issues. One of the major complaints for service users and their carers (family members or other support people) is the struggle to find appropriate and accepting services. The experience of being rejected from service provision has been very common, often being couched in terms of 'we can't help you until you deal with the other issue'. At worst this can mean that individuals don't receive treatment for long periods, which in turn worsens their prognosis as they lose other social supports. The longer psychosis is untreated, the harder it is to successfully treat. For the individual and their families, reducing the gap between first symptoms and treatment thus becomes vitally important. This is magnified in dual diagnosis where consumers may experience being pushed from one service sector to another.

In response to this, the term 'no wrong door' has been popularised to improve service responsiveness. At its core this approach recognises the reality that consumers can and will appear in numerous service sectors, and services have a responsibility to support and guide consumers to find services appropriate for their needs.

3. Person- and family-centred

It may seem a bit obvious to say that dual diagnosis practice should be person- and family-centred, however, the history of service system response often does not articulate how this can actually happen in our day-to-day practice. Person- or consumer-centred means actively considering the person's own understanding of their issues as well as reflecting the reality that intrinsic motivation for change is far more likely to be sustained compared to external motivators. In general, most consumer–professional relationships should aim at a therapeutic alliance that balances the lived experience of the consumer with professional knowledge. The aim should be to have the consumer involved in their own treatment planning. The degree to which this occurs will depend on numerous factors. It is important to note that consumer-centred is not the same as consumer-directed. While the latter may be optimal it would be unfair to expect all consumers to develop and direct all treatment decisions in a vacuum. A social worker has at their disposal a range of skills and information that would not necessarily be available to consumers. Health professionals also hold a duty of care to individuals, family and the wider community, which can impinge on individual consumer decision-making.

4. Integrated treatment

What does integrated treatment mean in practice?

- Recognition that mental health and substance use influence each other—they are bi-directional at all times;
- Mental health and substance use are both viewed as 'primary issues';
- Treatment planning takes into account the needs of the person in relation to both issues simultaneously as opposed to parallel or sequential treatment;
- Consumers may require a number of specialist services; however, where there is more than one service provider, regular communication using either one shared treatment plan or sharing of treatment plans maximises continuity of care.

Integrated treatment starts from the obvious position that an individual cannot be broken up into separate distinct treatment areas. They remain an integrated person even when they have multiple treatment providers. Unfortunately this obvious fact hasn't stopped service systems treating individuals according to separate diagnoses. A 2013 national mental health audit reported that: 'Despite isolated examples of good practice, estimates show that only seven per cent of people with a co-existing mental illness and substance use disorder will receive

treatment for both problems' (*Thriving, not just surviving: Australia's national mental health report card*, National Mental Health Commission, 2013: ch. 3).

5. Welcoming, responsiveness and hope

Minkoff and Cline (2004), US-based dual diagnosis experts, describe a key starting point for dual diagnosis capability as how welcoming a service is when first approached by consumers and their carers. Mental illness and substance use are both areas with a strong history of judgemental thinking and stigma. It is not surprising that consumers who often experience rejection are reluctant to open up for fear of further rejection by services. In the case of consumers who use illicit drugs there may be legal ramifications to consider also. Consumers and carers sometimes learn by bitter experience that they need to carefully tell their story in order to fit with service practice or in some cases prescribed eligibility criteria. Unfortunately, this occurs despite legal and policy documents that clearly state the opposite, such as the *Victorian Mental Health Act 2014*.

How consumers are welcomed into conversations around dual diagnosis therefore becomes a critical issue. Our experience is that this is not as hard as it may appear. The first step is to recognise that the main fear of consumers is that you might be judgemental and stigmatising in your response. Second, the fear is that you might ignore their views and try to force them into following your prescriptions for change. Probably the best guide to welcoming is to consider how you like to be treated. Although we all have different expectations stemming from our own cultural bases there are some common factors (such as being shown respect, characterised by being listened to, having our needs considered when making plans, not assuming that there is a shared understanding of an issue and being courteous).

Key resources to provide to consumers and their carers are *Consumers can ask* (developed by Kroes in 2016) and *Carers can ask* (developed by Kroes in 2014). These resources, co-designed with consumers and carers, have many of the questions someone who is contacting your service might wish to ask. Providing them with the resource emphasises that they not only have permission, but are entitled, to ask those questions. The resource list at the end of this chapter gives further information on locating the resources.

6. Recovery orientated

The concept of recovery has been increasingly accepted in both mental health and alcohol and other drug services (Best & Lubman 2012). Social workers should be aware that 'recovery' may not be a phrase that sits well with all consumers as it has connotations with a 'disease' model (Dahl 2014). Nevertheless, we have found the concept of recovery has been generally empowering for consumers and carers. Although there are a number of definitions of

recovery, they generally overlap in particular areas. The national framework for recovery-oriented mental health services defines personal recovery as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues (Australian Health Ministers 2013). 'Recovery-oriented approaches sit within the harm minimisation framework, acknowledging and building on people's own resilience and resources. Recovery-oriented approaches recognise that people come to treatment through many different paths and that their goals and journey towards recovery and wellbeing are individual and unique.' (Reavley et al. 2013)

7. Harm minimisation

Harm minimisation is an approach that aims to reduce the adverse health, social and economic consequences of misuse of alcohol and other drugs, by minimising or limiting the harms and hazards of drug use for both the community and the individual, without necessarily eliminating use. It has underpinned Australia's drug treatment strategy since 1985.

There are three elements to harm minimisation:

1. Supply reduction—for instance, restricting sales, border control;
2. Demand reduction—for instance, reduce general population advertising, instigate drink/drug driving laws;
3. Harm reduction—for example, needle and syringe programs, having water available at dance venues.

Harm reduction is a great way to engage with consumers as it sends a strong message that they are valued and empowers them to make decisions. 'Harm reduction is often made an unnecessarily controversial issue as if there was a contradiction between prevention and treatment on the one hand and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary' (Antonio Maria Costa, UN Office on Drugs and Crime, 2007).

Harm reduction in practice

A person who has been using heroin for ten years may not give up heroin but may learn to reduce the harm from the drug by using clean needles, learning how to inject properly; they may have their housing secured and be engaged in meaningful activities.

The parallels with social work

Australian Association of Social Workers Practice Standards for Mental Health Social Workers (2014) provides the following definition:

> Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing. The above definition may be amplified at national and/or regional levels.
>
> (referring to the International Federation of Social Workers [IFSW], Global Definition of Social Work, approved by the IFSW General Meeting and the International Association of Schools of Social Work [IASSW] General Assembly in July 2014)

Social work practice is, by its very nature, holistic and multilayered. This requires of the social worker a sense of working towards better outcomes for consumers from numerous angles. This can encompass individual consumer and family work, system-level engagement and advocating around cultural and stigma issues. The dual diagnosis approach mirrors this approach.

Examples of systems approach in practice

As part of our Nexus role, we (the authors) attend numerous network meetings with various stakeholders; for example, North East Dual Diagnosis Youth (NEDDY) and the Yarra Drug and Health Forum (YDHF), which both meet monthly.

NEDDY was set up in 2010 and aims to develop best practice in integrated care, to improve outcomes for young people who have dual diagnosis issues. Initial steps were to agree on ways to structure the group, schedule a monthly meeting time, give it a name, and develop strategic and action plans to get and keep people interested. NEDDY is now an established cross-sector collaboration aligned with state and federal dual diagnosis policy directives. Member agencies include clinical mental health, mental health community support services (MHCSS) and alcohol and/or other drug services. It is a way to bring many voices together, providing a locally based avenue for staff to access peer support, to improve skills and knowledge, to foster links between

programs (resulting in improved referrals), to develop and share resources (such as the *Carers can ask* resource) and run professional development opportunities, such as cross-sector case reviews and training on topics of interest.

The YDHF is a community-based collaborative originally funded under the Drug Hot Spots fund (State Government 2000). The broad membership—which includes alcohol and other drug services, MHCSS and housing services among others—facilitates submissions, research and advocacy that may not be possible or appropriate for individuals or organisations. YDHF has supported the roll-out of Naloxone training and distribution by Harm Reduction Victoria and partnered research on public injecting with the Burnet Institute (Dwyer et al. 2013).

Tools for dual diagnosis practice

Tools can be used in everyday practice to:

- hear a person's dual diagnosis story
- discuss with them the interactions between their mental health and substance use
- identify and reflect on their reasons for substance use
- collaborate on treatment possibilities and encourage change.

Reasons for Use Package

Nexus has, over many years, conducted meetings with various agencies, and engaged in discussions with staff, about the best ways to develop their capacity to provide evidence-based dual diagnosis treatment. The insights gained were that staff were asking for resources to assist them in developing treatment options. Staff reported they did not know, or did not feel confident in, how to implement or decide on the next intervention to use with consumers after they have completed initial screening to detect dual diagnosis issues. In light of these discussions Nexus was particularly interested in user-friendly interventions that could assist staff in opening up dual diagnosis conversations with consumers, and in particular how to link mandatory screening with interventions in a consumer-centred manner. To try to address this, Simon Kroes built a prototype dual diagnosis resource based on what he perceived to be a user-friendly questionnaire or scale that was already in use that consumers engaged with: The Reasons for Use (RFU) Scale.

The RFU Scale (Spencer et al. 2002) is a 26-item self-report instrument. It includes items from the Drinking Motives Questionnaire (Cooper et al. 1995) and additional motives specific to symptoms of mental illness.

Its reliability and validity has been demonstrated among individuals with psychotic disorders (Spencer et al. 2002). It is administered to better understand participants' reasons for substance use and thus tailor the intervention to meet an individual's needs. The RFU Scale (Spencer et al. 2002) already had a reputation as a simple and effective engagement tool in its use as a component part of the eight-session managing mental health and substance use collaborative therapy program.

Kroes wanted to build a tool that could be relatively easy to train staff in and implement. A key question was, 'What type of tool would assist staff to quickly start to address dual diagnosis issues?'

The RFU Package (RFUP) is a compilation of existing tools, interventions and information that may be used following the administration of the RFU Scale. The RFUP also includes training material and guides for mentors and mentees. The package is very much built on strengths and recovery principles. It explores consumer motivations in relation to their drug use and mental health, and assists staff and consumers to consider possible treatments or interventions.

The prototype was put out for consultation within Nexus. Colleague Kevan Myers came on board and he and Kroes further developed the tool and added a mentoring process to enhance implementation as they had found that training alone did not usually produce practice change. From the outset the tool was based firmly on practice wisdom. They then sought to see if this tool did what they thought it would do and this led to the research they conducted in partnership with Neami National and Monash University in 2015. Through this process staff told them that the RFUP was easy to use and effective in building staff and consumer confidence in working with dual diagnosis issues, and was one of the simplest ways to build dual diagnosis into core practice.

The approach to using the package is a fundamental aspect of it. How staff use the package is as important as, if not more important than, the contents of the package. We continually encourage staff to be curious and supportive and to explore issues with the consumer in a non-judgemental manner.

> *How you use the package is as important as, if not more important than, the contents of the package.*

The aim of the package is to improve the quality of life of the consumers, which may or may not include reducing or changing their drug use. Having

a respectful conversation with the consumer that explores their mental health and substance use, and then providing and negotiating potential strategies or treatments, is the best way to begin to address the sometimes complex but treatable issues that surround dual diagnosis issues (Myers et al. 2017).

Information gathered in the process of administering the package is used by the consumer and staff member to collaboratively develop potential treatments the consumer can explore. In this way the consumer is at the centre of their own treatment but they get support, if they want it, from the staff member who plays a facilitator or coaching-type role.

Carers and Consumers can ask resources

Carers can ask is a resource aiming to empower carers (family and friends of those requiring treatment services) to have informed conversations with services about treatment, discharge planning and post-discharge support.

Through NEDDY, Kroes consulted widely with carers, carer and consumer consultants, mental health and alcohol and other drugs staff to co-produce the resource. The resource provides questions that may help carers to find out about treatment and discharge planning. Some of these questions can take time to answer due to the often complex nature of mental health and alcohol or other drug issues. The questions are suggestions only and not intended as an exhaustive or prescriptive list.

The resource aligns with current strategic directions in mental health services. The Fourth National Mental Health Plan (Australian Health Ministers 2012: 13) states: 'Families and carers should be informed to the greatest extent consistent with the requirements of privacy and confidentiality about the treatment and care provided to the consumer, the services available and how to access those services. They need to know how to get relevant information and necessary support.'

Consumers can ask

Once the *Carers can ask* resource had been completed and globally distributed, the need emerged for a similar resource for consumers. Using the structure of *Carers can ask*, Kroes undertook further consultations with consumers and consumer consultants to develop the resource into one for consumers. Though these resources are aimed at carers and consumers, other people (such as health and welfare staff) could use them to assist in advocating for consumers or finding out information relevant to the consumer with whom they are working. These resources can be found at the Nexus website listed at the end of this chapter.

Motivational interviewing

Motivational interviewing (MI) is a form of collaborative conversation originally developed in the addictions arena but which now has an evidence base in numerous settings, including mental health, corrections and physical health (such as diabetes).

Key points in motivational interviewing

- *Four key processes in MI are engaging, focusing, evoking and planning.*
- Engaging *is the process of establishing a helpful connection and working relationship.*
- Focusing *is the process by which you develop and maintain a specific direction in the conversation about change.*
- *The process of* evoking *involves eliciting the client's own motivations for change and lies at the heart of MI.*
- *The* planning *process encompasses both developing commitment to change and formulating a concrete plan of action.*

Four key processes in MI are:

1. *Engaging*—the process of establishing a helpful connection and working relationship;
2. *Focusing*—the process by which you develop and maintain a specific direction in the conversation about change;
3. *Evoking*—the process of eliciting the client's own motivations for change, which lies at the heart of MI;
4. *Planning*—the process encompassing both developing commitment to change and formulating a concrete plan of action.

Miller and Rollnick (2013) define MI as a person-centred, collaborative, goal-oriented style of communication that focuses particular attention on the language of change. It is designed to strengthen personal motivation and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. Learning MI takes time and is best achieved through a range of activities, including training and reflective practice. Core elements, such as the spirit of MI, are within reach for those at the beginning of their practice. The spirit of MI is comprised of four elements:

1. partnership
2. compassion
3. evocation
4. acceptance.

Figure 9.1:The Readiness Ruler

This tool was originally designed by Stephen Rollnick as part of the motivational interviewing approach. It is a useful tool for evoking and developing change talk using a scaling process.

The desire in people to make change is common, but making change depends on how important it is as well as the degree of readiness and confidence the person has.

Once the consumer has identified a possible change behaviour, ask the following questions:

1. On a scale of 1–10 (where 1 is not at all important and 10 is extremely important) how important is it for you to make this change?

1	2	3	4	5	6	7	8	9	10

2. On a scale of 1–10 (where 1 is not at all confident and 10 is extremely confident) how confident are you in your ability to make this change?

1	2	3	4	5	6	7	8	9	10

3. On a scale of 1–10 (where 1 is not at all ready and 10 is extremely ready) how ready are you to make this change?

1	2	3	4	5	6	7	8	9	10

In relation to the three scales above ask the following questions to evoke further change talk and possible next steps:

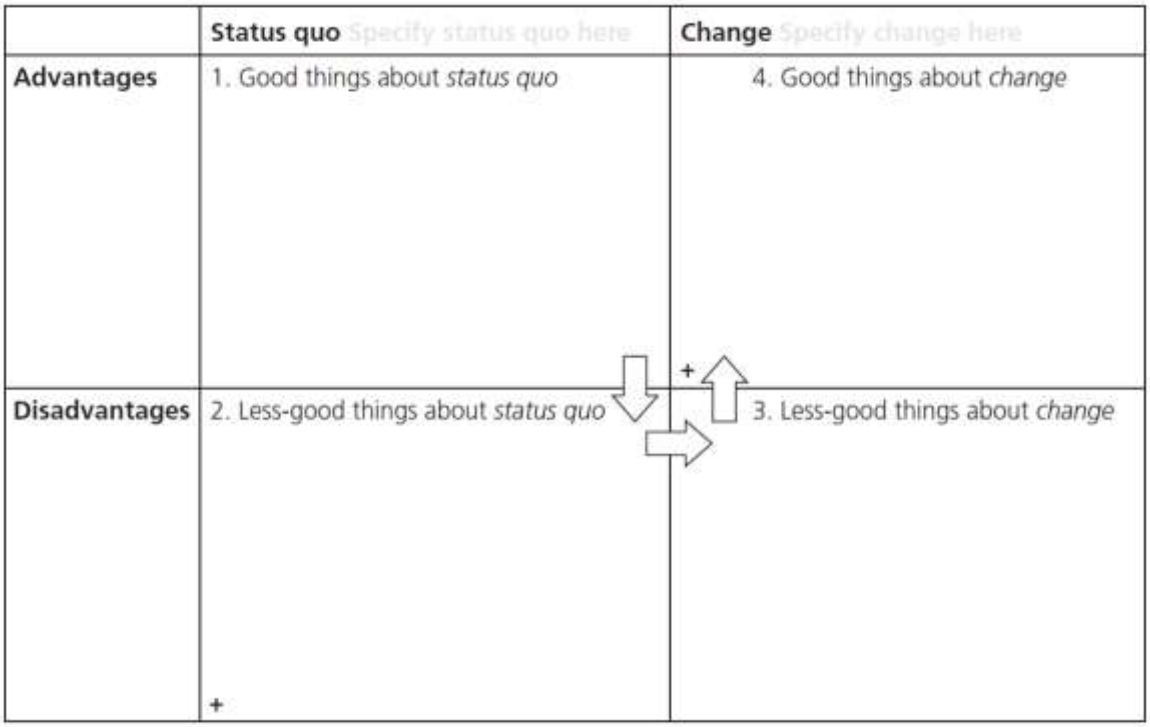
1. Why are you at your current score and not lower on the scale?
2. What would it take for you to get to a higher score?

Source: Rollnick, S., Heather, N., Gold, R. & Hall, W. Development of a short 'readiness to change' questionnaire for use in brief, opportunistic interventions among excessive drinkers. *British Journal of Addiction*. 1992; 87:743–54.

Decisional balance

Prochaska and DiClemente (1984) in their work in the eighties looking at change in addiction included the use of a decisional balance grid. The basic concept is that by exploring both sides of ambivalence, the person struggling with a change gains insight and potentially movement in their thinking on the topic. This technique has been used in a wide variety of settings and is easy to learn. A simple version of just looking at the good and not-so-good sides of an issue can open up a lot of ground quite quickly. In MI, the disadvantages of the status quo and the advantages of the change are stressed as they elicit change talk.

Figure 9.2: Decisional balance table



Relapse prevention

When working to change any pattern of behaviour, lapse and relapse are common events. This is particularly evident when consumers are trying to change substance use. Understanding and learning to manage cravings and relapse prevention are therefore key ingredients. 'It is possible to understand drug craving and to learn how to manage drug craving without returning to drug use. A model that allows people to identify set-up behaviours (these are ways of thinking, managing feelings and behaving that increase the risk of having a relapse), trigger events and the cycle of drug craving itself, and intervening upon this process has proven effective in reducing relapse' (Gorski 2001).

Wellness recovery action plans (WRAPs) have also been found to be of assistance in reducing the likelihood of relapse for consumers with a dual diagnosis (St Vincent's Mental Health 2014). The main aim of this type of document is to build understanding of possible relapse triggers and plan supports to mitigate them.

Conclusion

Social workers are very likely to come into contact with people who have or are likely to develop a dual diagnosis. It is incumbent on all social workers that

they should work towards having a basic dual diagnosis capacity so that rather than being a barrier to recovery they can support individuals, carers and the community to create an environment within which hope is maintained and recovery becomes the expectation. There are a range of evidence-based tools and resources that can be useful when working with a person who has a dual diagnosis. Social workers should look for opportunities to work for system change through advocacy and networking, to reduce the negative impacts of stigma, and to create environments that facilitate better outcomes for consumers with a dual diagnosis and their carers.

The key points are:

- Dual diagnosis may be complex but is treatable;
- Dual diagnosis is any impact drug use has on mental health, and any impact mental health has on drug use;
- The natural progression is for a person to trend towards recovery;
- Understanding and talking through reasons for use can be empowering for the consumer and create meaningful treatment pathways;
- There are evidence-based interventions for dual diagnosis that can aid individuals and carers on their recovery journeys.

Acknowledgement:
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Key website resources

Alcohol and Drug Foundation (ADF):
http://adf.org.au/drug-facts/.

Dual Diagnosis Australia and New Zealand:
http://www.dualdiagnosis.org.au/home/.

National Drug and Alcohol Research Centre (NDARC):
https://ndarc.med.unsw.edu.au/.

National Drug Strategy (NDS):
http://www.nationaldrugstrategy.gov.au/.

Nexus:
https://svhm.org.au/home/our-services/departments-and-services/n/nexus.
(Where resources *Carers can ask* and *Consumers can ask* can be located.)

References

Allsop, S. (2008). *Drug use and mental health*. Melbourne: IP Communications.

Australian Association of Social Workers (AASW). (2014). *Practice Standards for Mental Health Social Workers*. Canberra: AASW.

Australian Health Ministers. (2012). Fourth National Mental Health Plan. Canberra: Australian Government Publishing Service.

Best, D.W. & Lubman, D.I. (2012). The recovery paradigm: a model of hope and change for alcohol and drug addiction. *Australian Family Physician*, 41(8), 593.

Cooper, M.L., Frone, M.R., Russell, M. & Mudar, P. (1995). Drinking to regulate positive and negative emotions: a motivational model of alcohol use. *Journal of Personality and Social Psychology*, 69, 990.

Costa, A.M. (2007). *World Drug Report*. Vienna: United Nations Office on Drugs and Crime.

Dahl, S.L. (2014). Remaining a user while cutting down: the relationship between cannabis use and identity, drugs, education, prevention and policy. Available at http://informahealthcare.com/doi/abs/10.3109/09687637.2014.920765.

Department of Human Services. (2007). Dual Diagnosis: Key Directions and Priorities for Service Development. Melbourne: State Government of Victoria.

Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J. & Bond, G.R. (1998). Review of integrated mental health and substance treatment for patients with dual disorders. *Schizophrenia Bulletin*, 24(4), 589–608.

Dwyer, R., Power, R. & Dietze, P. (May 2013). *North Richmond public injecting impact study community report*. Melbourne: Centre for Research Excellence into Injecting Drug Use.

Gorski, T.T. (2001). *Cocaine, craving, and relapse*. Spring Hill, FL: GORSKI-CENAPS Web Publications.

Hartz, S.M., Pato, C.N., Medeiros, H., Cavazos-Rehg, P., Sobell, J.L., Knowles, J.A. & Vivar, A. (2014). Comorbidity of severe psychotic disorders with measures of substance use. *JAMA Psychiatry*, 71(3), 248–54.

International Federation of Social Workers (IFSW). (2014). *Global Definition of Social Work*. Approved by the IFSW General Meeting and the International Association of Schools of Social Work (IASSW) General Assembly, July. Berne, Switzerland: IFSW.

Miller, W.R. & Rollnick, S. (2013). *Motivational interviewing; helping people change*. New York: Guilford Press.

Minkoff, K. & Cline, C. (2004). Changing the world: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America*, 27(4), 727–43.

Mueser, K.T. & Gingerich, S. (2013). Treatment of co-occurring psychotic and substance use disorders. *Social Work in Public Health*, 28, 424–39.

Myers, K., O'Connor, S., Petrakis, M. & Kroes, S. (2017). The reasons for use package: development research and implementation lessons for the field. Paper presented at 26th Contemporary TheMHS in Mental Health Services, 'People: authenticity starts in the heart', 23–26 August 2016, Auckland, New Zealand. *2016 TheMHS Conference Proceedings*, Sydney, Australia: TheMHS Learning Network.

National Mental Health Commission. (2013). Chapter 3. 'Thriving, not just surviving' in *A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention*. Canberra: Australian Government.

NSW Health. (2000). The Management of People with a Co-Existing Mental Health and Substance Use Disorder: Service Delivery Guidelines. Sydney: NSW Health Department.

Pennebaker, D., Robinson, S., Gomes, A., Quigley, A., Bennetts, A. & Browton, R. (2001). *Co-occurring mental illness and substance abuse services review*. West Perth: Centre for Mental Health Services Research.

Prochaska, J.O. & DiClemente, C.C. (1984). *The transtheoretical approach: crossing traditional boundaries of therapy*. Homewood, IL: Dow/Jones Irwin.

Reavley, N., Bassilios, B., Ryan, S., Schlichthorst, M., & Nicholas, A. (2015). Interventions to build resilience among young people: A literature review. Melbourne: Victorian Health Promotion Foundation.

Roberts, B. (2013). The seeds of dual diagnosis discourse in an Australian state. *Mental Health and Substance Use*, 6, 4.

Schulte, S., Meier, P., Stirling, J. & Berry, M. (2010). Dual diagnosis competency among addiction treatment staff: training levels, training needs and the link to retention. *European Addiction Research*, 16, 78–84.

Spencer, C., Castle, D. & Michie, P.T. (2002). Motivations that maintain substance use among individuals with psychotic disorders. *Schizophrenia Bulletin*, 28(2), 233–47.

St Vincent's Mental Health. (2014). *The strengths model: a recovery-oriented approach to mental health services*. Melbourne: St Vincent's Hospital.

State Government (2000). *Final Report off the Drug Policy Expert Committee*. Melbourne: State Government.

Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse and mental disorders*. Rockville, MD: SAMHSA—US Department of Health and Human Services.

Teeson, M. & Burns, L. (eds). (2001). National Drug Strategy and National Mental Health Strategy, National Comorbidity Project. Canberra: Commonwealth Department of Health and Aged Care.

Teeson, M. & Proudfoot, H. (2003). *Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment*. Australia: National Drug and Alcohol Research Centre (NDARC), University of New South Wales.

Chapter 2

Literature Review

Mental health and substance use

The co-occurrence of mental health and substance use is the "expectation not the exception" (Minkoff, and Cline, 2004 p 734) for service users accessing care in mental health and substance use services. Despite this they have often been presented in the literature and in practice as two separate entities in much the same way as mental health is separated from physical health . In order to show why a "dual diagnosis" capacity building resource is a key area for research the background literature relating to mental health and substance use will be explored. This literature review will explore the context of attempts to build dual diagnosis capacity and the potential benefit of doing so.

The first point is that both mental health and substance use are contested historically, culturally and depending on one's position in relation to the issues.

Zinberg (1984) created a model for understanding the effect of substances according to the Drug, Set and Setting. "Drug" includes the type of drug, purity, amount and particular method of use, what it is used in combination and whether it is licit or illicit. "Set" is the mental state a person brings to the experience, i.e thoughts, mood and expectations as well as their biological and physical characteristics such as age, gender or existing health issue. "Setting" is the physical and social environment including cultural context and social supports. The purity and type of a particular substance will vary, i.e spirits compared to wine. The "set" will vary because of the age, gender, mood and expectations of the user, the Setting will also have an impact i.e smoking indoors rather than outside.

Marijuana use for example, depending on the cultural and historical setting you are in, might be seen as a medicine or an aid to religious practice rather than primarily a "problematic" substance.

Another example is Alcohol. Despite contributing to the burden of health care costs, family violence and suicide alcohol is actively subsidised by many governments around the world and is held up as a national icon. Festivals such as Octoberfest in Germany centre on this substance.

In a paper making the case for harm minimisation in 2004 Hamilton and Rumbold wrote

"A combination of protective trade practices, ethnic prejudice, concern about negative consequences of use, fear and a desire for control at the level of both the individual and the group or community have produced increased efforts during the twentieth century to outlaw many different psychoactive drugs. Decisions about which drugs should be legal and which ones should be banned have rarely been based on any scientific determination of innate risk or danger of the particular substance (Hamilton and Rumbold 2004 pp131).

A more recent study ranking drug harm in the United Kingdom used a multi-criteria decision analysis (MCDA) model and concluded that,

"MCDA modelling showed that heroin, crack cocaine, and methamphetamine were the most harmful drugs to individuals (part scores 34, 37, and 32, respectively), whereas alcohol, heroin, and crack cocaine were the most harmful to others (46, 21, and 17, respectively). Overall, alcohol was the most harmful drug (overall harm score 72), with heroin (55) and crack cocaine (54) in second and third places. Nutt, King, and Phillips, 2010.

Mental Health

The concept of mental illness or mental health, is contested area. The conceptual models that underpin the etiology of mental health conditions has followed a remarkably similar proce ss as that of substance use as discussed above.

Historically mental health issues were framed along religious or spiritual themes. With people with a mental health issue being viewed as possessed by the devil or evil spirits (Mercer et al 2013)

From this perspective the mental illness is often seen as a result of sin either by the person in

treatment or an ancestor. Deliverance from mental illness would therefore rely on spiritual healing. This perspective might be initially seen as a marginal, but from a historical and cultural perspective, this conception has an enduring impact and is still a major influencer in many parts of the world. A more nuanced understanding though tends not to endorse the concept of a mentally ill person being possessed and therefore needing deliverance. Rather that religious and spiritual approaches can have a positive impact for many people. Indeed as discussed earlier in relation to A.A, the spiritual path to recovery is a major focus for people who hold spiritual beliefs, (Verghese 2008). Whilst the dominant theme in Psychiatry in the western world had tended towards dismissing the role of religion, there is now acceptance that "spiritual health" plays a part in both the development and recovery from mental health problems for many people.

For many centuries people suffering from mental health issues were often subjected to horrific interventions in an attempt to cure them of the condition.

Around the early part of the 20th Century, two alternative theoretical approaches on mental illness began to emerge, Austrian neurologist Sigmund Freud's' (1856–1939) psychodynamic theory and the theory of behaviorism advanced by American psychologist John B. Watson (1878–1958). Freud's theory of psychodynamics centred on the notion that mental illness was the product of the interplay of unresolved unconscious motives, and should be treated through various methods of dialogue with the patient. Behaviorism, on the other hand, suggested that psychopathology occurred due to the effects of behavioral conditioning, and that treatment should focus on methods of adaptive reconditioning. Both these approaches had the common belief that talking to the "patient" was a key element. Whilst these approaches were being developed, the majority of people suffering from a so called serious mental illness were still treated by and large in "asylums".

In some ways the original "Asylums" provided a more humane starting point with the notion that a quieter more supported environment would help people to recover. Unfortunately large psychiatric hospitals soon became places which were by words for the wider community as people were carted off to the "mad house" or the original bedlam. In most cases the individual patient had little say over their own treatment and had little hope of discharge. In 1961 Erving Goffmans' ground breaking essays on asylums (Mac Suibhne, 2011) had shown how being in this environment had an adverse impact on recovery for many patients.

Despite Goffman, these institutions were the mainstay of psychiatric treatment in most of the developed world until the late 1990's, but there was a steady campaign particularly from relatives and friends of people with a mental illness to look at alternatives. De-institutionalisation (Novella, 2010) which in Australia was well under way by the late 1990's, was an attempt to reduce the impacts of being in an institution. It is worth pointing out that many of the campaigners for community care approaches formed the early versions of the community mental health non-government sector in places like Victoria. Organisations like Richmond Fellowship now Mind Australia and Schizophrenia Fellowship (now Wellways) had their origins in this period. The overwhelming ethos of these organisations was to humanise treatment rather than necessarily campaigning against psychiatry. It is also worth noting that the successful development of medicines that had a positive impact on mental health symptoms had increasingly began to offer hope for a variety of conditions. In Australia, the work of Dr John Cade who discovered that Lithium could be used to assist with mania in 1948 was a major step forward.

A combination of advances in pharmacotherapy for mental health issue, demands for de-institutionalisation and a burgeoning community mental health sector lay the groundwork for a major shift of focus during this period. Importantly it was during this period that the role of people with lived or living experience gained recognition as contributors to the design of services in jurisdictions such as Victoria. Consumer Consultants were employed in most Area Mental Health

Services with the specific remit of advising services. Over the next twenty or so years the voices of Lived and Living experience have increasingly found space to challenge the existing medical models (Byrne et al, 2016).

As the service user voice expanded in influence there was a growth in new ways of approaching interventions. The "Strengths model" (Rapp and Goscha, 2011) argued strongly that the medical model approach was dominated by deficit thinking. This tends to think of mental health through a lens that considers mental illness as a lack of sanity, capacity etc. Rapp and Goscha set out a different way of working with service users which encompassed the following principles.

- Consumers can recover, transform and reclaim their lives
- The focus is on the individual strengths rather than deficits
- The worker-consumer relationship is primary and essential
- The consumer is the director of the helping process
- The primary setting for our work is the community
- The community is viewed as an oasis of resources (Rapp and Goscha, 2011)

The impact of this approach was to enhance further the role of the service user in their own treatment particularly in mental health service provision.

Dual Diagnosis or co-occurring mental health and substance use issues

The co-occurrence of substance use and mental health issues is well documented in both Australian and international literature using a variety of descriptors such as Dual Diagnosis. (Minkoff and Cline, 2004). Conceptual discussion around this phenomenon has been going on in various forums for at least 50 years. Etiological explanations of dual diagnosis have ranged from the moral weakness position through to the concept that recognises that human beings regularly use substances for a variety of reasons including to change or cope with unpleasant mood, mania etc.

Sequential Parallel and Integrated treatment

The problem with sequential and parallel service provision rather than integrated treatment can be seen in the outcomes for service users (Woody, 1996). The bi-directional nature of dual diagnosis means that a treatment plan for one is likely to have an impact on the other. This in turn can lead to a breakdown in treatment or a lack of treatment taking into account both conditions (Kelly, and Daley., 2013). For service users their involvement in sequential or parallel treatment approaches are likely to bring with it a confusing array of philosophical perspectives.

"One of the major problems with parallel or sequential treatment is the fact that psychiatric and substance abuse treatment programs frequently have different philosophical orientations. Psychiatric programs often downplay substance use, or see it as merely a secondary problem or as a form of "self-medication" that will resolve with treatment of the psychiatric disorder. In some psychiatric settings (particularly for patients with psychotic disorders), substance use disorders frequently go undiagnosed (Weiss et al, 1998 p 89).

The case for an integrated approach

One of the key tenants of "dual diagnosis" is the concept of integrated treatment, described by Webb-Robins as being,

"..both psychiatric and substance use disorder treatment are provided by the same clinician or treatment team in a single agency" (Webb-Robins, 2004 p1). Others have argued that this can also be when two or more providers come together to provide integrated treatment (Drake, Mercer-McFadden, Mueser, McHugo, and Bond, 1998, Deady et al 2014).

The key point for integrated treatment is that it recognises and responds to both conditions. Rather than having to navigate and be aware of multiple different treatment modalities, service users benefit from bringing their various needs under an integrated plan. Integrated treatment has

been shown to improve outcomes in a range of studies compared to sequential or parallel treatment (George and Krystal 2000, Mangrum, Spence, and Lopez, 2006).

The burden for Service Users and Carers

In most cases, it is the service user and their carer who carry the burden of negative interactions with disparate service systems particularly when a lack of skill in the other side of a dual diagnosis presentation leads to worse outcomes for the service user (Nicholas et al 2017). An example might be if a person stops using a substance abruptly and then goes into withdrawal; this in turn may trigger an increased level of agitation. Staff in a mental health unit however may think that the increased level of agitation is a sign that the person has been using the substance and the person is then asked to leave the service.

It is imperative therefore for all service providers to have a basic level of dual diagnosis capacity. At a minimum this should include the ability to recognise and respond to mental health and substance use issues in an integrated treatment plan (Department of Human Services, 2007).

Preamble Paper 2 Thesis inclusive of Published works

Title: "Dual diagnosis competencies: A systematic review of staff training literature"

Author(s): Petrakis, M, Robinson, R, **Myers, K**, Kroes, S and O'Connor, S.

Journal: Addictive Behaviour Reports

Publisher: Elsevier

Status: Published 2018

Subsidiary research question:

With respect to dual diagnosis are there existing tools which assist in building dual diagnosis capacity?

This journal article emerged from the thesis project designed and guided by the research project team, with Rebecca Robinson joining in 2015 as an honours student mentored by this candidate and Associate Professor Melissa Petrakis to undertake a systematic literature review and data collection for the first focus group – the latter enhanced the robustness of data collection as it was one step removed from the PhD candidate. The Journal is Q1 and the article itself has been regularly cited.

How does it relate to the Research Question?

This article is a systematic literature review aimed at exploring the literature on dual diagnosis "staff training, workforce development, staff productivity, workforce training, workforce implementation and staff implementation". It identified gaps in the literature specifically around the lack of a dual diagnosis resource which aimed at enhancing staff knowledge and confidence as well as benefitting consumers.

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Dual diagnosis competencies: A systematic review of staff training literature☆,☆☆

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ABSTRACT

Objective: To conduct a systematic review of the literature regarding approaches to staff training in dual diagnosis competencies.
Methods: A search was conducted using eight databases: Informit, Taylor & Francis, Springer, Proquest, Expand, Sage, Psych info, Elsevier and Cinahl. The year range was 2005 to April 2015. An additional manual search of reference lists was conducted to ensure relevant articles were not overlooked.
Results: Of 129 potential results, there were only 11 articles regarding staff training in dual diagnosis. The limited studies included problems: small sample sizes, selection biases, and questions as to validity of some capability instruments, and low inclusion of service user perspectives. Organisational challenges to greater uptake of staff training including agency size, agency willingness to change, and a need to change policies.
Conclusions: There is a pressing need for more research, and quality research, in this important area of knowledge translation, dissemination and implementation of evidence-based practices. In particular there is limited literature regarding the efficacy of dual diagnosis competency resources, and a gap as to use of the mentoring in dual diagnosis capacity building.

1. Introduction

It is estimated that anywhere between 40 and 80% of service users who experience mental illness in Victoria, Australia also have issues with substance use. People who suffer from mental health disorders that are complicated by alcohol and or other drug use disorders are defined as having a dual diagnosis (Department of Human Services, 2010).

Living with a dual diagnosis can cause complex physical, psychological and social difficulties for a wide range of people (Roberts & Jones, 2012, p.664). Dual diagnosis is typically associated with negative consequences and widely affects many of life's domains. Research suggests that those with a dual diagnosis compared to those with a single disorder experience much higher rates of violent behaviour, suicidal ideation, suicide and physical health problems (Thornton et al., 2012 p.429). In addition to these complications, there are compounding impacts on a person's social circumstance including loss of support networks, stress on family and anti-social behaviour. This can lead to possible homelessness and incarceration (Donald, Dower, & Kavanagh, 2005 p.1372). On a more positive note there is literature to suggest that outcomes for service users with dual diagnosis can be enhanced when services provide integrated evidence-based treatment (Drake et al., 2015).

There is little research on the role of supervision among those with dual diagnosis training however the minimal evidence suggests that it is necessary. Supervision led by qualified and competent staff in a helping environment has found to support staff in difficult situations and allow the opportunity to reflect on the process that is happening (Cookson, Sloan, Dafters, & Jahoda, 2014).

The need for dual diagnosis training to be standardised within the mental health and alcohol and other drug fields across agencies and different discipline occupations has been raised in order to ensure that care is more service-user-oriented (Hughes, 2011).

☆ This paper is a Dual Diagnosis systematic literature review for the journal *Addictive Behaviors* intended as a full length article submission.
☆☆ Thank you for the encouragement regarding our team's December submission of 'Dual Diagnosis Assessment: A Case Study Implementing the Reasons for Use Package to Engage a Marginalised Service User' submitted as a short communications paper.

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1.1. Aims and objectives of the study

To investigate the extent and quality of staff training innovations in the dual diagnosis field, aiming to enhance staff skills to work with people experiencing severe and persistent mental illness (SPMI) comorbid with substance abuse.

2. Materials and methods

2.1. Systematic approach

A search for the relevant literature was conducted using 8 online databases – Informit, Taylor & Francis, Springer, Proquest, Expand, Sage, Psych info, Elsevier and Cinahl through the Monash library database search. The database search was conducted of material between year ranges of 2005 to the end of April 2015. An additional manual search of articles from reference lists was conducted to ensure relevant articles were not overlooked.

The keywords and National Library of Medicine, USA, Medical Subject Headings (MeSH*) headings used in the search were: Severe and persistent mental illness, mental health*, schizophrenia*, bi-polar, psych*, substance use, substance misuse, alcohol abuse, alcoholism*, Dual Diagnosis*, staff training, workforce development, staff productivity, workforce training, workforce implementation and staff implementation. Search terms were used in various combinations in order to include the maximum amount of relevant articles.

2.2. Inclusion criteria

This study was conducted in the state of Victoria in Australia. In that state the government Department of Human Services published the review and planning document *Dual Diagnosis key directions and priorities for strategic development* in 2010. The authors of the current study set out to canvas the international situation in dual diagnosis capacity building in services at that time through a review of studies in the 5 years prior (what was going on?) and 5 years post (what is or is not changing?). Studies were included in the current review if they were published after 1st April 2005 through until the end of April 2015 (when the systematic review was conducted). Literature was only included if participants were suffering from severe and persistent mental illness (SPMI) comorbid with substance abuse (of any kind), and also discussed the role of staff training.

2.3. Exclusion criteria

Studies were excluded if they were published prior to 2005, in order to canvas the most up to date literature. If the studies focused on service users with other mental health conditions and did not have comorbidity with substance abuse they were excluded because they did not meet the criteria of dual diagnosis. Studies were also excluded if they focused on children or adolescents under 18 years of age, as the focus for services in the current study setting was adult service users who would be receiving diagnosis and treatment. Articles were also excluded if they were not in English language, or if the article lacked sufficient detail to be clearly relevant.

3. Results

3.1. Database search results

Initially, 129 articles met the criteria through electronic database searching, with an additional 3 articles sourced through searching reference lists of eligible articles. The screening process was carried out by removing 2 duplicate articles and examining 34 article abstracts to remove further irrelevant articles. Following this process, 20 articles met the eligibility criteria. Of these articles, following a full review of the text of the articles, 11 were included in this review due to their discussion on staff training with relation to dual diagnosis in adult service users.

The articles included after the screening process ranged from behavioural studies, pilot studies and longitudinal studies with both qualitative and quantitative results. Articles were studies from Australia, the United Kingdom and the USA.

Themes that emerged from the articles were supervision, staff training and education, training programs and tools, organisational changes, and changes to policy and mission statement.

3.2. Supervision

Within the dual diagnosis training literature, there is little research regarding the role of supervision. The minimal evidence however suggests that it is necessary. Supervision led by qualified and competent staff in a helping environment has been found to support staff in difficult situations, allowing the opportunity to reflect on the process that is occurring (Cookson et al., 2014).

The article by Brunette et al. (2008) employed a longitudinal exploratory study method. They researched 13 community agencies within the USA over a 2-year period that had a new dual diagnosis training treatment program. They applied both a quantitative and qualitative approach to their research. Program data was collected using a quantitative fidelity scale to see the degree to which the new service adhered to established principles for integrated dual disorders treatment. The qualitative approach involved interviews, meetings and ethnographic observations to elicit responses regarding facilitators and barriers to implantation of the training program (Brunette et al., 2008, p.990).

Barriers to implementation of the program were researched. A major barrier to successful delivery was the lack of staff supervision. It was found that supervision played a key role in the success of the integrated dual disorder treatment teams in other, successful, agencies. The absence of high-quality clinical supervision was a common barrier observed in organisations with moderate or low fidelity (Brunette et al., 2008, p.994).

Sacks et al. (2013, p.489) produced similar findings to Brunette. This research reported on the capability of New York State outpatient programs to provide integrated services for dual diagnosis. They completed a longitudinal study over 3 years in which 447 outpatient programs dealing with dual diagnosis service users were researched, using the Dual Diagnosis Capability of Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDCHMT) tools.

One criterion in the DDCAT tool specifically looks at staff training. This criterion includes the element of staff supervision. Within these programs supervisory sessions with staff were not routinely scheduled; instead, supervision was conducted primarily on an as needed basis, which tended to narrow its focus or concentrated on specific problems that staff members were having. The 56% of staff who were surveyed suggested that having routine supervision would make them feel more capable in using the dual diagnosis training with service users (Sacks et al., 2013 p.489). However the instrument validity in this study has to be reviewed. It has been suggested that even though considerable effort has been put into developing both the DDCAT and DDCHMT indices, further study is needed to determine, among other things, the importance and proper weighting of each of the dimensions included, which in return may skew the findings in the study by Sacks and colleagues (Sacks et al., 2013 p.492).

Schulte, Meier, Stirling, and Berry (2010) also found that clinical supervision is a major element that needs to be in place to ensure careful monitoring of staff who work with dual diagnosis service users. Schulte et al. (2010) studied 124 service users with a dual diagnosis through use of a semi-structured interview and assessment, alongside 46 practitioners who were in charge of their treatment over six

assessment centres in the UK. The staff expertise had been measured against the retention rates of these service users in treatment over a three-month period. The key finding of this study was that service users who were treated by staff with lower levels of self-rated dual diagnosis competency were significantly more likely to drop out of treatment. Among external factors that were found to reduce dual diagnosis competency in self-assessment included the chance to debrief in supervision with a clinical leader (Schulte et al., 2010).

This study was limited due to the small sample size; a number of staff self-assessments also remained incomplete despite numerous reminders. It has to be noted that this study was one of the few studies that interviewed dual diagnosis service users alongside the practitioners. The inclusion of the service users in this research is likely to enable a more accurate overview of practitioner competence.

3.3. Staff training and education

The way staff training is implemented into the organisation has also been associated with successful dual diagnosis competency by staff. Matthews et al. (2011) completed a longitudinal qualitative study using the DDCAT tool in 5 organisations that provide residential inpatient programs in Australia. The DDCAT suggests that to be defined as competent in dual diagnosis treatment, staff training should be a priority, however most organisations found this to be a low priority within their organisation.

These findings closely correlate to the findings of Padwa and colleagues. Padwa, Larkins, Crevecoeur-MacPhail, and Grella (2013) conducted a study in California, USA, in which the research team evaluated the ability of 30 organisations to support dual diagnosis service users with use of the DDCAT. They found that the majority of programs did not have staff members with competency to provide dual diagnosis services other than to provide medication treatment on site.

Even though 80% of the programs in the study had care staff who had been provided with basic training for dual diagnosis, only half of the staff had more advanced training in specialised approaches for dual diagnosis service users. The highest scoring sites for dual diagnosis competency were found to have onsite staff with expertise in mental health alongside staff who had advanced training in specialised treatment approaches for dual diagnosis (Padwa et al., 2013 p.6). The need to complete further training, and be able to put knowledge into practice, may help enhance competency. Both studies, however, are limited in their sample size, and the use of the DDCAT scale as its validity has not yet been established. It shows the need for suitably qualified staff to ensure the best outcome for the service users.

A study conducted in Connecticut, USA (Bedregal, O'Connell, & Davidson, 2006), with 169 practitioners in 9 different agencies that worked with dual diagnosis service users, set out to determine knowledge and attitudes of staff toward service user dual diagnosis recovery. A quantitative tool, the Recovery Knowledge Inventory (RKI), was created by Bedregal and colleagues, in which the staff responses were ranked and used to assess the staff's views on recovery of a dual diagnosis service user (Bedregal et al., 2006). Even though specific to recovery, this study was incorporated as the findings have implications on dual diagnosis training and the needs for tailoring staff training to better prepare them to offer recovery-oriented care.

Bedregal et al. (2006) found that staff had least knowledge about the nature of the recovery process, including its non-linear nature; the idea that illness and symptom management can not only precede recovery but also be part of it (e.g., a person does not necessarily need to be free from illness and symptoms). Implications could result in dual diagnosis service users not receiving the best treatment. They determined that further training was necessary to enhance service user care (Bedregal et al., 2006 p.7).

Limitations of this study were that the training undertaken was specific to the Connecticut area, therefore data found may be specific to the attributes of the area, and replication may not be possible. Instrument validity of the RKI is also not known; Bedregal and colleagues determined the use of a larger sample size was needed to re-evaluate stability of components and reliability of the instrument (Bedregal et al., 2006, p.101).

In another USA study, this time in Texas, Mangrum and Spence (2008) focused on the education of staff and the implications this has upon the competency of staff. Mangrum and Spence (2008) researched co-occurring disorder (COPSD) programs in mental health (MH) settings versus substance abuse (SA) settings to analyse if education made a difference to staff dual diagnosis capability.

All respondents to the study had undergone 15 h dual diagnosis training independent of occupation in which they were employed. With the use of a 5-point self-rating scale, ranging from Poor to Outstanding, mental health and substance abuse workers rated their understanding and ability to demonstrate each of the competencies described by the items on the scale. It was hypothesised that SA staff would be the least academically qualified, however, results indicated that 45% of SA staff held a bachelor degree compared to only 25% of MH staff. MH staff had more years of work experience (Mangrum & Spence, 2008).

It was concluded that both MH and SA staff needed further training, which suited their area of expertise, irrespective of their qualification or work experience. Results indicated a need for increased training regarding documentation of psychiatric issues, to ensure integrated treatment planning and service delivery (Mangrum & Spence, 2008 p.168).

Schulte et al. (2010) conducted a longitudinal study into the work experience of staff at 6 treatment centres in the UK. The key findings demonstrated that service users who were treated by staff with higher levels of self-rated dual diagnosis competency were significantly less likely to drop out of treatment. Those with seven years or more of work experience in the dual diagnosis area ranked themselves highly and retained service users in treatment longer than those who rated their competency as lower (Schulte et al., 2010 p.82). However while this research is promising, it is also limited because it did not assess other variables for the service user retention, such as increased staff training. An additional limitation is that minimal numbers of participants were included in this study due to time constraints of the practitioners. Furthermore, the use of a self-rating scale could also hold social-desirability bias as participants have a tendency to give socially desirable responses instead of choosing responses that are reflective of their true feelings (Grimm, 2010, p. 2).

3.4. Training program and tools

Hughes explored the need for dual diagnosis training to be standardised across all agencies and occupations to ensure that care is more service user oriented. Hughes (2011) undertook a scoping study for the National Health Service in which an electronic survey was emailed to all lead clinicians or service managers within the North West region of England. Hughes (2011) explained that integration between mental health and alcohol and drug workers through standardised assessments would offer a better quality service for dual diagnosis service users.

The study was limited in its small sample size of only 12 individuals. Selection bias may also have been present as organisations that do not have contact details for their management online were excluded and no attempt to find contact details apart from via the internet was used.

Sacks and colleagues found, similar to Hughes, that standardised assessments should be used. The Sacks et al. (2013) research showed that even though a number of organisations had in place a standardised questionnaire tool, alongside a bio-psychosocial assessment, satisfying the criteria to meet a capable worker, it fell short of the state directive as not all staff were using the questionnaire nor felt the need to use the questionnaire. It was concluded that a standardised screening tool should be administered in a separate procedure prior to, and distinct from, the bio-psychosocial assessment to enrich dual diagnosis programs already in place (Sacks et al., 2013, p.491).

On the other hand, standardised scales are not always the most utilised tool of assessment for clinicians. McCabe, Staiger, Thomas, Cross, and Ricciardelli (2011) found that a standardised scale presented some challenges to clinicians who generally worked with a more open style of assessment. McCabe et al. (2011) conducted research to view the responses of staff to the screening tool used for dual diagnosis in an emergency department.

Dual diagnosis service users were monitored over 4 weeks and 7 clinicians undertook a focus group to discuss findings. The full two-part screening that was used in the research was thought to be cumbersome or difficult for service users to understand. Clinicians also found using the standardised scales in isolation created difficulties in recording important contextual detail around the dual diagnosis problems (McCabe et al., 2011). It should be noted that the study was specific to an emergency department of a hospital, where some questions may need to be more succinct than in other departments. Service users were also surveyed who had undertaken the questionnaire and found that it was at times confusing to answer; therefore more user-friendly questions would be beneficial.

So research shows that a structured tool is important in gaining vital information; the knowledge that every department is different and that every dual diagnosis service user is different may make using a standardised questionnaire difficult to work with.

3.5. Organisational changes

The organisation itself plays a role in supporting staff to be competent in dual diagnosis work. Schulte et al. (2010) founded that service factors such as organisational functioning and the level of organisation readiness to implement a new dual diagnosis treatment program determined success. Organisations that allowed for training to be introduced and sought further learning were more successful than those organisations that didn't allow for change (Schulte et al., 2010).

Roberts and Jones (2012) conducted a qualitative study that used a narrative approach. Participants were purposively sampled and from an initial 60 participants enough data was available to reach saturation after 19 interviews. It was found that there were three narratives that were commonly seen, 'radical, remedial and progressive' (Roberts & Jones, 2012, p.679), however all participants agreed that barriers to quality in relation to staff and dual diagnosis expertise include inadequate organisation models, including that the survival needs of organisations are often misaligned with the needs of potential service users.

Being able to implement change toward being an organisation that views the general wellbeing of service users to be of the upmost importance is necessary. However, these narratives may be limited due to their small sample size; and the narrative approach is dependent on participants narrating their lives and experiences without being overly guided. A strength of this study though is that they did include several occupational groups who support dual diagnosis service users: service user-researchers, nurses, occupational therapists, psychiatrists, psychologists, and social workers. This allowed for perspectives from several professional occupation groups, creating a more holistic view of dual diagnosis service user care.

Brunette et al. (2008) found that organisation structure plays a crucial factor in successful dual diagnosis treatment. Both chronic staff turnover and employers not supporting employee's time to train have been found to be limiting factors. In addition, some of these teams were short-staffed for long periods, resulting in high caseloads and overworked employees not being afforded time to train in dual diagnosis competency (Brunette et al., 2008).

Hughes (2011) also suggested that an organisation being willing to change is key to provide a successful dual diagnosis organisation. Hughes' research displayed that those organisations that were willing to implement change by improving attitudes and challenging stigma, as well as joint training and more collaborative work with service users, had the highest rates of competency (Hughes, 2011 p.147). However, only similar agencies were contacted in this research. Those contacted were all part of the National Health Service, therefore findings are restricted to this service and may not confer to other agencies in other countries.

Furthermore Gotham, Claus, Selig, and Homer (2010) completed an exploratory qualitative study in which semi-structured interviews were undertaken, alongside staff capability being analysed with the use of DDCAT and DDCMHT tools. A total of 66 staff were questioned in the study, both in rural and urban settings, in the USA. Findings showed that the size of an agency can denote competency of staff. Smaller agency size was associated with greater change in capability, and single-service agencies showed greater improvement than multiple-service agencies. Paradoxically, larger programs might therefore face greater challenges in initiating change despite the greater resources they have at hand (Gotham et al., 2010).

It may be that smaller agencies and agencies that have one main treatment focus are more able to quickly implement significant program change when they decide to do so, because there is less bureaucracy. However, limitations are present in implications from this research, as it would be a generalisation to infer applicability across a range of organisations and training packages, especially those carrying out different functions in their work with service users.

3.6. Changes to policy and mission statement

Matthews, Kelly, and Deane (2011) suggest that changes to organisations' mission statements and policies to include dual diagnosis service user care is necessary. Matthews and colleagues proposed that for full capability as determined by the DDCAT, an organisation's mission statement should indicate that services are provided for people with co-occurring mental health problems. Incorporating the role of dual diagnosis into the organisation's mission statement is likely to have positive implications for access and the identity of the unit itself, alongside providing a sense of belonging to the service user (Matthews et al., 2011, p.198).

Furthermore Matthews et al. (2011) suggested the inclusion of posters and informational pamphlets in reception areas and waiting rooms is needed in order to communicate that the treatment program provides services for those who have co-occurring mental health disorders. It was found that the waiting room is an ideal place to leave educational material. This improved service user-physician communication and enhanced shared decision making (Moerenhout et al., 2013, p.494). This could be very useful in helping remove the stigma felt by some service users due to their mental illness and substance abuse.

Padwa and colleagues' study further determined the need to accommodate the requirements of service users with dual diagnosis. Padwa et al. (2013) found that the programs that were rated less than competent were more informal, there was no inclusion of dual diagnosis protocols within mission statements or policy, and the availability of service user education materials for both mental health and substance use disorders was limited. Implications were that excluding this information could make the service user feel segregated and lonely. Therefore to include a role with dual diagnosis service users explicitly in organisation literature is a necessity.

4. Discussion

While there is a body of research regarding severe mental illness and substance abuse, the occurrence of studies including staff training is profoundly limited. Having reviewed 10 years of studies, there were only 11 articles that specifically addressed dual diagnosis staff training alongside mental illness and substance abuse. It is surprising there is not more published in this area. In Victoria, Australia, where the current researchers are based, it has been estimated that anywhere

between 40 and 80% of service users who experience mental illness also have issues with substance use (Department of Human Services, 2010). This should be core business, and well researched and understood core business for our sectors internationally.

Hughes explored the need for dual diagnosis training to be standardised across all agencies and occupations to ensure that care is effective and more service user oriented (Hughes, 2011). The current review endorses that position, and demonstrates a modest emerging body of work to that effect. The current systematic literature review took place in the context of a developing research project based around finding mechanisms to support staff to engage service users regarding the reasons for use of substances (Myers, Kroes, O'Connor, & Petrakis, 2017). The project team has, for some years, engaged in tertiary consultation with staff from health and welfare agencies. Staff in these agencies have expressed concern that, despite training on the impact of dual diagnosis and need to address service user identified dual diagnosis needs in an integrated manner, they did not an do not have tools and practices that would simultaneously assist to build their dual diagnosis capacity and assist them in working with service users in a more effective manner.

4.1. Limitations

This review is potentially limited by exclusion of articles that were not in English. Another limiting factor is that articles were excluded if they were published before 2005, which means that potentially relevant seminal articles might not have been included due to age. There are concerns around the power of the findings derived from the papers reviewed due to limited studies, small sample sizes, selection bias in some studies, and issues raised regarding the validity of the DDCAT tool and RKI instrument. Furthermore only two studies used responses from the service users themselves; and even then interviewers only asked service users questions in the presence of a practitioner, which may lead to influence and thus bias. It would be beneficial to seek further clarification from service users as to their views of supportive and competent practices in staff approaches.

5. Conclusions

The limited literature exploring dual diagnosis capacity building and tools so far has focused on either staff capability audit tools or screening and assessment tools for use with service users. The current review findings have provided the knowledge that supervision is necessary to ensure staff feel adequately prepared for the demands of working with service users experiencing dual diagnosis. Furthermore that staff training is often not to an optimal standard, and that competent leaders are necessary to help support dual diagnosis competent staff. It is also apparent that there are organisational barriers that exist to staff competence including agency size, organisational willingness to change, and the need to change policy to make for a more inclusive atmosphere. This review confirms a gap as to whether a dual diagnosis resource which can be used in treatment with a service user can also have an impact on dual diagnosis capacity.

References

Bedregal, L. E., O'Connell, M., & Davidson, L. (2006). The recovery knowledge inventory: Assessment of mental health staff knowledge and attitudes about recovery. *Psychiatric Rehabilitation Journal, 30*(2), 96.

Brunette, M. F., Asher, D., Whitley, R., Lutz, W. J., Wieder, B. L., Jones, A. M., & McHugo, G. J. (2008). Implementation of integrated dual disorders treatment: A qualitative analysis of facilitators and barriers. *Psychiatric Services, 59*(9), 989–995.

Cookson, J., Sloan, G., Dafters, R., & Jahoda, A. (2014). Provision of clinical supervision for staff working in mental health services: Jen Cookson and colleagues assess whether there is a difference between nurses and allied health professionals in adherence to a guideline that promotes best practice. *Mental Health Practice, 17*(7), 29–34.

Department of Human Services (2010). *Dual diagnosis key directions and priorities for strategic development.* State Government of Victoria, Australia: Department of Health & Human Services.

Donald, M., Dower, J., & Kavanagh, D. (2005). Integrated versus non-integrated management and care for clients with co-occurring mental health and substance use disorders: A qualitative systematic review of randomised controlled trials. *Social Science & Medicine, 60*(6), 1371–1383.

Drake, R. E., Luciano, A. E., Mueser, K. T., Covell, N. H., Essock, S. M., Xie, H., & McHugo, G. J. (2015). Longitudinal course of clients with co-occurring schizophrenia-spectrum and substance use disorders in urban mental health centers: A 7-year prospective study. *Schizophrenia Bulletin, 42*(1), 202–211.

Gotham, H. J., Claus, R. E., Selig, K., & Homer, A. L. (2010). Increasing program capability to provide treatment for co-occurring substance use and mental disorders: Organizational characteristics. *Journal of Substance Abuse Treatment, 38*(2), 160–169.

Grimm, P. (2010). Social desirability bias. *Wiley International Encyclopedia of Marketing Research*, 1–6. http://dx.doi.org/10.1002/9781444316568.wiem02057.

Hughes, E. (2011). Service provider response to mental health and alcohol in the North West Region of England: A scoping exercise. *Advances in Dual Diagnosis, 4*(3), 141–151.

Mangrum, L. F., & Spence, R. T. (2008). Counselor and client characteristics in mental health versus substance abuse treatment settings providing services for co-occurring disorders. *Community Mental Health Journal, 44*(3), 155–169.

Matthews, H., Kelly, P. J., & Deane, F. P. (2011). The dual diagnosis capability of residential addiction treatment centres: Priorities and confidence to improve capability following a review process. *Drug and Alcohol Review, 30*(2), 195–199.

McCabe, M. P., Staiger, P. K., Thomas, A. C., Cross, W., & Ricciardelli, L. (2011). Screening for comorbid substance use disorders among people with a mental health diagnosis who present to emergency departments. *Australasian Emergency Nursing Journal, 14*(3), 163–171.

Moerenhout, T., Borgermans, L., Scholl, S., Vansintejan, J., Van De Vijver, E., & Devroey, D. (2013). Patient health information materials in waiting rooms of family physicians: Do patients care? *Patient Preference and Adherence, 7*, 489–497.

Myers, K., Kroes, S., O'Connor, S., & Petrakis, M. (2017). The reasons for use package: Development research and implementation lessons for the field. *The mental health services (TheMHS) conference 2016 book of proceedings: PeopleAuckland, New Zealand: Authenticity Starts in the Heart (23–26 August 2016).*

Padwa, H., Larkins, S., Crevecoeur-MacPhail, D. A., & Grella, C. E. (2013). Dual diagnosis capability in mental health and substance use disorder treatment programs. *Journal of Dual Diagnosis, 9*(2), 179–186.

Roberts, B., & Jones, R. (2012). Dual diagnosis narratives and their implications for the alcohol and other drug sector in Australia. *Contemporary Drug Problems, 39*(4), 663–685.

Sacks, S., Chaple, M., Sirikantraporn, J., Sacks, J. Y., Knickman, J., & Martinez, J. (2013). Improving the capability to provide integrated mental health and substance abuse services in a state system of outpatient care. *Journal of Substance Abuse Treatment, 44*(5), 488–493.

Schulte, S. J., Meier, P. S., Stirling, J., & Berry, M. (2010). Dual diagnosis competency among addiction treatment staff: Training levels, training needs and the link to retention. *European Addiction Research, 16*(2), 78–84.

Thornton, L. K., Baker, A. L., Lewin, T. J., Kay-Lambkin, F. J., Kavanagh, D., Richmond, R., ... Johnson, M. P. (2012). Reasons for substance use among people with mental disorders. *Addictive Behaviors, 37*(4), 427–434.

Chapter 3

Methodology

The Reasons For Use Package which was co-designed by Simon Kroes and this candidate. A research partnership was developed in collaboration with an Australian community mental health support agency, Neami National, with the specific aim of looking at the perceived efficacy of this resource with respect to building the knowledge and confidence of their staff in dual diagnosis interventions. A subsidiary aim of the research partnership was to seek feedback from service users as to their experience of using the RFUP with their worker.

The Victorian Dual Diagnosis Initiative

In response to the growing acknowledgement of the problems associated with dual diagnosis a variety of jurisdictions have developed strategies to improve outcomes. The Victorian Dual Diagnosis Initiative is one such endeavour developed by the Victorian state Government (Roberts, Maybery and Jones, 2013). It began in 2000 with four distinct metro Melbourne teams focussing activity in separate areas of Melbourne with remote and rural Dual Diagnosis clinicians spread across other parts of Victoria. The VDDI shares a core objective of improving outcomes however each team and individual rural and remote clinician is auspiced by a different agency and there have been a variety of methods developed and employed to improve capacity. These included primary, secondary and tertiary consultation, education, training and cross sector networking amongst others. The VDDI meets regularly as a VDDI Leadership Group to discuss common issues. Nexus Dual Diagnosis Consultation Service, one of the four metro Melbourne teams where this candidate is based, is aupiced by St Vincent's Hospital Melbourne.

The VDDI was evaluated in 2011 with the Final report indicating that,

"The Initiative had had a dramatic impact with regard to building recognition that dual diagnosis is everyones business" (Australian Health Associates 2011 p 3).

The report noted however that "Integrated Treatment is an area where there is far less progress" (Australian Health Associates, 2011, p. 4). It noted that a key factor was: A lack of willingness of some organisations to drive the reform in their own organisation, particularly in clinical mental health (Australian Health Associates, 2011. p. 4).

The report made a number of recommendations calling for a VDDI Statewide Strategic Plan (VSSP) to be established. Two of these recommendations are particularly related to the RFUP.

Recommendation 3.2.1 " The workforce development strategy gives careful consideration to the development of training packages for senior managers, team leaders/supervisors and clinicians and workers that are relevant to individual sectors" (p. 9)

And

Recommendation 3.2.4 "A much stronger emphasis on the establishment of the capacity to deliver clinical and non-clinical interventions to be included" (p. 9).

The Development of the Reasons For Use Package

The vexed question of the motivations for drug use amongst people who have mental health issues was discussed in a key paper by Spencer et al in 2002. The paper explores the motivations based on the domains of the Reasons For Use Scale (RFUS) which had modified the Drinking Motives Questionniare (Cooper 1984) by adding questions about symptoms related to psychosis. The results indicated that participants used substances for a variety of reasons rather than only to cope with unpleasant affect. This isn't perhaps surprising given the large percentage of people who use substances for social or other reasons within the general population. Service users of course don't live in a vacuum they live within a distinct cultural and social setting (Amodia, Cano, and Eliason, 2005). Khat, a stimulant, is mainly chewed by people from the Horn of Africa, Cava is mainly used within Pacific Islander communities and coffee was only relatively recently a drug of choice in the United Kingdom and Ireland.

The RFUS questionnaire opens up the possibility of a number of different reasons for use; which in turn raises the possibility of change, i.e. a person's reasons for using alcohol may change over their lifetime. Increased awareness can then lead to curiosity about their current pattern of use and their current mental and physical health. In this way the RFUS doesn't set up a pro or anti substance use discussion, but puts the servicer user at the centre of understanding why and what they might want to do in future.

The RFUS had been offered to service users as part of an eight-session group program developed by the Mental Health Collaborative Therapy Unit. The designers of the RFUP (Myers et al, 2017) had extensive experience of delivering this package in the period 2006-2011. Service users seemed to respond very well to the RFUS questionnaire. In 2007 the Victorian government brought out a land mark dual diagnosis policy which explicitly set out key directions for service delivery. One of the major changes that occurred through this policy was an increased level of screening for mental health and substance use issues (Australian Health Associates, 2011). Staff in a number agencies began to seek support from Nexus saying that they had a lack of knowledge and confidence about what to do after screening. This was a major motivation for creating the larger RFUP which brought together the RFUS questionnaire and brainstorming treatment planning section and training and mentoring to support implementation.

The RFUP was designed to augment common practice wisdom across mental health and Alcohol and other drug services. This means that the options for consideration cover a range of possible interventions but are neither prescribed nor set out as the only things to consider. For example although one option is "consider self-help groups", the range of such groups will depend on the suitability and availability for a particular service user and locality. In training and mentoring staff are encouraged to link the broad approach of the RFUP to their particular setting. It is also worth pointing out here, that a staff member can collaborate with a service user to develop new awareness and a treatment plan, without necessarily being the person who will implement the

plan. Indeed it may well be that a plan may bring together a number of services to enact the plan in an integrated manner for example as part of a discharge process.

The reasons for use scale divides reasons for substance use into five domains. Social Use, Enhancement, Coping with Unpleasant Affect, Peer Pressure and Positive Symptoms and medication side effects. In the RFUP the last domain is separated into two sets of options for consideration one aimed at positive symptoms and the other medication side effects. This adaption was supported by Professor David Castle who had headed the RFU scale development team. Some options for consideration will appear in several domains such as developing assertiveness, as this might be useful for dealing with peer pressure or social situations. Throughout the RFUP staff and service users have the opportunity to add free text ideas to enhance and personalise the treatment plan.

Between 2012 and 2014 a number pilots and discussions with service users, staff and carers further enhanced the RFUP. In 2013 Neami National whose staff had enthusiastically called for the RFUP to be supported, formed a research partnership with Nexus and Dr Melissa Petrakis of Monash University to look at developing a greater understanding of the perceived impact of the RFUP. In 2014 Myers was encouraged to apply to undertake a Ph.D. as it was felt that framing and supporting this process through a tertiary and industry lens was part of the Monash Universities strategic plan. Neami National and Nexus where also keen to build published material which would support evidence based practice.

Research Context

In addition to the material described in the introduction to this Thesis it is worth exploring further the particular context within which this research was set as it occurred during a period of intense changes in service provision. In Victoria Australia there are a number of services which provide a range of psycho-social support rather than clinical or statutory support for mental health consumers. For many years these services were called Psychiatric Disability Rehabilitation and Support Service (PDRSS) which had developed often through concerned individuals and later supported by a range of block funding by State government (Ronnau, Papakotsias, and Tobias, 2008).

A Victorian Mental Health reform agenda in 2014 changed the name to Mental Health Community Support Services. The reform agenda attempted to increase consumer choice and distribute services more evenly across the state. Whilst this was being implemented during the period from 2014 to the time of writing there was an additional change to the sector with the staged roll out of the National Disability Insurance Scheme which was developed at a Federal level (Brophy, Bruxner, and Wilson, 2014).

The Victorian Government entered a bilateral agreement in 2015 that saw a shift of funding from MHCSS to the new NDIS based services. One of the major consequences of this change in policy was a focus on deficit-based eligibility criteria, which stressed enduring disability under NDIA (Williams, and Smith, 2014). This meant that many consumers with dual diagnosis struggled to maintain a service as mental health and substance use are often considered fluctuating conditions (Mental Health Australia, 2014). It also meant that many of the values, structures and services that had been the hallmark of the PDRSS/MHCCS sector for over 30 years were severely challenged; including concepts like strengths and recovery-orientated approaches.

The Training and mentoring of staff in the partner MHCSS organisation took place right in the middle of this period. At that point in time the organisation had a well-established and researched model of care based on the Collaborative Recovery Model (2007) which was supported through a strong coaching culture initially developed in Victoria but spread to a number of other states including NSW, SA and WA. This meant that both the participants and the organisation were philosophically and organisationally ready for the Reasons For Use Package.

Research Question

How do staff perceive the efficacy of a dual diagnosis intervention strategies package, namely the Reasons For Use Package (RFUP)? (This is a package that was specifically designed to assist mental health staff working with consumers with a dual diagnosis)

A subsidiary research question was: What is the Consumer experience of using the RFUP with mental health support workers?

Ontology and Epistemology

The Candidate's Ontological Position: Interpretivist /social constructivist

From this position, knowledge is a subjective interpretation rather than an objective reality. This concept of knowledge fits in very well with social work practice and dual diagnosis where meaning is different over time and will depend on the individual's perspective of terms like 'recovery' and 'relapse' (Worley, 2017). An example is the contested understanding of mental health/illness where the voice of consumers has increasingly challenged clinical knowledge (Byrne, Happell and Reid-Searl, 2015). Furthermore this research takes into account the contested historical social

context of substance use and how this impacts on drug use activity and associated harms (Duff,2007; Room, 2005;Westermeyer, 2005).

Epistemological Methodology: Pragmatism

Mixed methods: pragmatic epistemology underpins the mixed method research design (Morgan 2014). Dual diagnosis capacity building is a contested and multi-faceted term which is socially constructed and changes over time (Allsop, 2008; Roberts, 2012). Given the nature of the phenomenon being researched here, with multiple different sources of knowledge that can impact on each other a pragmatic approach is appropriate.

Pragmatist researchers focus on the 'what' and 'how' of the research problem (Creswell, 2013, p.11). This research is based on inductive reasoning, clarifying meaning, and analysing and exploring phenomenon. The research takes place in a specific social context and is in turn affected by social interaction between researcher and participants. Pragmatic research accepts the 'situating of the researcher within the context under investigation' (Maxcy, 2003, p. 82). Flynn and McDermott (2016) have explored the concept of emic (insider) and etic (outsider) researchers, and citing Kerstetter (2012, p. 12), note: 'it is more often the case that insider/outsider positioning occurs on a continuum, with researchers rarely being either/or'. Pragmatic research is aimed at increasing understanding of the research problem utilising methods which aid this process, thus the test of whether method should be used is whether it actually increases understanding of the research problem (Mackenzie and Knipe, 2006). In this research the candidate was potentially seen as being an outsider to some participants and an insider to others depending on their position within the organisation and relationship with the candidate.

Methodological Design

Research design

A national case-control comparison trial would be conducted with community mental health staff employed by Neami National in Victoria receiving training and mentoring in the Reasons For Use Package compared to a matched sample of staff respondents from the same organisation in NSW. A mixed methods approach including surveys, focus groups and a case study was used to collect data for the study. Consumers who participated in the study were offered the opportunity to give feedback on their experience of using the RFUP with their worker.

The Intervention

Figure 4 Intervention Steps

Study Sample

Description of Research Sample

Mental Health Community Support Service (MHCSS) staff from the same agency, based in two Australian states, Victoria and New South Wales. Whilst staff had a range of backgrounds including many with Nursing, Occupational Therapy, and Social Work qualifications, others had been employed based on their Lived or other experiences. Neami National's Annual Report 2015-16 gave the following statistics relating to overall staff profile.

"61.9% had a Bachelor degree or higher, 16.4% had a Diploma, 15.6% had a Certificate I-IV, 6.1% Secondary education, 69.2% identified as Female, 30.8% identified as Male, 4% identified as Aboriginal or Torres Strait Islander and 18% identified as being from Culturally Diverse Backgrounds (Neami National, 2016. P41)

All staff in this agency receive training in a number of areas which may have a bearing on their ability to feel confident and knowledgeable about working with consumers with a dual diagnosis. The core training includes the Collaborative Recovery Model, Motivational Interviewing and the World Health Organisation Alcohol Smoking and Substance Involvement Screening Test Version 3 (WHO ASSIST) screening tool. It should be noted that this particular MHCSS has for many years also had a strong culture of coaching to support professional development. This meant that the mentoring component of the intervention was complimentary to the existing structures.

Recruitment

Purposive sampling was employed in this research project, where the researcher deliberately chooses variables as opposed to for example random selection of participants (Alston and Bowles 2018). The aim of was that the comparison between Victorian and NSW cohorts would be possible as they was a degree of homogeneity with respect to setting. The intention being to

recruit from a similar group of staff in both states working with similar types of services users. For example as NSW did not have a dedicated youth team as compared to Victoria, Neami staff from these sites were not eligible to join the research. All the potential cohort had received standard Neami National training on the Collaborative Recovery Model, the World Health Organisation ASSIST screening tool and motivational interviewing which are recognised as contributing to dual diagnosis capability prior to being involved in the research study.

Two groups of Neami National staff who had similar professional backgrounds and working with a similar consumer cohort were recruited for the research project. This was facilitated by Neami National all staff as the relevant sites were sent an expression of interest flyer. A plain language statement explaining the research project and that their involvement was voluntary and that they could withdraw at any time with no impact on their current or future employment (see Appendix 1). Staff who wished to be involved signed a consent form (Appendix 2).

The NSW cohort was the control site. The Victorian cohort of Neami National staff was the intervention site. Participants from Victoria were additionally trained and received mentoring in their use of Reasons For Use Package with two consumers.

Sample Size

A total of 48 Victorian staff were recruited for the intervention site.

A total of 44 NSW staff were recruited for the control site.

19 Consumers consented to give feedback on their experience of using the RFUP with their worker.

Training and mentoring in the RFUP

The Victorian cohort received five hours of training in the RFUP. This included exploring the philosophical alignment of the RFUP, the recommended approach to using the RFUP with consumers including how to take into account the consumer's individual context, when introducing the tool. This session also included an experiential pair exercise whereby participants took turns to facilitate their partner's use of the RFUP to explore their substance use such as caffeine, nicotine or alcohol and develop a collaborative treatment plan. The experiential aspect of the training reinforced the desired approach i.e, a collaborative exploration rather than an interrogation of the participant as well as giving a valuable insight into how the questionnaire part of the RFUP can bring forth new insights which in turn can assist with both engagement and treatment planning. The session finished with an exploration of how the mentoring sessions would be ran as they used the RFUP with two consumers.

Each participant was allocated a mentor who had already been trained and mentored in the RFUP. The mentors were practice leads within each Victorian Neami National site. There was approximately one mentor to four participants. Participants and mentors were encouraged to complete using the RFUP with two consumers with two separate mentor sessions over about a 4-6 week period.

Data Collection

Quantitative Methods

In this study, the use of quantitative methods is justified by their role in deepening understanding of the phenomenon. "Quantitative data may be utilised in a way, which supports or expands upon qualitative data and effectively deepens the description" (Mackenzie and Knipe, 2006, p. 1). Two

self-report instruments, one for staff and one for consumers (the latter included space for qualitative data alongside survey questions) were designed for this research.

Staff Survey

The staff surveys (Appendix 3) captured the perceptions of participants in both N.S.Ws and Victoria at approximately the same time. The surveys occurred at three time points: coinciding with pre training, post training and post mentoring of the Victorian staff cohort. The survey questions looked at knowledge and confidence in dual diagnosis interventions related to the domains of the five reasons for use scale. Nb with the agreement of Professor Castle who had developed the Reasons for Use scale, domain one, substance use related to positive symptoms and medication side effects, had been split into two in the treatment planning section of the Reasons For Use Package. This meant there were 12 questions with a four point Likert scale; strongly agree, agree, disagree, strongly disagree.

Consumer Survey

It would of course be unsound to explore the capacity building efficacy for staff participants in isolation from the consumer experience. Feedback from Consumers and Carer representatives following initial presentation of the RFUP at a Nexus Dual Diagnosis Forum in 2015 strongly indicated that the RFUP design appeared sound, but that this would be enhanced by direct gathering of the consumer experience of the RFUP. This was facilitated by Neami National staff via a consumer plain language statement explaining the research project (see Appendix 4). Consent was provided through a consent form (Appendix 5).

A Consumer feedback survey was designed for this research (Appendix 6).

The consumer feedback added another layer of subjective meaning. Although each individual consumer is feeding back their subjective experience, triangulation of results with the staff surveys, focus groups and case study deepens understanding which can then offer new insights.

Measures

Consumers were surveyed using a 7-item questionnaire aimed at gathering consumer feedback about their experience using the RFUP with their worker. Responses were measured on a 5-point Likert Scale (strongly disagree, disagree, neutral, agree, and strongly agree).

Procedure

Workers offered the plain language statement and consent form feedback questionnaire to consumers after completing all the RFUP sessions from administration of the Reasons For Use Scale questionnaire, reflective discussion of the generated results and treatment planning. In order to maintain privacy and confidentiality consumers were provided with a reply-paid envelope to submit the completed questionnaire, without identifying information and completed the survey in their own time away from the staff member. This method aimed to reduce any likelihood that the consumer may have felt that any negative feedback risked their relationship with the worker and wider program. As mentioned below in limitations the drawback with this is approach was that it would not be possible to track individual consumers with individual worker responses.

Qualitative methods

Focus Groups

The utility of focus groups is well established in the literature (Wilkinson, 2015).Focus groups can elicit new insights and be used to explain, expand and illuminate quantitative data (Sagoe, 2012). They have been described by Alston and Bowles (2018) as:

> *Focus groups are small, homogenous groups that are representative of the target population and of key informants brought together to discuss pertinent issues.*
>
> (p. 218)

In this study it was felt that focus groups would be a suitable method to collect new data alongside the quantitative methods. Furthermore the self-reported perception of knowledge and confidence, gathered from the staff surveys were not able to capture the interactive components of mentors, mentees and their perception of how consumers responded to the use of the RFUP.

Mentor Sessions

Mentoring is seen as an integral component of the RFUP and is addressed below in a specific paper in the results section (Myers et al. 2018). Each Victorian participant received two mentor sessions with the mentors taking notes of various aspects of the conversation. The themes emerging from mentoring were explored in the Mentee and Mentor and Mentee Focus groups.

Two focus groups were held to explore the subjective experience of staff participants in Victoria. The first group used semi-structured questions and was a sample group of staff who had been trained and mentored in the package. Thematic analysis was used for this research project in order to record notable findings and patterns from the experience of the Victorian cohort of mentees (Bryman, 2012).

The second focus group which occurred around five months after initial training, involved both mentors and mentees who were shown the quantitative data from the surveys of staff and consumers. This session explored the participants' thoughts about the data and how this fitted with their experience. Further questions explored their thoughts about how the RFUP related to

the Collaborative Recovery Model and the implementation process for this research. The session was recorded, and a thematic analysis was conducted.

Case study exploration

A de-identified case study (Alston and Bowles, 2018, Pan and Tan, 2011) would be used to explore staff and service user experience of using the RFUP was conducted. Whilst it is not possible to make universal claims based on one case study, there is merit in in-depth analysis of an exemplar case to illustrate the complex nature of how the RFUP might simultaneously assist the consumer whilst building new knowledge and confidence for the staff member.

Triangulation

Triangulation (Denzin, 1989) uses two or more methods to increase understanding of the topic. Furthermore, triangulation itself is likely to give greater validation to any findings from the research, as any one method may not uncover relevant perspectives (Olsen, 2004).

Triangulation refers to a process whereby two or more methods of collecting data are used to increase understanding of the research topic (Alston and Bowles, 2018) It has been noted:

> *Triangulation is not for the purpose of corroboration, as much as it is to deepen understanding of the nuances and complexities of the people, places, or events in the study through multiple accounts* (Gringeri, Barusch and Cambron, 2013, p. 765)

Furthermore, triangulation itself is likely to give greater validation to any findings from the research, as any one method may not uncover relevant perspectives (Olsen, 2004).

In this particular research it was a conscious decision to employ a number of methods due to the complex nature of the phenomenon and the likelihood of different socially constructed interpretations of service users and staff as mentors and mentees.

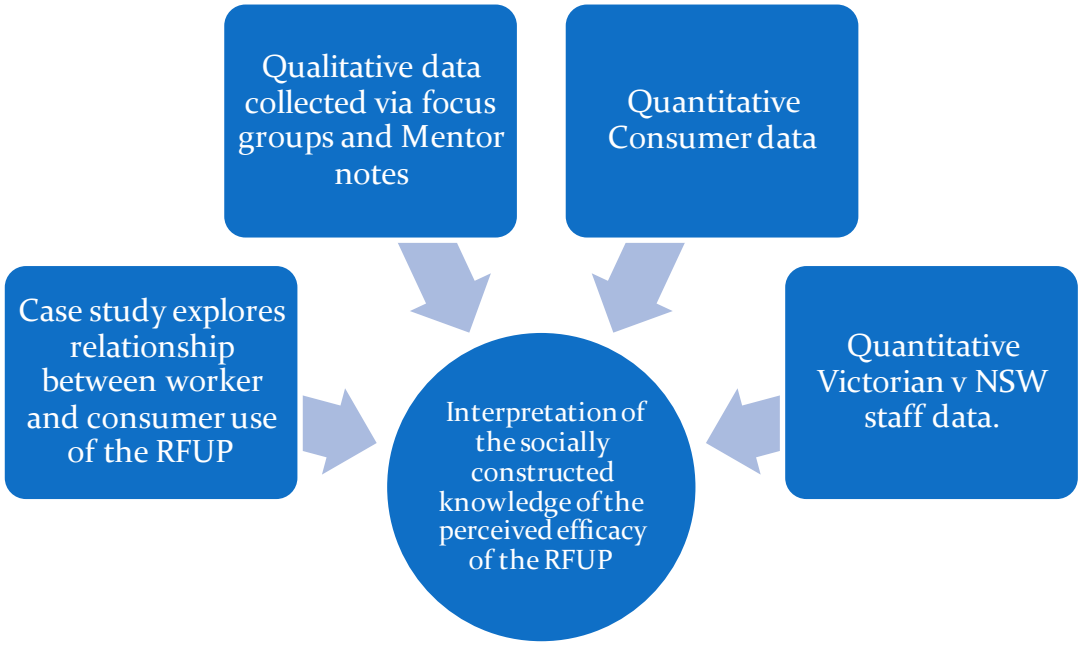

Figure 5 Triangulation

Research Ethics

As the candidate was employed at St Vincent's Hospital Melbourne, this research project was approved by the St Vincent's Hospital, Human Research Ethics Committee (HREC-A) in 2015. It was also given clearance at the Monash University Human Research Ethics Committee (MUHREC). Neami National where the staff and consumers were recruited also approved this project through their research committee.

The staff and consumers potentially recruited for this study already identified substance use issues through the use of the W.H.O ASSIST screener (Newcombe, Humeniuk, and Ali, 2005) and the MHCSS had existing policies outlining their ethical response to working with consumers around dual diagnosis. Duty of care for consumers and staff well-being was maintained by the MHCSS

rather than the researcher. The key ethical considerations in this research design fell into a number of categories. Firstly consumers who were invited to give feedback on their experience of using the RFUP with their worker needed to be assured that participating or not participating would have an adverse impact on care, secondly when consumers agreed to give their feedback they needed to be assured that there would be no adverse impact from negative comments about either the research, the RFUP or the relationship their worker. Each consumer was given a plain language statement (Appendix 4) that outlined the purpose of the research, potential risks and benefits and what their involvement would entail. A consumer consent form was signed before giving feedback on their experience of using of the RFUP (Appendix 5).

With respect to staff ethical issues covered a similar of issues. Staff needed to know that that participating or not in the research or negative comments about the RFUP would have no adverse impact on their employment. A staff plain Language Statement and Consent form was provided prior to commencement (Appendices 1 and 2).

Reliability and Trustworthiness

The concepts of reliability and trustworthiness are essentially asking whether other researchers looking at the same data would draw similar conclusions and secondly that if someone else followed the same research design for a subsequent study they would be able to compare results. There are a number of reasons why these are important issues, firstly any claims of new knowledge need to be stated from the standpoint of what was already known. The evidence base is thus built on the back of previous research. Secondly all research carries a risk of bias i.e that the researcher(s) are looking for data which supports their original hypothesis or interests.

The research design in this study employed a number of methods to ensure reliability and trustworthiness. Staff and consumer participants were able to give their survey feedback

anonymously, Mentor notes did not identify either the staff or consumer participant. Attendees at the staff mentee focus group were not identified and this focus group was facilitated by a M.S.W student attached to the project via a placement with Neami National. The combined mentor and mentee focus group was held later in the research processes and was attended by the candidate and Simon Kroes RFUP designer. It was felt that having Kroes and Myers involved would deepen the dialogue around the data. This may have had some impact on the willingness of participants speak negatively about their views of the data. Whilst it is not possible to fully mitigate this risk, in order to reduce this possibility Sarah O'Connor research office and a senior staff member from Neami National facilitated the session. However as a further step the session was videoed and a thematic analysis was completed, including an additional sense checking step utilising a Masters of Public Health student who was on a different placement at Nexus.

The Case study paper was co-written by a Neami National case worker who had was able to provide her own insights from the using the RFUP with a service user, thus adding an additional level of reliability to the perceived impact of the RFUP.

Limitations, Summary and Conclusion

All research by its very nature has limitations whether these are deliberate or unforeseen. These are factors which need to be understood in order to place the research results and conclusions in a particular set of parameters, essentially this should make it possible to compare results if a replication study occurred. A discussion about limitations is not about undermining the validity of the research under taken, it is about clarifying what can safely be drawn or built on in the future. Since this research was conducted with a particular cohort of staff and consumers in a specific time and context, there is a need to be careful of drawing universal conclusions. In this case Neami National was an organisation which already had a strong philosophical and operational alignment

with the RFUP. A repeat of this research methodology, with a separate organisation of staff and consumers, would therefore be an appropriate recommendation for future study.

As mentioned, this research was designed to capture the experience of both staff and consumer participants. It is highly likely that favourable or negative consumer response to the RFUP would have an impact on the perceived efficacy of the RFUP of staff members. However a conscious decision was made to collect de-identified responses including the demographics of the consumer and the nature of their dual diagnosis i.e substance and mental health issue as this would have made it more likely to be able to identify individual consumers. A limitation of this approach is that it was therefore not possible to match the individual staff responses with the consumer response.

Another limitation of this research design is that the surveys and focus group data were collected over a relatively short time period of around five months. A longer study time with follow up at 6 and 12 months may have picked up different trends for both staff and consumers.

Chapter Summary and Conclusion

This methodology chapter has described and explained the research design for this study. A pragmatic methodology was employed with mixed methods of data collection including both qualitative and quantitative methods, surveys, focus groups and a case study. This design is consistent with a social constructivist ontological stance and is particularly relevant to this phenomenon where interpretations of varied actors are present. Furthermore, the triangulation of different data sets combined together strengthen the validity of any conclusions drawn from this research.

Chapter 4

Results

This chapter covers results and as well as including three published papers, also has two sections which report on consumer feedback and focus group findings.

The first published paper in the results chapter is titled "The Reasons for Use Package: development research and implementation: lessons for the field".

This paper was presented at the TheMHS (The Mental Health Services) conference, Auckland New Zealand in 2016. TheMHS is an international learning network for improving mental health services in Australia and New Zealand. It brings together service users, carers and their respective peak bodies with service providers and government bodies and has long been recognised as a key industry influencer since it began in 1991. It is worth noting that the Reasons For Use Package research was a nominee for a service innovation award that year. TheMHS conference awards, are funded by Australian and New Zealand governments. The first TheMHS conference awards in 1992, were presented by the then Australian Deputy Prime Minister and Health Minister the Honourable Brian Howe. The prestige and influence of the conference was a decisive rationale for publishing a paper with TheMHS.

The second published works in the results chapter is titled "The Reasons For Use Package: how mentoring aids implementation of dual diagnosis practice.'

This paper was published in New Paradigm The Australian Journal of Psychosocial Rehabilitation which is produced by a coalition of Australian Mental Health Peak bodies including Vicserv the Victorian Peak Mental Health Service Body. Vicserv is now called, Mental Health Victoria (MHVic), and at the time of writing has a major role in the implementation of recommendations from the Royal Commission into the Victorian Mental Health System. This particular edition of New Paradigm, was dedicated to practice based research with the cover title

"Research into Practice" and included two other papers, which have been included in Monash University thesis inclusive of published works in the Medicine, Nursing and Health Sciences Faculty.

The paper focuses on the mentoring aspect of the RFUP and how the approach taken, needed to be congruent with the approach staff applied when using the RFUP with service users. The paper explicitly discusses the role of mentoring in sustaining dual diagnosis capacity rather than training alone. This was consistent with Neami National's internal coaching support structures which had been used to build and maintain overall organisational capacity in other interventions and approaches such as the Collaborative Recovery Model (CRM) and motivational interviewing (Miller and Rollnick, 2012).

The third results paper was published in a Q1 peer reviewed journal Research on Social Work Practice and is titled "Reasons for Use Package: Outcomes From a Case Comparison Evaluation". The paper reports on the quantitative data comparing results from between the control cohort New South Wales (NSW) the intervention cohort of matched staff from Victoria.

Preamble Paper 3 for Thesis inclusive of Published works

Title: 'The reasons for use package: development research and implementation: lessons for the field'

Authors: **Myers, K.**, Kroes, S., O'Connor, S. and Petrakis, M.

Journal: Conference proceedings e-book

Publisher: TheMHS Learning Network

Status: Published 2017

This paper explores the background to the development of the Reasons For Use Package, the early pilots of the tool and the development of the research partnership. The paper outlines the research methodology and outlines early results.

Addressing the subsidiary research question:

How did the RFUP research partnership come about and are there lessons for the field?

Conference presentation:

This paper was co-presented with Ms Sarah O'Connor from Neami National who is also a co-author. "*People. Authenticity Starts in the Heart"*. TheMHS Learning Network Conference, Auckland, New Zealand 23 - 26 August 2016.

TheMHS (The Mental Health Services) conferences are attended by consumers, carers and service providers in the Oceania region. It has a well established reputation as an avenue for bringing research into practice.

THE REASONS FOR USE PACKAGE: DEVELOPMENT RESEARCH AND IMPLEMENTATION LESSONS FOR THE FIELD

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ABSTRACT

Background: The Reasons for Use Package (RFUP) was designed by Nexus Dual Diagnosis Service, St Vincent's Hospital (Melbourne), to facilitate therapeutic conversations about dual diagnosis issues. It assists in collaborative treatment planning between staff and consumers. It includes the Reasons for Use scale, a menu of possible interventions and a staff mentoring process.

Methods: From a 2012 Quality Improvement Pilot, Nexus, Neami National and Monash University have collaborated to build the evidence base. A national research comparison has taken place, with an intervention group of Neami National Victorian staff compared with a matched cohort in NSW. Groups were surveyed at 3 time points: baseline, training and mentoring. Consumers involved in the research were offered a feedback questionnaire, and further qualitative data was collected from focus groups.

Results: Over 100 Neami National staff have participated, with findings that the RFUP resource significantly increased staff confidence and dual diagnosis knowledge.

REASONS FOR USE PACKAGE PARTNERSHIP

Simon Kroes and Kevan Myers designed the RFUP in response to a gap identified by the field as to how to effectively follow up initial screening for dual diagnosis issues. Consumers, carers and staff confirmed this through a needs analysis survey at the 2012 VIVSERV conference. After the successful initial Victorian pilot in 2012, Nexus, Neami National and Monash University agreed to collaborate in research partnership to evaluate and develop an implementation model for the RFUP.

Nexus Dual Diagnosis Service

Nexus is auspiced by St Vincent's Hospital (Melbourne), Victoria. Established in 2000, as part of the Victorian Dual Diagnosis Initiative (VDDI), Nexus works with more than 40 agencies to improve their dual diagnosis capacity via training, consultation and resource development. In the Australian (Allsop 2008; Roberts 2013) and international service delivery literature (Minkoff & Cline 2004), the need to resource and support services to focus on comorbid or co-occurring mental health and substance use in an integrated manner is important since it is so common that a person presents with *both* a mental health and substance use problem or set of challenges (Teeson & Proudfoot, 2003).

Neami National

Neami National commenced in Victoria in 1986 as a community mental health service supporting people living with mental illness to improve their health, live independently and pursue a life based on their own strengths, values and goals. They now provide services in diverse communities in Western Australia, Queensland, South Australia, Victoria and New South Wales (Neami National Australia 2014). They currently support over 4,000 Australians annually in their recovery.

Monash University

Monash University is ranked in the top one per cent of world universities according to the Times Higher Education World University Rankings (2013-2014). The 2012-2013 rankings noted Monash as one of only six Australian universities in the world's top 100, and the 34th university in the world for Clinical, Pre-Clinical and Health. Monash is a member of the Group of Eight, an alliance of leading Australian universities recognised for excellence in teaching and research. The departments of Social Work and Art, Design and Architecture, based at Caulfield Campus (Melbourne), actively engage with industry to support mutually beneficial innovations for students the broader community.

THE REASONS FOR USE PACKAGE

What Is It?

The package is currently a Power Point file with links to other supporting documents. It can be used in WORD format also. It is a user friendly, package that can be applied in a number of circumstances to a wide range of consumers. It provides a framework for working with consumers with dual diagnosis issues. A web based platform is being developed in

partnership with Monash University Art Design and Architecture with the aim of increasing availability.

Who Made It?

Designed by Simon Kroes and Kevan Myers from Nexus Dual Diagnosis Service at St Vincent's Hospital Melbourne, building on the Reasons for Use Scale developed and researched by Professor David Castle and colleagues (Spencer, Castle & Michie, 2002).

Why Did You Make It?

The Reasons for Use Package (RFUP) was designed in response to workers in the field asking for resources to assist them after they have done initial screening for dual diagnosis issues.

Is It User Friendly?

The RFUP has been built to align with common health and welfare skills that workers already have. It provides a framework for applying these skills in a practical and user friendly manner. Workers from a range of disciplines, including psychology, occupational therapy and social work, who have used the RFUP found the package easy to use.

Quotes from workers that have used the RFU Package:

> "Simple, meaningful and related to work practice"
>
> "Good for building dual diagnosis into core practice"
>
> "…very personal approach to their (the consumer's) situation"

A Significant Contribution to the Field of Mental Health on a Local, State or National Level

The RFUP research and implementation developed in this collaborative research partnership has added a new approach to building dual diagnosis capacity building. The RFUP assists workers to successfully create an atmosphere where consumers can explore the interaction between their mental health and substance use. This therapeutic conversation is in itself a useful process for building rapport however it is also an essential pre cursor to collaborative treatment when and if the consumer wishes to take the discussion to potential strategies.

Neami National staff in Victoria, have expressed strong support for its efficacy. Victorian Neami National management have committed resources and funds to ensure that the RFUP is rolled out across the organisation.

Thus far 19 Victorian sites including an aboriginal program and 4 youth residential services have been trained in the RFUP. The next stage will be to train and mentor Neami National staff across Australia

Furthermore the implementation strategy that has been developed through this partnership is now being used with St Vincent's Mental Health staff and CoHealth a Victorian community health service.

Nexus are also in negotiation with Asia Australia Mental Health to develop trial sites in Asia and have had preliminary discussions with 2 universities in the United Kingdom to do the same.

Benefits Noted In the Evaluation

RFUP has several benefits, including but not limited to:

- Increases confidence and knowledge around dual diagnosis interventions in a straight forward manner
- Recovery based and consumer friendly
- Staff friendly
- Highly cost effective to train and use the resource
- Can be used by a wide variety of services and professionals
- Aligns with current State and National mental health and alcohol and other drugs strategy

Innovation and recognised best practice

In Victoria, Australia, in 2007 the state government released a report: 'Key directions and priorities for service development'. There are five Key Service Development Outcomes (SDO's)/priorities identified in this document:

1. Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as core business in both mental health and drug and alcohol services.
2. Staff in mental health and alcohol and other drug services are 'dual diagnosis capable', (DDC) that is, they have the knowledge and skills necessary to identify and respond appropriately to dual diagnosis clients and advanced practitioners can provide integrated treatment and care.
3. Specialist mental health and alcohol and other drug services establish effective partnerships and agreed mechanisms that support integrated treatment and care.

Working with dual diagnosis as core business within each sector will ensure that people of all ages are not excluded from a service. Their needs will be addressed within the most appropriate service setting by suitably trained staff and treatment and care that they receive is of high quality.

4. Outcomes and service responsiveness for dual diagnosis clients are monitored and regularly reviewed.
5. Consumers and carers are involved in the planning and evaluation of service responses to dual diagnosis.

(Department of Human Services 2007)

The RFUP offers an innovative approach to addressing these issues particularly SDO 2.

The RFU scale was part of the Collaborative Therapy 'Managing mental health and substance use' program. Nexus has a long history of involvement in the development, training and use of this program. The RFUP is influenced by Motivational Interviewing Strengths and Recovery frameworks.

A key innovative aspect of the RFUP is that it provides a framework for meaningful engagement with the consumers' lived experience of dual diagnosis in a collaborative strengths based manner. Through RFUP training and mentoring the worker is able to facilitate therapeutic conversations with a consumer. If the consumer wishes to, this can lead to working collaboratively on treatment goals using a range of optional strategies.

How to Use the RFUP

The RFUP has a number of key steps as shown in the flow chart (Figure 1).

1) Consider the context for consumer, i.e. what is their current mental state, stage of change for both mental health and substance use, literacy, cultural issues etc.? How and when will the RFUP be introduced to the consumer?
2) Consumer completes the 26 item RFU questionnaire with support as required.
3) Scores are entered into Excel to create a graph based on the five reasons for use domains.
4) Worker reviews graph and consults domain strategies and considers which strategies might be offered as an initial menu of options.
5) The Consumer is given feedback based on graph results. This followed by a collaborative exploration of the Consumers thoughts about the graph and optional strategies from the RFUP. This may lead to a treatment plan.
6) In the event that a treatment plan is developed this would be trialled then reviewed as appropriate. Other strategies may be trialled over time.

Figure 1

Another innovative aspect of the RFUP is the mentoring model which is an essential aid to implementation and has been shown to maintain gains in confidence and knowledge.

Participation of Mental Health Consumers in Planning, Implementation and Evaluation

Nexus and Monash SW Department created a Needs Analysis Survey for the 2012 Vicserv Conference Vicserv is the peak body for the Victorian community managed mental health support sector. This survey gathered data at a workshop ran by Nexus on the RFUP which included Consumers and Carers The results of the survey endorsed the need for the development of a dual diagnosis resource to assist workers to successfully engage consumers in therapeutic conversations.

Nexus held Stakeholder Forum's in 2013 and 2015 which included Consumer and Carer representatives. Carer and consumer consultants from St Vincent's and Austin Hospital as

well as Tandem, the Victorian peak mental health Carer body, gave positive feedback on the RFUP and research design.

Direct consumer feedback on their experience of the RFUP was collected as part of the National comparison trial involving Neami National staff from Victoria and NSW.

The data from the Consumer feedback questionnaire has added another level endorsement of the programs efficacy. Consumers overwhelmingly felt that the RFUP helped them explore areas of their life in relation to substance use helped them and their worker develop goals to work on.

Partnerships and Linkages (Collaboration for Continuity between Organisations)

Nexus Dual Diagnosis Service, Neami National and Monash Social Work Department set up a research partnership in 2013 to build on the successful pilot initially developed by Nexus in consultation with Monash in 2012.

This partnership has since met on a monthly basis for over 4 years and has collaborated on training, research design and evaluation, student placements (to support the research), conference presentations, creating and sharing resources.

Staff from Neami National for example made up the largest contingent at the focus group scoping exercises with MADA (Monash Art Design and Architecture) in the development of an online version of the RFUP.

Building an Evidence Base

Three pilots with a range of health, welfare and housing staff in 2012, 2013 and 2014 have overwhelmingly endorsed the RFUP for its utility in building staff confidence and knowledge of dual diagnosis interventions. Indirect reports from consumers indicated that they found the RFUP a useful way to explore their dual diagnosis issues. The first pilot in 2012 included 6 Neami National Staff in October 2012 who enthusiastically called on Neami National management to support a wider roll out within their organisation.

The RFUP research partnership aimed to developing an evidence base, increase the number of Neami National staff able to use the RFUP and developing an implementation strategy which could be replicated for similar agencies. In 2014 due to the Victorian State Government reform of the PDRSS sector, research design including ethics applications was the main focus of activity

In April 2015 10 senior practice leaders from Neami National were trained and mentored in the RFUP by Nexus. This group then went on to provided mentoring to their Victorian colleagues who received training in June 2015 as part of a national comparison trial.

Research Design for National Comparison Evaluation 2015

- Two groups of 40+ Neami National staff from comparable sites. Similar consumer and staff profiles matched by Neami National.
- Ethics Approval gained from St Vincent's Hospital HREC –A, Monash University Ethics and Neami National Research Committee
- Control group: NSW sites.

- Intervention sites in Victoria received 5 hours training and 2 x one hour mentoring sessions on how to use the RFUP.
- Neami National mentors in Victoria recorded de-identified notes from their mentoring sessions using a Mentoring Template.
- Matched survey of both staff groups to coincide with 3 time points; Pre Training, Post Training and Post Mentoring
- Staff Survey involved 12 Questions on knowledge and confidence in Dual Diagnosis interventions. These were based on the domains of the RFU Scale.
- Focus groups of Mentors and Mentees were held in order to gain qualitative data

Consumers who consented to participate in the RFUP evaluation were offered a Feedback Questionnaire.

The efficacy of the RFUP as a dual diagnosis capacity building resource has been verified by both quantitative and qualitative data collected through the National comparison between staff in NSW and Victoria. The quantitative evidence from staff surveys showed that training and mentoring in the RFUP significantly increases both confidence and knowledge of dual diagnosis interventions across all domains.

Qualitative data from both focus groups and mentor session notes add weight to the statistical data.

All participants agreed that their knowledge of Dual Diagnosis had increased since using the RFUP. Since the RFUP training, and after using the RFUP with consumers and in particular exploring the interventions, they had developed new insights into Dual Diagnosis:

> *"RFUP allows us to step back and be comfortable with how little we know. The consumer is the expert in their own substance uses not us."*

Participants found that the RFUP questionnaire was really useful to spark conversation with consumers. Participants found that the RFUP provided both themselves and the consumers with an increased vocabulary and understanding about Dual Diagnosis and their reasons for use. This allowed both the worker and the consumer to learn and define the difficulties they were having with appropriate understanding and terminology:

> *"Think about Dual Diagnosis, it is like the chicken or the egg, it is not simply answering the question instead it looks at the area in which it impacts your mental health."*

Furthermore, one participant described how their knowledge of the term addiction had developed. The participant stated that after completing the questionnaire themselves in training, they found that they were more aware and reflective of their own addictions and that sometimes workers forget that consumers are no different to anyone else. The participant reflected how this had made her more of an empathic worker:

"Consumer's use substances for the same reasons as we do"

From the perspective of the worker, all were in agreement that the RFUP really helped develop rapport with the consumer. The RFUP allowed a conversation to stem from mentee to consumer in which the whole process was consumer led. Participants agreed that as the consumer completed the questionnaire with only support from the worker if needed, the RFUP provided consumers with full ownership of their own reasons for use.

Furthermore the evidence shows that mentoring assists to maintain gains made from baseline. All participants agreed that the mentor session allowed time to brainstorm and explore results prior to considering interventions.

Participants found that the mentor was normally more experienced and having someone aware of reasons for use and Dual Diagnosis allowed the worker to use their mentors experience as a guide to finding the most suitable intervention/s to offer to the consumer.

Summary

- The research partnership established in 2013 has successfully built an evidence base for the RFUP
- The evidence collected demonstrates the usefulness of the RFUP in increasing staff knowledge and confidence about dual diagnosis interventions (see evidence section below)
- Consumer feedback strongly endorsed the use of the RFUP as being beneficial
- 19 out of 23 Victorian Neami National sites have been involved in the roll out to date. This includes Adult, Youth and Aboriginal Programs.
- Neami National management have committed to rolling out the RFUP nationally.
- Neami National staff continue to provide a valuable contribution to the development of an online version of the RFUP and the dissemination of research results.

  A St Vincent's Catalyst Innovation fund has been granted to build an online version of the RFUP. This is through an extension of the current research partnership and includes Monash Art Design and Architecture

CONCLUSION

Through its work with numerous stakeholders Nexus, in collaboration with Neami National and Monash University, identified an opportunity to build dual diagnosis capacity through the development and evaluation of an innovative and practical resource called the Reasons for Use Package.

The evidence collected thus far demonstrates that the Reasons for Use Package builds confidence and knowledge about dual diagnosis interventions in a practical and user friendly manner.

The strong partnership developed through this process will act as a springboard into the next phase of translating the package into an online platform that also includes online learning and data collection possibilities.

The partnership is committed to collaborating with local and international services to further promote evidence based practice in relation to addressing dual diagnosis issues gained through the Reasons for Use Package Project.

Moving on from the successful completion of the research trial Nexus is now working with Monash Art Design & Architecture (MADA) to develop an online version of the RFUP which will increase its accessibility nationally and internationally.

References

Allsop, S., 2008, *Drug Use and Mental Health*, IP communications, Melbourne.

Department of Human Services, 2007, *Dual diagnosis – key directions and priorities for service development*, State Government of Victoria. Melbourne.

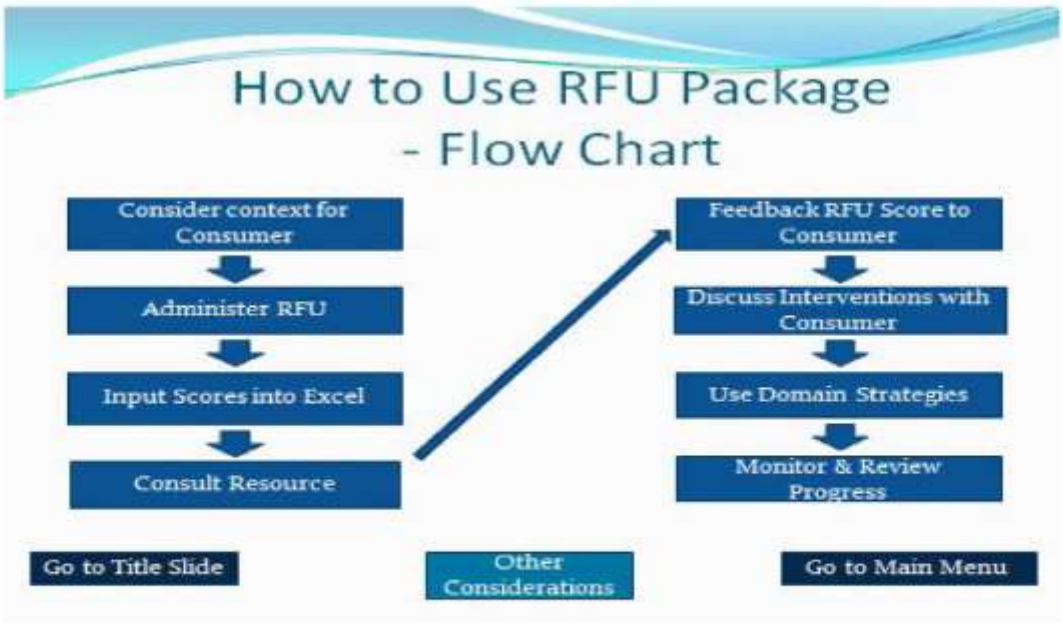
Minkoff, K. & Cline, C., 2004, *Changing the World: The design and Implementation of Comprehensive Continuous Integrated Systems of Care for individuals with Co-occurring Disorders*, Psychiatric Clinics of North America. Vol 27.4

Neami National Australia, 2014, *Who is Neami National?*, viewed 12th May 2015 http://guides.lib.monash.edu/content.php?pid=346637&sid=3021664#OrgAuth

Roberts, B., 2013, *The seeds of Dual Diagnosis discourse in an Australian State*, Mental Health and Substance Use, Vol 6, 4.

Spencer, C., Castle, D., & Michie, P.T., 2002, *Motivations that maintain substance use among individuals with psychotic disorders*, Schizophrenia bulletin, 28, 2, 233-247.

Teeson, M. & Proudfoot, H., 2003, *Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment*, NDARC.


How to Use RFU Package
- Flow Chart
Consider context for Consumer
Administer RFU
Input Scores into Excel
Consult Resource
Feedback RFU Score to Consumer
Discuss Interventions with Consumer
Use Domain Strategies
Monitor & Review Progress
Go to Title Slide
Other Considerations
Go to Main Menu

10

Preamble Template for Thesis inclusive of Published works

Preamble to Paper 4

Title

Myers, K., Kroes, S., O'Connor, S. and Petrakis, M., 2017. 'The Reasons For Use Package: how mentoring aids implementation of dual diagnosis practice' *New Paradigm journal*, pp.25-29.

Answering subsidiary research question:

How does the mentoring within the RFUP impact on building perceptions of confidence and knowledge?

New Paradigm is the peer reviewed Australian Journal of Psychosocial Rehabilitation, jointly published by Psychiatric Disability Services of Victoria (Vicserv) the Victorian peak body for community mental health services and Community Mental Health Australia (CMHA) which is a coalition of peak community mental health and mental health organisations from each State and Territory.

"CMHA provides a unified voice for over 700 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA advocates to improve all mental health and allied social services across Australia, with a strong focus on the value and contribution that not-for-profit, non-government community mental health services and people with lived experience bring to ensuring the economic and social inclusion, and the mental and emotional health and wellbeing of all." (CHMA website 2018)

The Paper

This particular edition of New Paradigm was subtitled Research into Practice and specifically called for papers which showed how research had contributed to practice. This paper explores how the training and mentoring approach used in the Reasons For Use Package was explicitly designed to be congruent with the desired approach staff were expected to employ when using the RFUP with consumers. The paper describes elements of the implementation at Neami National which may be a useful guide for other organisations wishing to implement the RFUP. Additionally the paper adds to the understanding of how the RFUP aids organisational practice change around dual diagnosis.

The *Reasons For Use* Package: how mentoring aids implementation of dual diagnosis practice

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Implementing a consumer-focussed dual diagnosis tool through a mentoring process creates sustainable practice culture that is reflective of the consumer experience.

A research collaboration between Nexus, Neami National and Monash University, commencing in 2013, has resulted in a new approach to dual diagnosis capacity building. During 2015, more than 100 Neami National staff across New South Wales and Victoria participated in a case-comparison trial as to the efficacy of training and mentoring to change dual diagnosis practice in mental health community support.

The *Reasons for Use Package* (RFUP) – a dual diagnosis package with an embedded mentoring component – assists workers to successfully create an atmosphere where consumers can explore the interaction between their mental health and substance use.

This therapeutic conversation is in itself a useful process for building rapport however it is also an essential precursor to collaborative treatment when and if the consumer wishes to take the discussion to potential strategies.

This article explores the RFUP mentoring model, which is an integral and evolving part of the RFUP and indeed, the pilot suggests, is the key ingredient to embedding practice change.

Policy environment

Victorian and federal policies over the past decade (Department of Human Services 2009; Council of Australian Governments 2012) have stressed the need for improved service response to consumers with dual diagnosis issues – one or more diagnosed mental health problems occurring at the same time as problematic drug and alcohol use.

This has led to services engaging in a multitude of dual diagnosis professional development activities such as consultation, training and resource development. Despite the number and type of activities being undertaken in this area, there was still an apparent lack of knowledge and confidence in engaging consumers in order to structure

appropriate interventions in the Victorian Dual Diagnosis Initiative evaluation (Australian Healthcare Associates 2011) and the Commonwealth Improved Services Initiative evaluation (McDonald 2015).

Pockets of confident dual diagnosis practice existed within organisations, usually residing with individual staff rather than service wide, and organisational capacity fluctuated as a result (Mental Health Commission 2013). This had the potential to undermine consistent, hopeful, recovery orientated practice and could lead to reduced growth of practice wisdom, potentially weakening future efforts to build capacity (Roberts 2013).

Background to Reasons for Use Package

The *Reasons For Use* Package (RFUP), a dual diagnosis resource, was developed by Nexus, a Melbourne dual diagnosis service, in consultation with consumers, carers and staff. The RFUP consists of the Reasons for Use Scale (Castle et al. 2006), and a number of potential follow-up strategies to explore with the consumer (Figure 1).

The package includes a specific "spirit" guiding the desired approach. This entails a collaborative and supportive process between staff and the consumer using the RFUP as a doorway to conversation about dual diagnosis. Staff receive training and, importantly, mentoring in how to use the RFUP which reinforces this "spirit."

The consumer is supported to actively explore their dual diagnosis issues. This deliberately shifts the power balance to the consumer rather than the more passive approach whereby the staff member "assesses" the consumer and decides on treatment options. The consumer and the staff member gain a shared understanding and, importantly, the consumer is actively involved in negotiating their treatment plan.

Mentoring as a part of the RFUP

"Mentoring is a developmental relationship and, like education and training, the primary objective is learning." (McDonald J 2002, p.11)

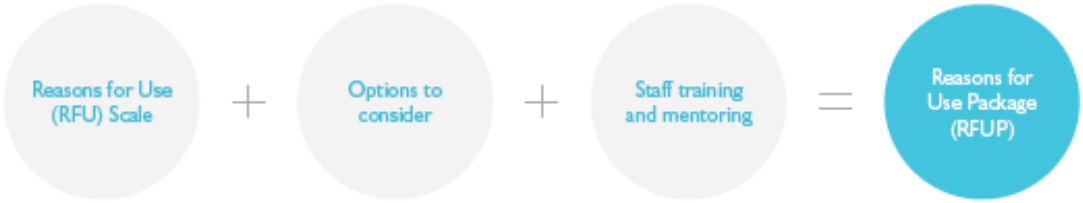
The RFUP mentoring process has a number of purposes. Firstly to facilitate reflection on initial use of the RFUP. Secondly, to generate a potential source of new mentors who then sustain the use of the RFUP practice, as individual staff articulate and discuss their thoughts around its use. Staff who are involved are then more able to facilitate mentoring of colleagues in their own engagement with and use of the package.

The mentoring model is outlined in separate guides for the organisation, mentor, and mentee. These have been developed and refined in response to feedback from various inputs and serve as a useful starting point when implementing RFUP mentoring.

The model was designed to mirror the spirit of the RFUP so that mentoring sessions reflected the desired collaborative explorative style of the consumer and staff interaction. Individual staff feel supported in exploring their practice and are thus able to move into mentoring their colleagues by following a structure based on facilitation rather than the perceived need for expert knowledge.

Mentoring helps externalise practice so it can be explored and change can occur (Scott & Spouse 2013). The two-part mentoring process reflects the two-part consumer process. Exploration prior to, or as part of, intervention in an environment of trust means that if the consumer or staff member wishes to make a change they do so with insights and energy from the process.

Figure 1 Components of the Reasons For Use Package



Staff need to feel that they can explore the use of the RFUP at different levels according to their experience. A staff member's initial use should not be judged based on the consumer outcome alone, as this will vary according to the consumer's circumstances.

In practice, staff confidence in their use of the RFUP often reflects the consumer's experience. Thus an organisational approach which aggregates various experiences is more likely to build practice wisdom. Implementation appears to work best when the RFUP process is completed within teams and organisations rather than to a group of disparate attendees from various services coming together.

At the first meeting with the creators of the package, the mentoring model is explained so that the organisation gains a clear understanding of the model and its benefits and issues to consider.

Importantly, at this stage, the organisation agrees to fully support the process, which includes freeing up staff to attend mentoring sessions. The creators of the RFUP suggest the allocation of a coordinator type role to assist with this process. Management identify staff who they think would be effective mentors; usually these are experienced staff who are seen as *practice leaders*. This organisational endorsement of engaging in the full RFUP rather than just training alone contributes to capacity building and culture change. Practice wisdom on both the use and impact of the RFUP for consumers is given support and conveyed through mentoring. Positive experiences can multiply over time rather than being lost as one-off events.

Method

A case comparison evaluation of the RFUP was completed with Neami National, a large national mental health community support service. Two groups of staff were recruited in New South Wales and Victoria; control and intervention groups respectively. The groups were matched for similar service types and staff make-up. In the evaluation both control and intervention groups had a 12 question survey of knowledge and confidence of dual diagnosis intervention, based on the domains of the RFUP, delivered at three time points. The intervention group received training and mentoring in the RFUP.

Results

The national evaluation trial held in 2015 found that the RFUP has several benefits including that it:

- increased staff confidence and knowledge around dual diagnosis interventions in a straightforward manner
- aligned with current State and National mental health and alcohol and other drugs strategies
- was recovery based and consumer friendly, user friendly for a range of health and welfare staff, and highly cost effective.

Data consistently found that mentoring assisted in maintaining gains in confidence and knowledge following training (See Figures 2 and 3 as examples). This evaluation provided valuable evidence of the utility of mentoring and informed the Australia-wide implementation across Neami National that is currently occurring.

Figure 2 shows that confidence and knowledge increased during the mentoring stage.

Figure 2: "I am confident/knowledgeable about dual diagnosis strategies for how to manage medication side effects."

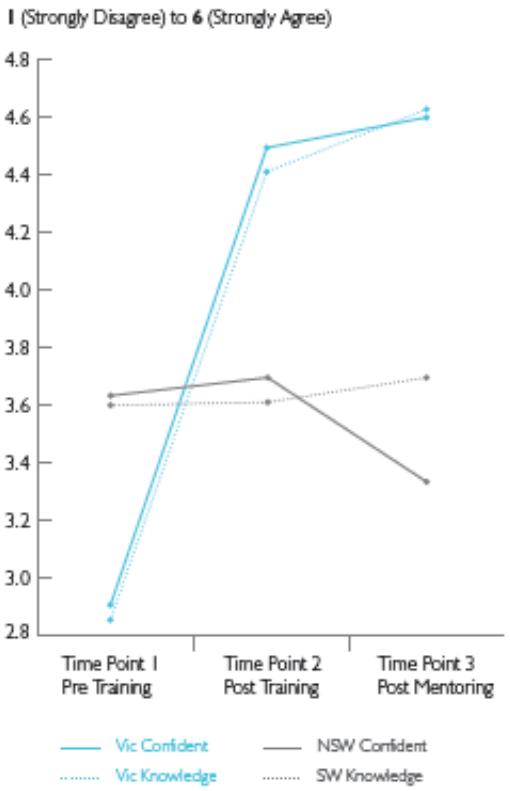


Figure 3: "I am confident/knowledgeable about dual diagnosis strategies for coping with unpleasant effects, including low mood, distress, anxiety."

1 (Strongly Disagree) to **6** (Strongly Agree)

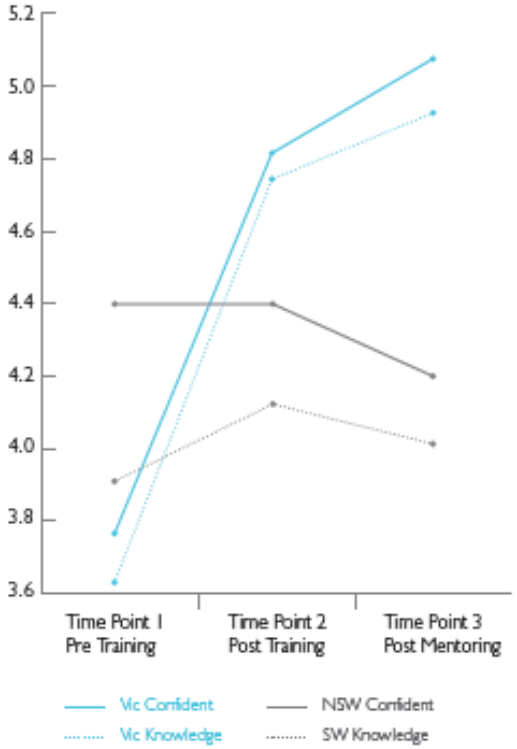


Figure 3 shows that confidence and knowledge increased during the mentoring stage.

Evidence from staff feedback focus groups indicated that the mentoring process is valuable in supporting a deeper exploration of dual diagnosis issues than would have occurred through training alone. Additionally staff provided qualitative feedback that the mentoring process has helped them to internalise the concepts of, and more effectively implement, the RFUP at their workplace (Myers, O'Connor, Petrakis & Kroes 2017). Staff reported that they could draw on thoughts and ideas in mentoring. This was similar to the discussion between staff and consumer.

Feedback from workers who have used the RFUP:

"Simple, meaningful and related to work practice."

"Good for building dual diagnosis into core practice."

"…very personal approach to their (the consumer's) situation."

Discussion

In less than two years Neami National, a large national mental health community support service (MHCSS), went from having a handful of individuals who had been trained and mentored by Nexus, a Melbourne dual diagnosis capacity building service, to being able to implement a nationwide rollout reliant on internal MHCSS staff holding and developing their RFUP practice wisdom and being able to train and mentor their colleagues.

Nexus developed and implemented a collaborative process of consulting to Neami National and building on its existing infrastructure to drive this capacity building project.

This type of collaboration is a model for other organisations and is currently being followed in a number of other settings. That Neami National staff felt confident in providing mentoring to colleagues without a large degree of extra training and support is critical. This is possible because of the mentoring structure that emphasises facilitation rather than being reliant solely on expert knowledge.

Limitations

It is possible there could be some over-statement of the impact of training, due to the self-reported data measures used in this study. The present study indicates that further research on the role of training, and particularly of mentoring, in implementing dual diagnosis tools is warranted. Overall however the gains achieved by mentored staff through training and mentoring, and reported benefits experienced by consumers through enhanced trust in the therapeutic relationship, suggest this package has much to offer the field.

Conclusion

The authors have found the RFUP mentoring model to be a crucial aspect in assisting the development of individual staff and organisational dual diagnosis capacity. It is vital that mentoring be congruent with the desired approach of the RFUP for sustained practice change. Training in the RFUP is also greatly enhanced when combined with this particular approach to mentoring.

For a moderate investment in time, mentoring produces the clinically and personally meaningful results of enhanced knowledge and confidence with which to engage in dual diagnosis practice. Structured, supported and evidence-informed mentoring should be considered an integral part of relevant training in the health and welfare fields.

Partners

Nexus

Auspiced by St Vincent's Hospital (Melbourne), Nexus is part of the Victorian Dual Diagnosis Initiative (VDDI). It is one of four Melbourne metropolitan teams with rural partners established in 2001 to assist dual diagnosis capacity building in clinical mental health, mental health community support services and alcohol and other drug services. Nexus works across local government areas including Banyule, Boroondara, Nillumbik, Yarra, Darebin, and alongside rural VDDI colleagues in regional Bendigo and Mildura.

Neami National

Neami National is a community mental health service supporting people living with mental illness to improve their health, live independently and pursue a life based on their own strengths, values and goals. It provides services from over 60 sites in diverse metropolitan, regional and remote communities in Western Australia, Queensland, South Australia, Victoria and New South Wales.

Monash University

Monash University is ranked in the top one per cent of world universities according to the Times Higher Education World University Rankings (2013-2014). It is a member of the Group of Eight, an alliance of leading Australian universities recognised for excellence in teaching and research.

References

Allsop, S (ed) 2008, *Drug Use and Mental Health*, IP Communications, Melbourne.

Argyris, C & Schon, D 1978, *Organizational learning: A theory of action approach*, Addison Wesley, Reading, MA, USA.

Australian Healthcare Associates, 2011, *Evaluation of the Victorian Dual Diagnosis Initiative* (final report), accessed on 19 November 2017 at http://www.dualdiagnosis.org.au/home/images/stories/newsletter/vddi_evaluation_final_report_appendices.pdf.

Australian Health Ministers 2009, *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*, Department of Health and Ageing, Canberra.

Commonwealth of Australia 2017, *National Drug Strategy 2017-2026*, Department of Health, Canberra, available at https://campaigns.health.gov.au/drughelp/resources/publications/report/national-drug-strategy-2017-2026.

Council of Australian Governments 2012, *Roadmap for National Mental Health Reform 2012-2022*, Commonwealth Government, Canberra.

Department of Human Services 2007, *Dual diagnosis – key directions and priorities for service development*, Victorian Government, Melbourne.

Department of Health 2004, 'Training frontline workers – young people, alcohol and other drugs, *Topic 6 Harm Minimization in AOD work*, Commonwealth of Australia, available at http://www.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front5-wk-toc~drugtreat-pubs-front5-wk-sach~drugtreat-pubs-front5-wk-sach-6~drugtreat-pubs-front5-wk-sach-6-1).

Department of Health 2011, *Victorian alcohol and other drug client charter*, Victorian Government, Melbourne.

Department of Health 2012, *Victoria's alcohol and drug workforce framework, strategic directions 2012-2022*, Victorian Government, Melbourne.

Department of Health 2012, *Organisational capability in Victoria's alcohol and drug workforce framework implementation plan 2012–15*, Victorian Government, Melbourne, p. 28.

Department of Human Services 2009, *Because mental health matters: Victorian mental health reform strategy and implementation plan: 2009-2019*, Victorian Government, Melbourne.

McDonald, D 2015, *Evaluation of the alcohol and other drugs 'peak bodies' roles in building capacity in the non-government alcohol and other drugs sector*, South Australian Network of Drug and Alcohol Services (SANDAS), available at http://sandas.org.au/wp-content/uploads/2016/03/Capacity-Building-Evaluation-Final-Report.pdf.

McDonald, J 2002, *Mentoring: An age old strategy for a rapidly expanding field – a What, Why and How primer for the alcohol and other drugs field*, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.

Mental Health Commission 2013, 'Thriving not just surviving', *Australia's National Mental Health Commission report card*, Commonwealth Government, Canberra, available at http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2013-report-card.aspx.

Minkoff, K & Cline, C 2004, 'Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders', *Psychiatric Clinics*, 27(4), 727-743.

Myers, K, O'Connor, S, Petrakis, M & Kroes, S 2017, 'The Reasons for Use Package: Development research and implementation lessons for the field', presentation at the TheMHS Learning Network, 'People: Authenticity starts in the heart' conference 23-26 August 2016, Auckland and the 2016 TheMHS Conference, Sydney.

Neami National Australia 2014, *Who is Neami National?*, viewed 10 August 2017 at http://guides.lib.monash.edu/content.php?pid=346637&sid=3021664#OrgAuth.

Roberts, B 2013, 'The seeds of dual diagnosis discourse in an Australian state', *Mental Health and Substance Use*, 6(4), 323-338.

Roche, AM & McDonald, J 2001, *Workforce development and capacity building: new directions for the alcohol and other drugs field*, National Centre for Education and Training on Addiction, Adelaide.

Scott, I & Spouse, J 2013, *Practice based in nursing, health and social care mentorship, facilitation*, John Wiley & Sons, Chichester, West Sussex, UK.

Spencer, C, Castle, D & Michie, PT 2002, 'Motivations that maintain substance use among individuals with psychotic disorders', *Schizophrenia bulletin*, 28(2), 233-247.

Teesson, M & Proudfoot, H 2003, *Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment*, Australian National Advisory Council on Alcohol and Drugs (ANACAD), Department of Health, Canberra.

Subsidiary Results: Consumer Data

The subsidiary research question answered in this chapter is:

What is the Consumer experience of using the RFUP with community mental health support workers?

Although the main focus of this research was aimed at exploring the impact on staff, as explored in the introduction it was recognised that it wasn't fitting to measure the impact on staff in isolation from the consumer experience. Secondly, staff understanding of how the consumer responded to the RFUP and interacted with the package is likely to have a direct bearing on their perception of the efficacy of the RFUP. Indeed both focus groups and mentoring notes made regular mention of how well consumers appeared to engage with the RFUP and how this enabled staff to feel more confident.

All consumers in the study settings where the research was being undertaken were offered the opportunity to complete a seven-question survey. This was returned via a stamped addressed envelope to ensure anonymity. 19 of 85 consumers consented to give feedback and completed the survey, which is around 25% of potential participants. A paper reporting on consumer results and a case study was published in cogent medicine (Kroes, S., Myers, K., Officer, S, O'Connor, S. and Petrakis, M., 2019). As this paper is being included in the body of Simon Kroes' MPhil thesis it has been included in the appendices of this Thesis for reference (Appendix 10). It is appropriate to report and discuss below some of the key consumer results as they intertwine with the staff perception particularly in relation to confidence. It is worth noting that the case study the exploring the process of using the RFUP illustrates the sometimes hidden nature of substance use. In the case study example the consumer was using nicotine gum. Prior to the use of the RFUP the worker, who had good rapport with the consumer, had not considered this as a potential problem

assuming that it was a harm reduction major. The RFUP revealed the consumer was using the nicotine gum to cope with anxiety at a dangerously large quantity, up to 40+ pieces of gum, which had caused choking at night on several occasions. Thus the use of the RFUP assisted in exploring this issue and led to different methods to address the consumer's anxiety.

Consumer Survey Results

Shared here is feedback from consumers regarding their experience using the RFUP (Kroes et al. 2019, p. 4)

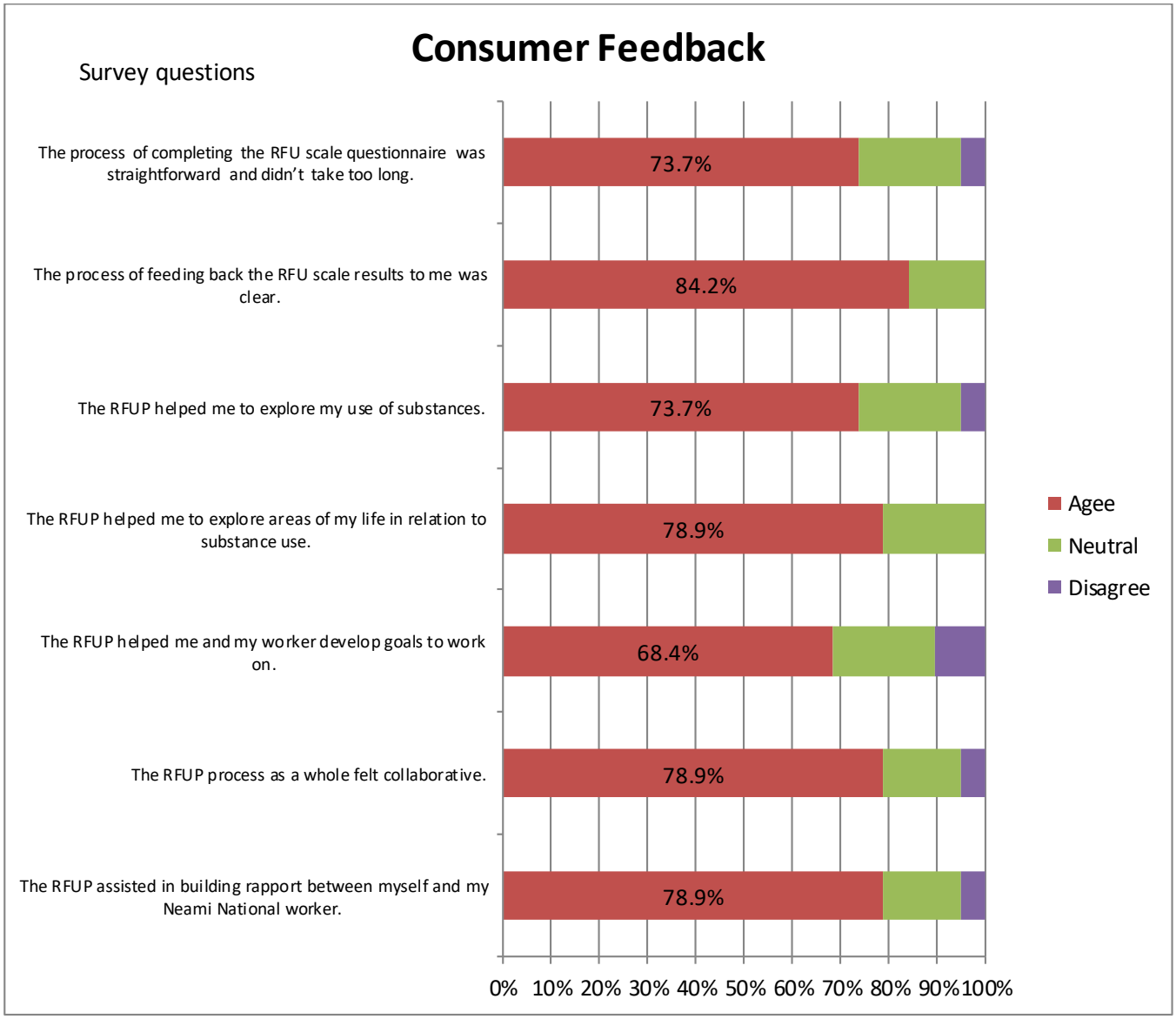


Figure 9 Consumer Feedback

Discussion

RFUP process

Consumers consistently felt the RFU scale was straight forward 73.7% and feedback on the results were clear 84.2%. It is worth noting here that if consumers don't feel the process is relatively clear there is a possibility that this might impact on their engagement and in turn this would potentially impact staff confidence.

Rapport and Collaboration

Results from the consumer data indicated that the RFUP felt collaborative 78.9% and that it helped improve the consumers' therapeutic relationship with the staff member also 78.9%. These figures can be correlated with the comment from the staff focus groups "that the RFUP really helped develop rapport with the consumer" Focus Group One participant.

Exploring mental health and substance use

Furthermore 73.7% of Consumer respondents agreed that the RFUP helped them explore their use of substances and 78.9% agreed that the RFUP helped them to explore areas of their life in relation to substance use. Again this correlates with a staff focus group two participant's feedback that the RFUP "is more interesting, going into other areas of conversation and allowing the client to talk about their own experience and clearly acknowledging it is a choice; shifts the dynamic" Staff focus group participant. One of the other main themes here is that rather than staff concentrating only on the substance use issue which is often perceived by the consumer as external pressure for change which can lead to discord (Miller and Rollnick, 2012) the RFUP allows wider discussion and thus draws out intrinsic motivators for change across numerous domains of a consumer's life.

Goal planning

Nearly 69% of participants said that they had goals to work on after completing the RFUP. At first glance this last result is not as impressive as the results for other questions however, it is in sharp contrast to the common experience of both staff and consumers that arriving at goals can often take a long time and is often hindered by non-integrated assessment tools (Rickards, 2003).

One of the major differences with the RFUP that is worth noting is that by setting out overtly possible interventions based around, but not limited to the domains of the Reasons For Use Scale the consumer is actually empowered to make active choices. In many treatment settings the staff member suggests treatment options for the consumer to consider. This is a more passive and ultimately can be a disempowering approach and of course the consumer would not be aware of the plethora of choices available that the staff member didn't offer. So the RFUP approach appears not only to draw out the thoughts of the consumer about the interaction between their mental health and alcohol and other drug issues but also allows them to drive their own treatment plan. This is line with the principles of the Intentional Peer Support approach.

IPS is unique from traditional human services because:

- **IPS relationships are viewed as partnerships** that invite and inspire both parties to learn and grow, rather than as one person needing to 'help' another.
- **IPS doesn't start with the assumption of a problem.** With IPS, each of us pays attention to how we have learned to make sense of our experiences, then uses the relationship to create new ways of seeing, thinking, and doing.
- **IPS promotes a trauma-informed way of relating.** Instead of asking "What's wrong?" we learn to ask "What happened?"

- **IPS examines our lives in the context of mutually accountable relationships and communities** — looking beyond the mere notion of individual responsibility for change.
- **IPS encourages us to increasingly live and move towards** what we want instead of focusing on what we need to stop or avoid doing. (Intentional Peer Support, 2018)

Limitations

The first limitation is that the consumer feedback survey captured the thoughts of the consumer after a relatively short time frame after using the RFUP. It is possible and even likely that that they may have deeper and different thoughts over a more extended period like two - six months. Secondly although there was the opportunity for consumers to add more thoughts through an open texts field this didn't garner much material. Brief comments like "it was fine" or "I liked it" indicated overall approval for the tool but didn't give much depth. This suggests that the consumers may have benefitted from a more supported data collection methodology. Lastly, the deliberate choice to use anonymous data collection from consumers meant the link between individual consumers, the characteristics of their 'dual diagnoses' and their actual workers was not correlated. Given the positive commentary from staff about their positive perception of how consumers responded to the RFUP and the limited size of quantitative data from consumers this is a potential area for future research. The conclusion to this thesis will describe a study commenced by the research team with lived experience researchers in 2020. This study is aimed at expanding the understanding of the consumer experience through in-depth interviews.

Results: Focus Groups

This chapter presents the research findings from the two focus groups described in the methodology chapter.

Focus Group One

This focus group occurred around four weeks after the completion of the mentoring stage of implementation. Individual staff completed mentoring at different times as this depended on when they had used the RFUP with consumers. Neami National staff members who had received training and mentoring were invited to join the group. Six staff attended with two participants working together on the same Neami National office. All participants shared the same job role as a Community and Rehabilitation Support Worker. There was a diverse range of professional qualifications within the sample including community care, psychology and social work with varying experience of working with dual diagnosis. Four participants identified as male with two identifying as female. They were broadly representative of the staff profile except for the expressed gender which is mainly female in the wider organization and with respect to time working at Neami National which was only six months for four participants and one year for two participants.

Semi structured interview questions were used. The responses provided by participants answer address the overarching research question:

> 'What was the experience of staff involved in the Neami National Evaluation of the RFUP (Reason For Use Package)?'

Major Emergent Themes

Overall there were five emergent key themes from the data once analysis was undertaken.

Themes were:

- Compatibility of RFUP with Assist and the Collaborative Recovery Model
- Potential to increase knowledge of dual diagnosis practice
- Centrality of mentoring and learning support
- Enhancement of the engagement and relationship with the consumer
- Issues of time and access

Compatibility of RFUP with WHO ASSIST V3 and the Collaborative Recovery Model

All participants provided the feedback that the RFUP includes easy to follow instructions, which staff, regardless of level of experience, can implement:

"It's collaborative. It is not up to the worker to be expert in everything." Focus Group 1 Participant

All participants noted that the RFUP engenders a collaborative approach to viewing challenges faced by the consumer and a suitable series of interventions for substance use. Further the package is compatible with the principles of the Collaborative Recovery Model; which is the framework used at Neami National, the partner agency. All participant noted that the RFUP was a useful clinical instrument that consumers found useful as it target exploration of their reasons for use. In comparison the Alcohol, Smoking and Substance Involvement Tool (ASSIST), in use at the service, to screen for substance use, while useful, was noted to require the worker to have a thorough understanding of substance use. The RFUP was more user-friendly.

The only "critical" feedback of the RFUP from this focus group was that further detail in the interventions section would be helpful to provide more information to consumers. I.e additional

material on nicotine cessation, assertiveness training etc.

Potential to increase knowledge of dual diagnosis practice

All participants noted that their knowledge regarding dual diagnosis had increased due to use of the RFUP through the implementation. Two participants stated that dual diagnosis was new to them as a specialist clinical area. Following the RFUP training, and after using it with consumers exploring the interventions, the staff noted that they had developed greater insight into basic competencies in dual diagnosis practice. Three participants spoke of how the RFUP questionnaire was useful to engage in conversation with consumers. The RFUP provided staff themselves and consumers with increased vocabulary and understanding regarding dual diagnosis and potential reasons for use. This enhanced worker and consumer rapport and learning together

> "Think about Dual Diagnosis, it is like the chicken or the egg, it is not simply answering the question instead it looks at the area in which it impacts your mental health." Focus Group 1 participant (Myers, Kroes, O'Connor and Petrakis, 2017 p 7)

Furthermore, one participant described how, after completing the questionnaire on themselves in training, they found they became more self-aware and reflective in terms of their own addictions and behaviors; that workers might at times forget that consumers are like other people. The participant reflected upon how this realization had made her more of an empathic worker:

> *"Consumer's use substances for the same reasons as we do"* Focus Group 1 participant (Myers et al 2017 p 8)

Centrality of mentoring and learning support

Implementation of this package included all participants being supported by a mentor these session took approximately an hour and occurred at least twice. Four participants had mentors on site and two visited mentors externally. Feedback was that having a mentor was beneficial during the implementation. All participants reported that a mentor session offered time to brainstorm and explore results from the RFUP prior to choice of an intervention. While the mentor may not have attended the visits with the participants, to have in-depth first-hand knowledge of the consumer, it was still useful to have space and time to discuss the visit.

> *"A second set of eyes from the mentor would have been useful. It would have been good to get an opinion whilst out on the road"* Focus group 1 Participant

Participants reported the mentor needed to be more experienced in reasons for use and dual diagnosis practice, enabling the worker to use the mentor as an experienced guide to considering the most suitable intervention/s. While all six participants reported that they could gain some support from other colleagues or in professional development sessions, a focused space to develop skills was valued. For the two participants with mentors based externally, the participants had to arrange meetings to discuss the RFUP. One participant reported that not knowing the mentor resulted in having to more fully prepare for the mentor meeting, ensuring they could deliver a full case history and reasons for use. The benefits were very explicit regarding an external mentor for this participant, allowing the worker to develop a very clear understanding of the consumer and the potential future intervention. For the second participant with an external mentor arranging to meet a mentor at an external location was reported as difficult, as were time constraints and the chance of a consumer cancelling a meeting or not discussing the RFUP in a given session. Challenges in scheduling and rearranging mentor sessions was an issue that resonated with all participants.

Issues of time and access

Participants experience their role as very unpredictable as activities are varied according to the mental health of the consumer. All participants reported that scheduling the RFUP for a particular day may require it to be rescheduled.

> *'We work with people with all things happening, if they cancelled the RFUP wasn't priority the welfare of the consumer was"* Focus group 1 Participant

Use of the tool in a designated time frame was a challenge for four of the participants. Participants were advised in training to try to deliver the questionnaire in one session, then discuss possible treatment options the in the next session. In practice, the participants agreed that they needed to be flexible, to tailor the information and reflective process so it was not overwhelming for the consumer:

> *"It was too much in one session. The consumers didn't have a clear domain as to why they used. They scored highly in 2 or 3."* Focus group 1 Participant

Enhancement of the engagement and relationship with the consumer

All participants noted that the RFUP helped develop rapport with the consumer, allowing a conversation to be encouraged by the mentee to support the consumer such that the direction of the whole process became consumer-led:

> *"RFUP allows us to step back and be comfortable with how little we know. The consumer is the expert in their own substance uses not us."* (Myers et al 2017 p 7)

Participants reported that the consumer would complete the questionnaire themselves, with only minimal support from the worker as needed, providing consumer's greater ownership of discussion regarding their reasons for use.

'Consumers can have the answer themselves, not spinning it etc. one consumer took it in, looking completely at every angle, when stats came back he was totally in agreement.'

Focus group 1 Participant

Participants reported that having a previous working relationship with the consumer made it easier to explore substance use. This contributed to therapeutic gains in using the tool, according to five of the six participants. This was especially pertinent in determining interventions, if workers had prior knowledge of what the consumers' goals and values were. Regardless, one participant noted that completing the RFUP with one consumer they had not met before was successful; the package alone allowing for a successful session independent of an established relationship with the consumer.

Several of the participants reported difficulties in pinpointing which consumers might most benefit from the RFUP. Even though some consumers had a dual diagnosis and used substances, not all consumers potentially approachable were wanting to change their pattern of use. Four participants stated that consumers with more severe drug addiction were experienced as more challenging to engage and, as first-time users of the RFUP, workers wanted to encourage concentrating on substance use that was more common in the community, such as smoking cigarettes.

Focus Group Two

This focus group was held around 5 months after the mentoring stage of the intervention. Both mentors and mentees were invited to attend the session. Two mentors (one male and one female) and 16 mentees (seven males and nine females) attended the session which took place after the quantitative data from the staff and consumer surveys had been statistically analysed and after the mentee only staff group which had occurred around four weeks post mentoring. This was a deliberate strategy allowing participants with different perspectives to "check" whether the data aligned with their experience and to widen interpretation and themes. It is worth noting that this group of staff included a number of lived experience workers, all of whom like other participants had experienced the RFUP for themselves during training and mentoring. This session was facilitated by Sarah O'Connor who was the MHCCS Researcher assistant for this project. The session was recorded with informed consent.

The format for this focus group began with participants being shown the data sets relating to the staff and consumer.

The following questions were asked of participants:

- What have you learnt about implementing this package? Barriers? Enablers? Logistics? Team/workplace culture? Workload? Skills? Etc.
- How do you prepare the ground for the RFUP?
- What are the challenges for maintaining fidelity of the package, training, mentoring?
- What are the best ways of sharing experiences of the RFUP with other Neami National staff and other services?
- How compatible is the RFUP with CRM model?
- What do you think of the current implementation model? (training, trail the RFUP with two consumers, , two x mentoring sessions, etc.)

Results from Focus Group 2

The major theme to emerge from the focus group was that the results from the staff and consumer survey data rang true and that trialling the package with two consumers with a supportive mentoring process was a useful approach. Both mentors and mentees felt that their knowledge and confidence of dual diagnosis interventions had improved. Interestingly mentors felt that being a mentor gave them another level of understanding as to how the RFUP builds confidence as the mentors discussed results with a number of staff and thus were more able to see a pattern emerge.

> "Being a mentor provided a greater understanding of the RFUP" Mentor Participant Focus Group 2

With respect to the perceived impact of their work with consumers mentees commented on their change of practice, with particular emphasis on putting the consumer in the driving seat.

> "Changes the way you speak to client; paves the way you work with people, more exploring and unpacking in various domains more confidently" Mentee participant Focus Group 2

> "RFUP is valuable, worth doing with clients as it contributes to a good conversation; provides a holistic scope" Mentee Participant Focus Group 2

> "More interesting, going into other areas of conversation and allowing the client to talk about their own experience and clearly acknowledging it is a choice; shifts the dynamic" Mentee Participant Focus Group 2

Reflecting on the current implementation approach mentors and mentees agreed that using the RFUP on themselves helped them to understand the tool, echoing the comments in the first focus group. Furthermore mentoring had allowed deeper understanding of the process and assisted in building confidence across sites.

It is worth noting here that mentors were generally practice leads and that they had been through the same experience of being trained and mentored in the RFUP. This process quite rapidly built a new layer of mentors for further implementation.

> ..Smooth transition to become a mentor; good to have clarification of mentoring aspect"
>
> Mentor Participant Focus Group 2

With respect to other tools and approaches used at Neami National there was agreement that the RFUP was compatible to the Collaborative Recovery Model, ASSIST WHO screening tool and Motivational Interviewing. The degree of compatibility between an organisation's existing tools and approaches is likely to have an influence on the implementation. This is discussed in Chapter 5.

Discussion

Both focus groups indicated that the RFUP had impacted positively on the therapeutic relationship with the consumer by shifting the balance of the conversation towards the consumer voice. This in turn reduced the anxiety of staff regarding providing solutions. One of the philosophical underpinnings of the RFUP, motivational interviewing stresses the consumers intrinsic motivations for change being a key to successful change rather than extrinsic motivators for change (Miller and Rollnick, 2012). The RFUP appears to be operating in a similar fashion, that is as the consumer

feels confident about exploring their thoughts and ultimately having the choice as to what treatment plan they develop, the staff member becomes more a facilitator offering advice/information rather than the director of the treatment plan. This not only causes less discord but also means that if the consumer decides on making a change they are more likely to provide the positive energy for its enactment.

The mentoring model described in paper 4 in this thesis makes the point that the mentoring sessions should be congruent with the staff /consumer interaction, i.e. the mentor facilitates discussion of the mentees experience of using the RFUP with a consumer and offers reflections and ideas to the mentee, rather than directly telling the mentee what they should do. This approach potentially reduces the pressure on both mentor and mentee with less chance of discord and more room for workforce development. In this study the Victorian cohort expressed support for mentoring as an aid to improving perceptions of knowledge and confidence. It is worth noting that a third comparison cohort involving a group of staff who only received training would be needed to see whether a lack of mentoring significantly impacted perception of changes to knowledge and confidence.

Both focus groups reported increased levels of confidence and knowledge of dual diagnosis practice and interventions after the implementation, in line with the quantitative staff survey data. The second focus group also felt that the consumer survey results fitted with their perception of how consumer's positively experienced the RFUP.

Preamble Paper 5 for Thesis inclusive of Published works

Title: Reasons for Use Package: Outcomes From a Case Comparison Evaluation.

Authors: **Myers,K.**, Kroes,S., O'Connor,S. and Petrakis,M.

Journal: Research on Social Work Practice

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Status: Published 2020

The research question was: What is the perceived efficacy of a dual diagnosis intervention strategies package, namely the Reasons For Use Package (RFUP)?

This article focusses on the quantitative data comparing the perceived shifts in knowledge and confidence of the Victorian Cohort, who received training and mentoring in the RFUP with their NSW colleagues. It is worth noting that the Victorian staff maintained this perceived change in knowledge and confidence through mentoring which is discussed in more detail in Paper 4.

Conference presentation

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Reasons for Use Package: Outcomes From a Case Comparison Evaluation

Kevan Myers[1], Simon Kroes[1], Sarah O'Connor[2], and Melissa Petrakis[3]

Abstract

The objective was to explore the efficacy of a dual diagnosis resource—the Reasons For Use Package (RFUP)—to build staff capacity to work with service users and explore service user experiences. A two-state case comparison evaluation was conducted employing a mixed methods action research design, utilizing staff and service user surveys combined with focus groups involving staff trained and mentored in use of the RFUP. Results were that both staff and service users responded positively to the RFUP. Staff self-reported improvements in knowledge and confidence, and service users reported the RFUP assisted them with reflecting on interactions between their mental health and substance use; this assisted them with goal planning and improved their working relationship with staff. Implications were that training and mentoring in the RFUP can contribute to building staff knowledge and confidence in dual diagnosis interventions in mental health community services, and benefit service users.

Keywords

addictions, field of practice, mental health, case control study, outcome study, mixed methods, dual diagnosis

Service users who experience mental health issues frequently also have substance use issues (Meque et al., 2019). This is likely to be the "expectation not the exception" (Minkoff & Cline, 2005) and indeed is often associated with other complex presentations such as physical health problems. There is not a homogenous group but there are some common themes.

In this article, the term "dual diagnosis" is used as two of the authors are associated with the Victorian Dual Diagnosis Initiative (VDDI). This term, however, is neither the best nor the only descriptor. Other phrases such as comorbid, co-occurring, and so on, appear in the literature that is cited in this article. This article specifically explores quantitative data collected during a two-state case comparison evaluation of a dual diagnosis resource called the Reasons For Use Package (RFUP) and its efficacy for building staff knowledge and confidence in dual diagnosis interventions. The experiences of service users who were involved in a national comparison trial have also been gathered through mixed methods data collection (Myers, Kroes, O'Connor, & Petrakis, 2018).

Background Literature

This article and research is informed by international literature regarding the extent of comorbidity experienced by people suffering from mental illness and using alcohol and other drugs (AODs), and the problems with parallel treatment systems (Drake et al., 1998), and findings from overseas (SAMHSA, 2002). There is a large body of literature going back over 30 years both in Australia and internationally, which explores dual diagnosis. Seminal texts in Australia include McDermott and Pyett (1993) "Not welcome anywhere," which highlighted the systemic issues relating to siloed service design which had a negative impact on these service users who often fell through the gaps. The report also argued that approaches which operated within the philosophy of harm minimization showed promise. Australian and international literature is extensive in terms of identifying the prevalence and problems associated with service responses to service users with dual diagnosis issues. A 2010 article looking at the global burden of disease for mental health and substance use disorders in *The Lancet* interpreted the data as follows:

> Mental and substance use disorders are major contributors to the global burden of disease and their contribution is rising, especially in developing countries. Cost-effective interventions are available for most disorders but adequate financial and human resources are

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> needed to deliver these interventions. Mental health policy and services research is necessary to identify more effective ways to provide sustainable mental health services, especially in resource constrained environments, if the burden of mental and substance use disorders is to be reduced. (Whiteford et al., 2013, p. 1583)

Systematic Literature Review

As part of this research study, a systematic literature review was conducted in 2015, which looked at literature regarding approaches to staff training in dual diagnosis competencies. Some of the key themes emerging included the following point, "In particular there is limited literature regarding the efficacy of dual diagnosis competency resources, and a gap as to use of the mentoring in dual diagnosis capacity building" (Petrakis et al., 2018, p. 53).

Australian Dual Diagnosis Initiatives

At a national level in Australia, in the late 1990s, the National Drug Strategy and National Mental Health Strategy developed the "National Comorbidity Project" (Teesson & Burns, 2001). The VDDI, of which the capacity building service in the current study is a component part, commenced in 2000. Similar initiatives were developed in other states in Australia (New South Wales Health, 2000; Pennebaker et al., 2001).

The purpose of the VDDI is to promote development of a systematic and integrated approach to service provision, so that people of any age experiencing dual diagnosis have prompt access to quality treatment and support, focused on recovery and optimizing individual outcomes. The intention has been to provide a coordinated hierarchy of client-centered service responses that respond to varying levels and complexity of need. Dual diagnosis should be managed early in the most appropriate service setting, with clear referral pathways in place. The emphasis has been that through the VDDI, services provide a balance of direct care and consultation and support to primary care and other sectors working with people experiencing dual diagnosis (which would include housing, employment, education, and community organizations). The priorities included that service users and families/carers were to be involved in policy and service development both centrally and locally to enable services to be easier to use, seen as useful and aligned with their needs.

Policy Directions to Address Dual Diagnosis in Victoria, Australia

In Victoria, Australia, in 2007, the state government released a report: "Key directions and priorities for service development." There are five key directions/priorities identified in this document:

1. Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as core business in both mental health and drug and alcohol services.
2. Staff in mental health and AOD services are "dual diagnosis capable," that is, they have the knowledge and skills necessary to identify and respond appropriately to dual diagnosis clients, and advanced practitioners can provide integrated treatment and care.
3. Specialist mental health and AOD services establish effective partnerships and agreed mechanisms that support integrated treatment and care.
4. Working with dual diagnosis as core business within each sector will ensure that people of all ages are not excluded from a service. Their needs will be addressed within the most appropriate service setting by suitably trained staff, and treatment and care that they receive is of high quality.
5. Outcomes and service responsiveness for dual diagnosis clients are monitored and regularly reviewed.
6. Consumers and carers are involved in the planning and evaluation of service responses to dual diagnosis (Department of Human Services, 2007).

RFUP Research Partnership Service Descriptions

The capacity building clinical service. The current clinical capacity building service is a dual diagnosis service based at an inner urban public hospital in Melbourne, Victoria. The service was established in 2000 as part of the VDDI. The service works with more than 40 agencies in urban, regional, rural, and remote settings. The service is a multidisciplinary team with staff from nursing, social work, and psychology backgrounds. It is not a direct clinical service provider. The key role of the service is to enhance dual diagnosis capability of staff in mental health, AOD, and mental health community support services (MHCSS). To do this, a range of methods are employed, including training, facilitation, and consultation within the context of a close working relationship with stakeholders, addressing gaps and opportunities. It is worth noting that Nexus has a consultation rather than a direct service user relationship. Thus, the direct duty of care for service users is held by the treating team at the clinical mental health service and MHCSS.

MHCSS

The MHCSS involved in the current study is supporting people living with mental illness to live independently in the community.

Academic partner setting. The collaborating university social work department is partnering here to support evidence-based practice implementation and research engagement with the field.

Rationale for Developing the RFUP

Screening for substance use and/or mental health. The literature suggests at least two major issues with current screening. First, screening tools tend to be single issue either mental health or

substance use in nature. The lack of duality of use of the tools, of course, compounds the separation of treatment modalities rather than fostering integrated treatment and service responses. Furthermore, while screeners may help to identify issues, they do not necessarily assist in integrated treatment planning for service users or staff. Thus, screening often leads to the question: *What next*? One of the main drivers behind designing the RFUP was to assist staff in developing next steps with service users.

Asking about Reasons for Use

The capacity building service was particularly interested in user-friendly interventions that assist staff in opening up dual diagnosis conversations with clients. Using screens or other tools can be useful in these processes (Byron, 2019). One such tool is the Reasons for Use Scale (RFUS; Spencer et al., 2002).

The RFUS (Spencer et al., 2002) is a 26-item self-report instrument. It includes items from the Drinking Motives Questionnaire (Cooper et al., 1995) and additional items specific to symptoms of mental illness. Its reliability and validity has been demonstrated among individuals diagnosed with psychotic disorders and substance use/cannabis use (Spencer et al., 2002). It is used to explore service user reasons for substance use with the hope that this will assist in interventions that are individually tailored. The 26 items relate to the five subscales (with Domain 1 divided into two parts in the RFUP) that are believed to reflect a participant's reasons for drug use. The RFUS assists exploring the relationship between mental health and substance use and impacts.

Myers and Kroes had extensive experience in the RFUS, which was originally part of an eight-session Dual Diagnosis Collaborative Therapy Group program. The rationale for this study was staff observations that service users often showed a high degree of engagement with this tool and that it could be used separately as a brief intervention.

Reflective practice sessions, meetings with various agencies, and discussions with staff about the best ways to develop their capacity to provide evidence-based dual diagnosis treatment indicated staff were asking for resources to assist them in developing treatment options. Staff reported they did not know, or did not feel confident in, how to implement or decide on the next intervention to use with clients after they have done initial screening to detect dual diagnosis issues. Kroes identified that the RFUS could be used to address this gap and built a prototype RFUP and together with Myers further developed and researched the efficacy of this resource. The RFUP was designed and intended to act as a user-friendly tool to assist workers from mental health, MHCSS, and AOD when they develop treatment plans with service users experiencing dual diagnosis challenges. The capacity building service set out to design a package that aligned with the broad skill base, philosophies, and contextual settings of the sector. Elsewhere, the authors have described some key elements of dual diagnosis best practice (Myers, Kroes, & Petrakis, 2018). Key aspects include welcoming, recovery focused, person and family centered, harm minimization–integrated treatment.

Once staff members have used the package across a number of occasions, the longer term intention is that the staff will start to instinctively adopt the concepts, skills, and the overall knowledge within the package. In practice training and mentoring enable a reflective space that is encouraged, rather than premature focus on solutions; this is an important aspect of the RFUP and a point of difference to other tools that may rush to solutions and therefore miss a valuable reflective space.

The RFUP is a dual diagnosis resource that was developed as a tool, which would be simultaneously useful to service users as well as building dual diagnosis capacity for staff (Myers et al., 2017). The RFUP has three basic steps: a 26-item RFUS questionnaire, which creates a graph of results, a reflective consultation menu of options, and a treatment planning section. Following numerous successful trials, Kroes and Myers secured funding to develop the RFUP into a stand-alone website that was launched in May 2018.

Through use of the RFUP, the aim is to significantly change the core practices of staff. It assists to widen staff understanding of the nature of dual diagnosis and change staff approach in terms of opening up conversations based on lived experience wisdom of the service user in collaboration with staff practice wisdom. Additionally, the aim is to impact the service user to staff power relationship, shifting it toward a more service user–centered one. In the treatment planning process, the aim is that potential options are openly discussed rather than being the sole domain of the staff member. Building a reflective space rather than rushing to solutions is the goal.

Pilot initiatives. Three pilots with a range of health, welfare, and housing staff in 2012, 2013, and 2014 have overwhelmingly endorsed the RFUP for its utility in building staff confidence and knowledge of dual diagnosis interventions. Indirect reports from service users indicated that they found the RFUP a useful way to explore their dual diagnosis issues. The first pilot in 2012 included six staff in October 2012 who enthusiastically called on management to support a wider rollout within their organization.

The Two-State Case Comparison Evaluation

The successful pilots of the RFUP lead to an agreement between the capacity building service, the community support service, and the university to research the impact of training and mentoring in the RFUP on staff knowledge and confidence in dual diagnosis interventions. The evaluation also aimed to gather service user feedback on their experience of using the RFUP with their worker (Myers et al., 2017).

Method

Research Design for National Comparison Evaluation

Methodology. The methodology had to take into account the multiple roles and relationships to the phenomenon under

investigation. The designers of the RFUP, Kroes and Myers, also have consultation roles with the community service around their response to dual diagnosis issues. Furthermore, the interaction between quantitative and qualitative methods and any interpretation of data is a collaborative process. This research has adopted a pragmatic approach. Pragmatic researchers focus on the "what" and "how" of the research problem (Creswell, 2014, p. 11). This research is based on inductive reasoning, clarifying meaning, analyzing, and exploring phenomenon. The research takes place in a specific social context and is in turn affected by social interaction between researcher and participants.

Pragmatic research accepts the "situating of the researcher within the context under investigation" (p. 82, Maxcy, cited in Tashakkori & Teddlie, 2003). The research will reflect the subjective understanding of the participants rather than an objective "truth." Pragmatic research is aimed towards increasing understanding of the research problem utilizing methods that aid this process; thus, the test of whether method should be used is whether it actually increases understanding of the research problem (Mackenzie & Knipe, 2006). The research partnership collaborated at all stages of design, recruitment, running the evaluation interpretation of data, and dissemination including conference presentations and writing articles for publication.

A mixed methods approach was employed in order to gather data including service user and staff questionnaires, focus groups, mentor session notes, and a case study. As mentioned above, this article focuses on the staff quantitative data, while being aware that the service user experience of using the RFUP with their worker is likely to have a direct bearing on the confidence of the said workers. We would also postulate that increased self-report of staff confidence is likely to be positively correlated with self-reported increases in knowledge. The service user experience has been discussed elsewhere (Myers, Kroes, O'Connor, & Petrakis, 2018), illustrated through a case study and aggregated service user feedback data.

Research Design for the Evaluation

A control and intervention group of staff from the community support service, who worked with similar cohorts of service users, were recruited in New South Wales (NSW) and Victoria. The NSW group were the control group. The Victorian group received training and mentoring in the RFUP. Both groups were surveyed at three time points coinciding with pretraining, posttraining, and postmentoring of the Victorian participants. Mentor notes and focus groups of mentors and mentees provided further qualitative data. Service users in Victoria who experienced the RFUP were given the opportunity to provide feedback via a questionnaire.

Ethics. An earlier Needs Analysis study was registered as a quality improvement project at St. Vincent's Hospital (Melbourne) in May 2012. When the initiative became a research study in 2015, full ethics clearance was sought and obtained from both the clinical and MHCSS organizations involved. Ethics approval was gained from the hospital Human Research Ethics Committee, the university ethics, and the MHCSS Research Committee.

Recruitment. In Phase 1, 10 existing lead practitioners from the MHCSS were trained and mentored in the RFUP by the capacity building service. These mentors then went on to provide mentoring to their Victorian colleagues who received training as part of a national comparison trial.

Two groups of over 40 MHCSS staff were recruited from comparable sites. Similar service user and staff profiles were matched by the service development officer in the community service.

Intervention group: Victorian sites. Intervention sites in Victoria received 5 hr training and 2 × 1-hr mentoring sessions on how to use the RFUP. MHCSS mentors in Victoria had previously been trained and mentored by the capacity building service in early 2015. These mentors also recorded de-identified notes from their mentoring sessions using a mentoring template and matched survey of both staff groups to coincide with three time points: pretraining, posttraining, and postmentoring.

Staff survey involved 12 questions on knowledge and confidence in dual diagnosis interventions. These were based on the five domains of the RFUS. The first domain was divided into two in the RFUP, to better reflect the possibility that positive symptoms and medication side effects can be both linked and/or separate reasons for use; thus, there were 12 rather than 10 questions. Focus groups of mentors and mentees were held in order to gain qualitative data.

Service users who consented to participate in the RFUP evaluation were offered a feedback questionnaire. The service user experience has been discussed elsewhere (Myers, Kroes, O'Connor, & Petrakis, 2018) with aggregated survey questions and illuminated through a case study example.

Participants. A total of 92 support workers participated in this study as well as a further 10 lead practitioners in Victoria who acted as mentors. The intervention group consisted of 48 support workers from Victoria. The comparison group consisted of 44 support workers from New South Wales.

Measures. Participants were surveyed using a questionnaire that required them to respond to 12 self-report measures of knowledge in using dual diagnosis strategies in their practice. Measures of knowledge and confidence in using dual diagnosis strategies in their practice, which relate to responses, were measured on a 6-point Likert-type scale (1 = *strongly disagree*, 2 = *disagree*, 3 = *slightly disagree*, 4 = *slightly agree*, 5 = *agree*, 6 = *strongly agree*).

Procedure. The questionnaire was administered to participants in the intervention group at three time points: (1) pretraining, (2) posttraining, and (3) postmentoring. The postmentoring time point was defined as a worker having used the RFUP with at least one service user and having completed at least two

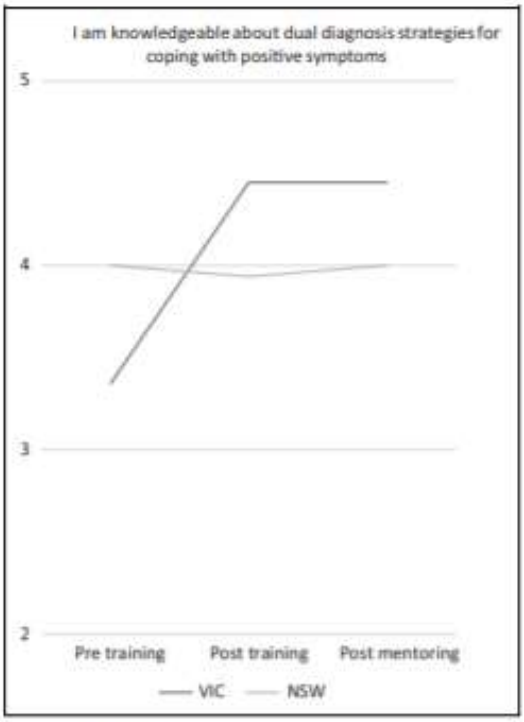

Figure 1. Staff knowledge about dual diagnosis strategies for coping with drug use related to coping with positive symptoms.

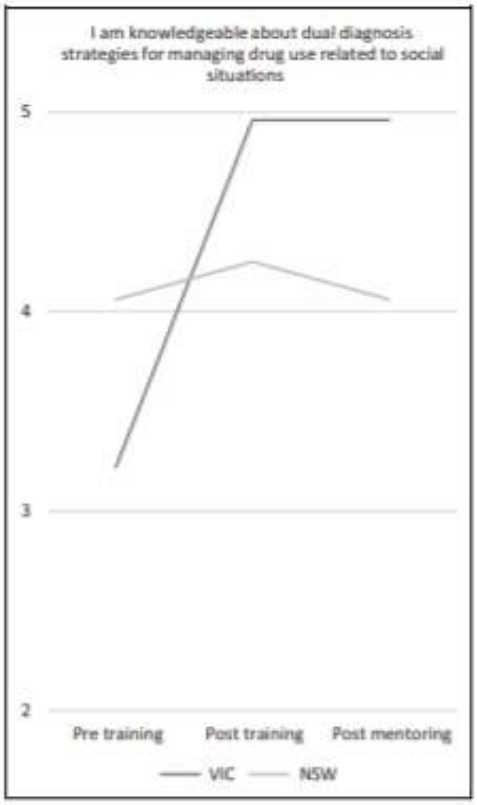

Figure 2. Staff knowledge about dual diagnosis strategies for managing drug use related to social situations.

sessions with a RFUP mentor. Participants in the comparison group did not complete training or mentoring but completed the survey at comparable time points.

Data analysis. Responses were analyzed utilizing the Survey Methods software package to examine raw numbers, percentages, and strength of agreement or disagreement to the proposed package of strategies for interventions with service users.

Statistical analyses. Multiple two-way repeated measures analysis of variances were run to determine the effect of training and mentoring over three time points on confidence and knowledge measures.

Results

The analysis demonstrated that the state that received the training (VIC) demonstrated a statistically significant increase in confidence and knowledge on all aspects (the 12 questions) from pretraining to posttraining, compared to the state that did not receive the training/mentoring (NSW). This increase in knowledge and confidence was maintained at the follow-up time point postmentoring (all $p < .05$) for all aspects (12 questions) except Question 1, which was approaching significance ($p = .058$).

Knowledge

Workers' scores for self-reported knowledge in the intervention (VIC) group significantly increased from pretraining to posttraining ($p \leq .05$; see Figure 1) on all six measures of knowledge. This increase in knowledge was maintained postmentoring as demonstrated by significant increases between pretraining scores to postmentoring scores on all six measures of knowledge ($p \leq .05$; see Figures 1 and 2).

Confidence

There was a statistically significant main effect of training, $F(2, 76) = 14.559$, $p < .001$, partial $\eta^2 = .381$. There was a statistically significant interaction between training and time on "confidence measures," $F(2, 76) = 5.513$, $p = .006$, partial $\eta^2 = .127$ (Table 1). This increase in confidence was maintained postmentoring (see Figures 3 and 4).

Discussion and Applications to Practice

Stakeholders have consistently expressed the need to improve their skills, knowledge, and confidence in having meaningful conversations with clients about the interaction of their mental health and AOD issues. The "Psychiatric Disability and

Table 1. Statistical Analysis.

Domain	Time Point	Victoria ($N = 23$) $M \pm SD$	New South Wales ($N = 17$) $M \pm SD$	p Value
I am *confident* about dual diagnosis strategies for coping with positive symptoms.	Q1 Pretraining	3.52 ± 1.12	3.82 ± 0.95	—
	Q1 Posttraining	4.65 ± 0.71	4.06 ± 1.09	.003
	Q1 Follow-up	4.39 ± 1.12	4.12 ± 1.11	.058
I am *knowledgeable* about dual diagnosis strategies for coping with positive symptoms.	Q2 Pretraining	3.36 ± 0.95	4.00 ± 0.97	—
	Q2 Posttraining	4.45 ± 0.80	3.94 ± 0.93	<.0005
	Q2 Follow-up	4.45 ± 1.01	4.00 ± 1.46	<.0005
I am *confident* about dual diagnosis strategies for how to manage medication side effects.	Q3 Pretraining	2.91 ± 0.90	3.65 ± 1.06	—
	Q3 Posttraining	4.52 ± 0.85	3.71 ± 1.11	<.0005
	Q3 Follow-up	4.61 ± 0.84	3.35 ± 1.32	<.0005
I am *knowledgeable* about dual diagnosis strategies for how to manage medication side effects.	Q4 Pretraining	2.86 ± 0.83	3.62 ± 1.03	—
	Q4 Posttraining	4.41 ± 0.91	3.63 ± 1.20	<.0005
	Q4 Follow-up	4.64 ± 0.73	3.69 ± 1.40	<.0005
I am *confident* about dual diagnosis strategies for managing drug use related to social situations.	Q5 Pretraining	3.22 ± 0.98	4.06 ± 0.93	—
	Q5 Posttraining	4.96 ± 0.71	4.25 ± 1.24	<.0005
	Q5 Follow-up	4.96 ± 0.706	4.06 ± 1.34	<.0005
I am *knowledgeable* about dual diagnosis strategies for managing drug use related to social situations.	Q6 Pretraining	3.30 ± 1.02	4.06 ± 0.85	—
	Q6 Posttraining	5.00 ± 0.67	4.19 ± 1.22	<.0005
	Q6 Follow-up	4.91 ± 0.73	4.19 ± 1.42	<.0005
I am *confident* about dual diagnosis strategies for managing drug use related to peer pressure.	Q7 Pretraining	3.52 ± 1.12	4.13 ± 1.06	—
	Q7 Posttraining	4.70 ± 0.88	4.20 ± 1.15	.004
	Q7 Follow-up	4.91 ± 0.67	4.27 ± 1.10	.001
I am *knowledgeable* about dual diagnosis strategies for managing drug use related to peer pressure.	Q8 Pretraining	3.43 ± 0.99	3.94 ± 1.03	—
	Q8 Posttraining	4.74 ± 0.86	3.88 ± 1.22	<.0005
	Q8 Follow-up	4.87 ± 0.82	4.00 ± 1.37	<.0005
I am *confident* about dual diagnosis strategies for coping with unpleasant affect.	Q9 Pretraining	3.78 ± 0.95	4.40 ± 0.51	—
	Q9 Posttraining	4.83 ± 0.89	4.40 ± 0.63	.003
	Q9 Follow-up	5.09 ± 0.73	4.20 ± 1.15	<.0005
I am *knowledgeable* about dual diagnosis strategies for coping with unpleasant affect.	Q10 Pretraining	3.64 ± 1.00	3.94 ± 0.77	—
	Q10 Posttraining	4.73 ± 0.70	4.13 ± 1.03	.001
	Q10 Follow-up	4.95 ± 0.95	4.00 ± 1.41	.002
I am *confident* about dual diagnosis strategies for managing drug use when it is perceived as a positive activity.	Q11 Pretraining	3.35 ± 1.03	3.88 ± 0.89	—
	Q11 Posttraining	4.83 ± 0.94	4.06 ± 1.18	<.0005
	Q11 Follow-up	4.96 ± 0.71	4.00 ± 1.10	<.0005
I am *knowledgeable* about dual diagnosis strategies for managing drug use when it is perceived as a positive activity.	Q12 Pretraining	3.35 ± 1.03	3.65 ± 0.86	—
	Q12 Posttraining	4.83 ± 0.98	3.94 ± 1.14	<.0005
	Q12 Follow-up	4.83 ± 0.78	3.94 ± 1.25	.001

Rehabilitation and Support Services Reform Framework Consultation Paper" (Department of Health, 2012; *the previous name for MHCSS*) states the need to develop and deliver "training and professional development programs to support use of evidence-based recovery models and tailored training and professional development to improve capability, capacity and confidence" (p. 45). The MHCSS service wanted to clarify how to fulfill this need within the sector.

Results show a greater staff awareness of how to apply existing knowledge base of interventions from a dual diagnosis perspective and develop new skills where required. This was demonstrated in the staff self-reported knowledge and confidence scores after using the RFUP in the field. We would contend that there is a strong likelihood that there is a relationship between the positive service user experience (Myers, Kroes, O'Connor, & Petrakis, 2018) and self-rated staff surveys on their knowledge and confidence. As the study design maintained the need for de-identified service user data, it is not possible to definitively address this connection. This is worthy of further study.

The limitations in this study are that the case comparison study took place within a particular organization within a specific context. While the results are likely to be of interest to similar organization staff and service users, the degree to which these results could be replicated is worthy of further study as each individual organizational culture could impact on results. It is worth noting that there were consistently higher baseline ratings of staff knowledge and confidence pretraining for New South Wales compared to Victoria. Explaining these differences between groups was not within the scope of the current study.

In conclusion, the self-report measures of knowledge and confidence of the Victorian-based staff who received training and mentoring in the RFUP indicated statistically significant increases in five out of six domains. Additionally, the sixth domain showed marked improvement. Further exploration of

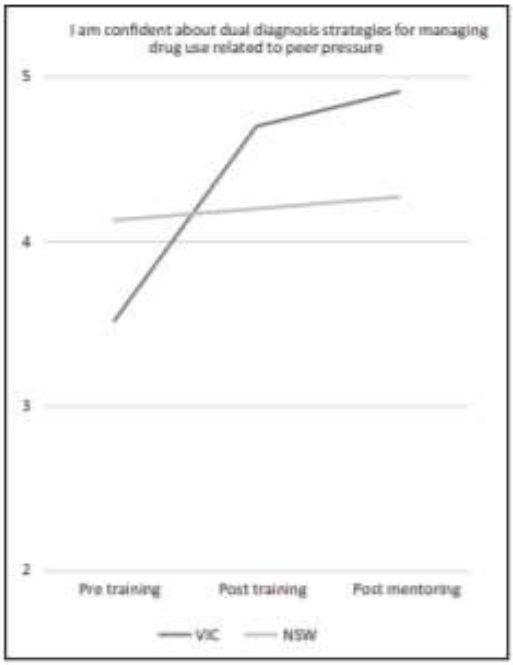

Figure 3. Staff confidence about dual diagnosis strategies for managing drug use related to peer pressure.

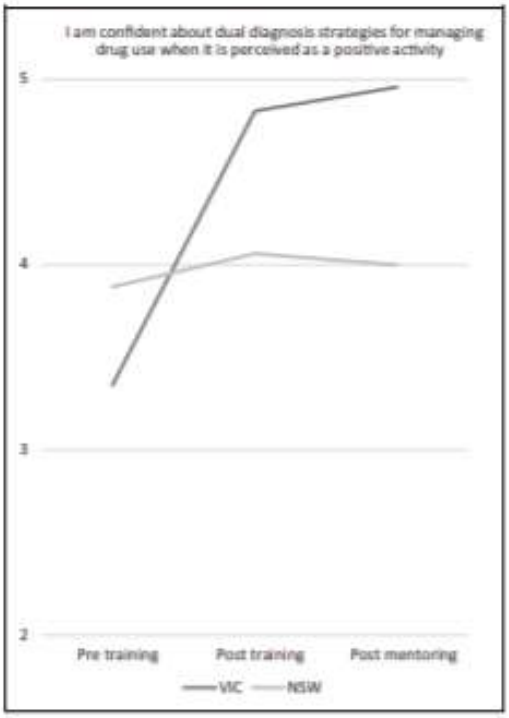

Figure 4. Staff confidence about dual diagnosis strategies for managing drug use when it is perceived as a positive activity.

the use of this resource is therefore warranted. In Victoria, the state government 2019-2020 Royal Commission into Victoria's Mental Health System is specifically asking for solutions to complex issues such as dual diagnosis presentations. Rather than merely describing the problems associated with dual diagnosis, the evidence in the current study strongly suggests that the RFUP is both useful for service users and effectively increases service capacity that can make a significant contribution to better outcomes.

The wider implications of this study are that the success of the RFUP trial described herein leads to a national rollout of the RFUP with the MHCSS involved in the trial and interest from international observers from Denmark, United Kingdom, China, and South Africa. A range of AODs, housing services, and mental health services in Melbourne are now using the RFUP.

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References

Byron, P. (2019). 'Apps are cool but generally pretty pointless': LGBTIQ+ young people's mental health app ambivalence. *Media International Australia*, *171*, 51–65.

Cooper, M. L., Frone, M. R., Russell, M., & Mudar, P. (1995). Drinking to regulate positive and negative emotions: A motivational model of alcohol use. *Journal of Personality and Social Psychology*, *69*(5), 990–1005.

Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches* (4th ed.). Sage.

Department of Health. (2012). *Psychiatric Disability and Rehabilitation and Support Services Reform Framework Consultation Paper—Consultation Report*. State Government of Victoria.

Department of Human Services. (2007). *Dual diagnosis—Key directions and priorities for service development*. State Government of Victoria.

Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*, *24*(4), 589–608.

McDermott, F., & Pyett, P. (1993). *Not welcome anywhere: People who have a serious psychiatric disability and problematic substance use*. VICSERV.

Meque, I., Salom, C., Betts, K. S., & Alati, R. (2019). Predictors of alcohol use disorders among young adults: A systematic review of longitudinal studies. *Alcohol and Alcoholism, 54*(3), 310–324.

Minkoff, K., & Cline, C. A. (2005). Developing welcoming systems for individuals with co-occurring disorders: The role of the comprehensive continuous integrated system of care model. *Journal of Dual Diagnosis, 1*(1), 65–89.

Myers, K., Kroes, S., O'Connor, S., & Petrakis, M. (2018). The reasons for use package: How mentoring aids implementation of dual diagnosis practice. In *New Paradigm: The journal of the psychiatric and disability support services* (pp. 25–29). VICSERV.

Myers, K., Kroes, S., & Petrakis, M. (2018). A foundation for dual diagnosis practice: Wisdom, tools and resources. In M. Petrakis (Ed.), *Social work practice in health: An introduction to contexts, theories and skills* (pp. 135–152). Allen & Unwin.

Myers, K., O'Connor, S., Petrakis, M., & Kroes, S. (2017). The reasons for use package: Development research and implementation lessons for the field. 26th Contemporary TheMHS in mental health services. In *'People: Authenticity starts in the heart' 23–26 August 2016, Auckland New Zealand. 2016 TheMHS Conference Proceedings*, Australia. https://www.themhs.org/resource/the-reasons-for-use-package-development-research-and-implementation-lessons-for-the-field/

New South Wales Health. (2000). *The management of people with a co-existing mental health and substance use disorder—Service delivery guidelines*. https://catalogue.nla.gov.au/Record/558467

Pennebaker, D., Robinson, S., Gomes, A., Quigley, A., Bennetts, A., & Browton, R. (2001). *Co-occurring mental illness and substance abuse services review*. Centre for Mental Health Services Research.

Petrakis, M., Robinson, R., Myers, K., Kroes, S., & O'Connor, S. (2018). Dual diagnosis competencies: A systematic review of staff training literature. *Addictive Behaviors Reports, 7*, 53–57.

Substance Abuse and Mental Health Services Administration. (2002). *Report to congress on the prevention and treatment of co-occurring substance abuse and mental disorders*. Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.

Spencer, C., Castle, D., & Michie, P. T. (2002). Motivations that maintain substance use among individuals with psychotic disorders. *Schizophrenia Bulletin, 28*(2), 233–247.

Tashakkori, A., & Teddlie, C. (Eds.). (2003). The past and future of mixed methods research: From data triangulation to mixed model designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 671–701). Sage.

Teesson, M., & Burns, L. (Eds.). (2001). *National Drug Strategy and National Mental Health Strategy* (National comorbidity project). Commonwealth Department of Health and Aged Care.

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., Charlson, F. J., Norman, R. E., Flaxman, A. D., Johns, N., Burstein, R., Murray, C. J. L., & Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: Findings from the Global Burden of Disease Study 2010. *The Lancet, 382*(9904), 1575–1586.

Chapter 5

Discussion and Conclusions

This study was premised on the need to the build dual diagnosis capacity of mental health community staff. It was specifically focussed on the exploring the perceived efficacy of a particular dual diagnosis tool called the Reasons For Use Package. To understand the context of this study it was first necessary to explore the literature relating to substance use, mental health and the co-occurrence of these two issues referred to in this study as dual diagnosis. These issues where explored in the introduction chapter, which include the first published work, addressing the subsidiary question "What is dual diagnosis, why does it matter, and are there models for approaching this issue?"

The literature review chapter further explored the literature relating to the topic, which included a systematic review of dual diagnosis training approaches which was the second published work. The latter identified that there was a gap in the literature as to whether a dual diagnosis resource such as the RFUP could positively impact staff perception of improvements in knowledge and confidence addressing the subsidiary question With respect to dual diagnosis are there existing tools which assist in building dual diagnosis capacity?

The overarching research question was: What is the perceived efficacy of a dual diagnosis intervention strategies package, namely the Reasons For Use Package (RFUP)?

The discussion and conclusion of this thesis is timely as yet again the issue of dual diagnosis is being raised by Australian governmental agencies.

In a submission to the Australian Government Productivity Commission Mental Health Inquiry by the Matilda Centre for Research in Mental Health and Substance Use, begins by exploring the issue of prevalence. KEY points highlighted

> *The co-occurrence of substance use disorders and mental health disorders have a high prevalence in Australia and come with substantiated disability; 1 in 2 Australians will*

develop a substance use, anxiety or mood disorder in their lifetime, and 1 in 5 Australian adults meet criteria for a substance use, anxiety or mood disorder annually. Furthermore, findings from the most recent Australian National Survey of Mental Health and Wellbeing (NSMHWB) show that these disorders frequently co-occur with 35% of individuals with a substance use disorder (31% of men and 44% of women) also meeting diagnostic criteria for at least one co-occurring mood or anxiety disorder. Prevalence is even higher among individuals entering alcohol and other drug (AOD) treatment programs, with estimates indicating between 50–76% of Australian clients of AOD treatment services meet diagnostic criteria for at least one comorbid mental disorder (Mills, Marel, , Madden, and Teeson, 2019 p.1) .

The submission cites estimates of the economic burden from early death related of people with mental health substance use and physical health issues to be a staggering $54 billion in Australia alone, highlighted in a 2016 report commissioned by The Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian Health Policy Collaboration at Victoria University (AHPC).

The recommendations from the Australian Productivity Commissions Mental health Inquiry Report makes the following statements with respect to improving outcomes for people with comorbidities.

"Mental health services should be required to ensure treatment is provided for both mental illness and substance use disorder for people with both conditions. (Action 14.2)

Mental health and alcohol and other drug services should jointly develop and implement operational guidelines covering screening, referral pathways, and training, guidelines and other education resources for mental health and alcohol and other drugs workers. (Action 14.2)" (Australian Government, 2020 pp 73).

Service design and integrated treatment responses to co-occurring issues then is a key issue, this relates directly to the rationale for this research thesis. The RFUP was developed with a desire to both build staff knowledge and confidence in dual diagnosis interventions and approaches and to facilitate therapeutic conversations between staff and consumers who have co-occurring mental health and substance use issues. The existing literature on dual diagnosis prior to this study was dominated by descriptions of the phenomenon rather than whether such a resource enhances practice change. Exploring the perception of staff around the efficacy of the RFUP and the consumer feedback on using the resource with their worker, was aimed at addressing the gap in the literature. It is hoped that any new knowledge discovered in this research will have a direct bearing on improving outcomes for consumers, their carers and service providers.

This research was undertaken with the view that outcomes for consumers with mental health and substance use issues and their families had been a key theme in the literature for over 30 years (Staiger et al 2011). The major gap identified in the systematic literature review in chapter 2 was the lack of tools to assist staff to enhance their practice in this area. The Reasons For Use Package had shown promise in earlier pilots and there was considerable interest in exploring the perceived impact of this tool for both staff and consumers.

How did the study address the Principle Research Question?

What is the perceived efficacy of a dual diagnosis intervention strategies package, namely the Reasons For Use Package (RFUP)?

The two state comparison trial involving staff from an Australian mental health community support service was used to explore the main research question. The control cohort received the standard training and coaching at Neami National which included CRM, motivational interviewing

and dual diagnosis generic training. The Victorian cohort received the same basic training and coaching with additional training and mentoring in the RFUP.

The methodology for exploring the research was a mixed methods pragmatic approach. This reflected the complexity of the phenomenon under investigation. Although the research question may look deceptively simple there are many variables which impact on the perceived efficacy of the RFUP. Staff have different understandings of dual diagnosis and have a variety of different perspectives with respect to how they might judge how the RFUP impacted on their practice. Nevertheless, by using a mixed methods approach with different methods including surveys and focus groups, through a process of triangulation to draw out a more generalizable conclusion.

The research involved collecting quantitative data at three time points. The surveys of staff perception of their knowledge and confidence in their ability to provide interventions related to six different domains of dual diagnosis practice. The surveys occurred for both cohorts to coincide with pre and post training in the RFUP and post mentoring undertaken by the Victorian cohort.

Qualitative data was collected through two forms of focus groups. The first focus group was held approximately one month after the final mentoring session in Victoria with a purposive sample of mentees. The second focus group involving a purposive sample of mentors and mentees. This focus group took place around six months after the last mentoring session and explored perception of staff with respect to the quantitative data from the surveys.

How did the study seek to address the subsidiary question?

What is the Consumer experience of using the RFUP with mental health support workers?

Consumers who participated in the study where given an anonymous seven question feedback survey with a five point Likert scale, with space for additional comments (see appendix 6).

Key Outcomes from the study

The multiple two way repeated measures reported in paper 5 (Myers et al 2020) comparing broadly similar staff groups, showed a statistically significant $p<.05$, increase in the perceived knowledge and confidence in Victorian cohort post training which was maintained in 11 of 12 questions at the post mentoring stages. The analysis of the results for the 12th question "I am confident about dual diagnosis strategies for coping with positive ?" was approaching significance $p= .058$.

These results where then triangulated with the qualitative feedback reported in the results chapter from the two different focus groups. One involving mentees only and one involving both mentors and mentees. Attendees at the first focus group felt that being trained and mentored in the RFUP had increased their knowledge and confidence in dual diagnosis. Attendees at the second focus group commented that both the quantitative staff data and the consumer feedback data rang true from their perspective. As discussed in the results chapter, there was a strong correlation between staff perceptions and the views of consumers. i.e that both staff and consumers felt the RFUP improved the therapeutic relationship and assisted the consumer and staff member to explore the interaction between the consumers' mental health and substance use issues.

The study suggests that the Victorian staff perceived that being trained and mentored in the RFUP had indeed been effective in building their dual diagnosis capacity. The Consumer data, as reported in the results chapter indicated positive support for the use of the RFUP.

RFUP Post study

Since the research began the RFUP has been continuously used in a number of clinical and community mental health settings. This was despite the enormous changes that occurred with the introduction of the NDIS which changed the model of service provision in the Community Mental Health Support Services. The understanding gained through the study has informed implementation strategies. In addition over 30 organisations have been trained and mentored in the RFUP since the study began over seven years ago. Hundreds of staff across a range of organisations have now used the tool with service users to develop treatment plans.

RFUP website

The original version of the RFUP which was based on Powerpoint worked well, indeed has been embedded and continues to be used in this format within Neami National. However this version had more limited accessibility for a wider audience from a technical perspective. . Kroes and Myers successfully applied for the Catalyst Innovation Fund at St Vincent's Hospital Melbourne in order to fund the design of a website version. The RFUP website (Rose, Myers, Kroes, Guglielmetti and Hwang, 2018) Reasons For Use Package Online was designed in collaboration with Monash Art, Design and Architecture. The website was launched to packed audience of consumers and staff from across Victoria in 2018 at the Melbourne Docklands Library. Since 2018 the website has been used by staff and consumers in Victoria, Western Australia and Queensland. Myers and Kroes were finalists in the St Vincent's Health Australia national Innovation Awards in Brisbane in 2019 for their work on the RFUP.

National and International Interest in the RFUP

Although this thesis has been conducted in the state of Victoria in Australia the implications discussed below are directly relevant to an international audience and delegates to the three International conferences where this research has been presented have shown strong interest. The RFUP research has also been show cased at Social Work Departments at the University of Sussex in 2016 and University of Swansea 2017. Also in 2016, this candidate was an invited speaker at a gathering of mental health and substance use practitioners from Copenhagen, hosted at the Gladaxe Drug and Alcohol Service in Denmark. In Victoria, Australia the RFUP has been used by people from a range of ethnic backgrounds and there has been early discussion around translation into Vietnamese.

Implications for practice

The major implications for practice is that implementation of the Reasons For Use Package could increase perceived knowledge and confidence of staff and that consumers found the use of the RFUP improved their rapport with workers and aided treatment planning. These two implications have to be seen against the stark figures of outcomes for consumers experiencing mental health and substance use issues across the literature.

As the Royal Commission into the Victorian Mental Health System (RCVMHS 2021) found;

"people who access both mental health and alcohol and other drug services are 25 times more likely than the Victorian population overall to use an ambulance for a mental health related reasons, 48 times more likely to visit Victoria's emergency departments for reasons relating to suicidal ideation or suicide attempt 40 times more likely to access ambulance and emergency departments for reasons relating to self-harm (RCVMHS Final report Volume 3 2021 p.303)".

The impact of trauma and trauma informed care

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and the impact on health outcomes (Dube et al., 2010). The original ACE study was conducted with over 17,000 members of a health insurance scheme from Southern California. They completed confidential surveys regarding their childhood experiences and current health status and behaviours. The study's participants were mostly white 80%, black 10%, Asian 10%, middle and upper-middle class college-educated 74% with good jobs and great health care. In other words, they were not people who might be, stereotypically seen as likely to develop mental health or substance use issues.

The study compared the risk of developing a range of different health and well-being concerns in relation to the ten Adverse Childhood Experiences (ACE), including neglect, sexual and verbal abuse, domestic violence and having a parent diagnosed with mental health or substance use issues. The data set produced some startling results with respect to the increased risk of becoming an Injection Drug user with an ACE score of 4 being 1350%, compared to those without ACE's. Furthermore, the increased risk of becoming an injection drug user with an ACE score of 6 jumped to 4600%!

Trauma informed care has increasingly been a focus for improving service provision for co-occurring disorders (Horsfall, Cleary, Hunt, and Walter, 2009). This study didn't directly look at whether being trained and mentored in the RFUP supported a trauma informed approach. Nevertheless staff did consistently report increased knowledge and confidence in strategies to deal with substance use related to unpleasant affect.

Integrated Care

Although numerous policy documents talk about the need to implement integrated treatment (Lowe, and Abou-Saleh, 2004 there has been a lack of consumer-friendly tools which actually help guide staff practice in this area (Sinha, Garg, and Prakash, 2018). Merely ramping up the rhetoric about improved responses without looking at the "how" to actually do it may in fact cause further pressure, indeed could impact negatively on staff morale and in turn reduce consumer confidence in raising this issue with service providers. The RFUP by providing an alternative narrative i.e that consumers can respond well if approached in the right manner and that they are able to not only "help" create their own treatment plan, but actually drive the process also fits with the burgeoning peer workforce with Intentional peer support as the preferred approach (Intentional Peer Support, 2018).

Like the IPS, the RFUP offers a different way to work in partnership, without the prescriptive assumption that there is a substance use problem or that the person needs to stop using substances. The focus group feedback as well as the mentor session notes talked about the RFUP bringing new energy as consumers first reflected on their situation, then made choices and move into action. Although not all consumers will react in this way, close to 70% indicated the RFUP gave them goals to work on according to the consumer feedback data as reported in the results chapter.

Although this thesis explores the impact of the RFUP within Neami National, since the case comparison two state trial, other organisations have keenly embraced the same model with very similar improvements in perceived knowledge and confidence. This would suggest that the RFUP itself rather than necessarily the organisational context within which it is used is having a generalizable effect.

At the time of writing another large Victorian mental health service Wellways Inc is implementing the RFUP across their PARCs (Prevention and Recovery Centres) across the Northern, Western and Eastern regions of Melbourne with measures of perceived changes to knowledge and confidence data being collected, based on the two state comparison trial with Neami National. Thus far Wellway staff surveys of their perceived knowledge and confidence around dual diagnosis interventions show the same trend as the study reported in this thesis.

Implications for policy

Whilst both the Federal Productivity Commission and the RCVMHS explicitly call for integrated treatment and the need to develop and support innovations neither identifies particular evidence based tools. Policy can effectively drive practice change as was seen in the period between 2008-2011 in Victoria. The introduction of the "Dual Diagnosis Key Direction document" saw a concerted effort to improve service delivery (Roberts, 2015). Whilst it remains unlikely, state or Federal Governments could endorse specific tools that can endorse the use of evidenced based tools rather than allowing service providers to utilise non evidenced based approaches. The evidence from this research would suggest that the RFUP should be considered as an effective tool to translate policy objectives into practice.

Ongoing Research

Further research has already commenced to explore in more detail the consumer experience of the RFUP. Neami National a long-time research partner alongside Monash University Social Work Department collaborated with Myers and Kroes in a co-designed research project. A Neami National Youth residential service which has used the RFUP for the past five years was the setting for this research. A qualitative research method using semi-structured interviews conducted by Lived Experience Researchers and MSW students collected the thoughts of consumers who had

used the RFUP whilst at the service. The data collected is currently being thematically analysed by the research team and the aim is to submit a paper for publication in 2022. It is noteworthy that that Research team where invited to run a Research Masters session show casing co-design at Monash University in November 2020.

Future research

There a number of future research options that could be undertaken following the two state comparison trial, four options are raised below.

A repeat two state comparison trail with a different cohort of staff for example from a clinical mental health setting. Essentially a research of this nature could explore whether similar results are discovered despite potential differences in organisational roles and cultural setting and staff group profile.

A longitudinal Consumer Outcome Study

Whilst the study above enhances our understanding of the consumer experience of the RFUP it would also be useful to look at a more longitudinal consumer outcome study over at least 24-month period. This is because consumer recovery journeys are often extended over a longer time scale. It would also be useful if outcomes measures such as HoNOS, Health of the Nation Outcome Scale (Rees, Richards, and Shapiro, 2004) or WHOQOL, World Health Organisation Quality of Life (Skevington, Lotfy, and O'Connell, 2004) were utilised.

Potential impact of the RFUP on staff empathic distress

Similarly, whilst the RFUP appears to have an positive impact with respect to knowledge and potentially more importantly confidence, it would be useful to explore whether this is a protective factor with respect to reducing "burn out" or empathic distress fatigue (Ling, 2019) in health and

welfare workers. This would necessarily be a longer-term study perhaps beginning with health undergraduates and or new graduates to see whether those who are trained and mentored in the RFUP develop a different approach to working more collaboratively with consumers with a dual diagnosis and whether this had any impact on their levels of empathic distress.

Potential efficacy of the RFUP for Mental Health and Gambling

After the two state comparison trial had concluded a number of staff from Neami National informed this candidate that they had used the RFUP with other service users to explore mental health and gambling. Anecdotal reports indicated that despite the RFUP being designed to explore mental health and substance use, service users found it useful with respect to gambling. It would therefore be worth pursuing further research to explore the perceived efficacy of the RFUP with this issue and whether further needs modifications would be beneficial for this context.

Limitations

The comparison trial results are specific to a particular organisation, with a strong culture of using a recovery, coaching and motivational interviewing approaches and in a particular setting in Victoria where the state-wide Victorian Dual Diagnosis Initiative had been operating for over 15 years, thus generalisability of these results need to be seen in this context. It is also worth noting that the consumer results are from a short time frame whilst in practice further impact might be seen over a longer timeframe. With respect to staff impacts the comparative data covered three times points over approximately two months with the second focus group occurring around six months later. Nevertheless, this is still a relatively short time frame for building and sustaining practice in this area.

Concluding Comment

The RFUP does not operate in isolation from other change levers such as policy and funding however it is clear that it can play a role in creating a better way of working to address dual diagnosis. This candidate is confident that the reform agenda following the RCVMHS and the Australian National Productivity Commission into mental health will provide opportunities for building on the successful implementations thus far particularly in Victoria and other Australian states and territories.

Australian implementation has now been extensive, and there are existing contacts who have expressed support for trials in overseas jurisdictions such as Professor Castle in Toronto. To date the introduction of the RFUP across numerous agencies in Victoria and a number of Neami National sites in Western Australia and Queensland, since 2017 has mainly been provided by the designers of the RFUP. It is obvious therefore that scaling up the implementation of the RFUP Australia wide and internationally will require investment by governmental agencies and health service providers. The positive results of this research project provides evidence to justify doing so and furthermore the implementation process used during this research has created a framework that can be readily adapted by other similar organisations and workforces.

The co-occurrence of mental health and substance use issues has been discussed in the literature for over many years. In Australia there have been numerous State and Federal service projects delivery aimed at improving outcomes for consumers and carers. The two state comparison evaluation that is described in this thesis, and the subsequent national and international publications that have emerged, have established the Reasons For Use Package as an evidenced based tool which can directly impact on the perceived staff knowledge and confidence of dual diagnosis interventions and in turn successfully improve outcomes for service users.

References

Allsop, S,. 2008. *Drug Use and Mental Health*. IP communications Melbourne.

Alston, M. and Bowles, W., 2018. *Research for social workers: An Introduction to methods*. London: Routledge.

Amodia, D.S., Cano, C. and Eliason, M.J., 2005. An integral approach to substance abuse. *Journal of Psychoactive Drugs*, *37*(4), pp.363-371.

Australian Government Productivity Commission 2020. *Mental Health: Productivity Commission Inquiry Report*, viewed 18 January 2021, <https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf>.

Australian Health Associates., 2011. *Evaluation of the Victorian Dual Diagnosis Initiative* https://www.ahaconsulting.com.au/projects/evaluation-of-the-victorian-dual-diagnosis-initiative. Viewed 17th June 2018

Boyle, D. and Harris, M., 2009. The challenge of co-production. *London: new economics foundation*, *56*, p.18.

Brophy, L., Bruxner, A. and Wilson, E., 2014. Consumer choices about mental health support services. *New paradigm*, (Summer 2014), pp.27-29.

Bryman, A,. 2012, *Social research methods,* 4th edition, Oxford University Press, New York

Burr, V,. 2015, *Social Constructivism,* 3rd edition, Routledge London New York.

Butler, L.D., Critelli, F.M. and Rinfrette, E.S., 2011. Trauma-informed care and mental health. *Directions in Psychiatry*, *31*(3), pp.197-212.

Byrne, L., Happell, B., and Reid-Searl, K,. 2015. 'Lived Experience Practitioners and the Medical Model: Worlds Colliding' *Journal of Mental Health*, vol. 25, no. 3.

Cabral, T.S., 2017. The 15th anniversary of the Portuguese drug policy: Its history, its success and its future. *Drug Science, Policy and Law*, *3*, p.2050324516683640.

Carey, M., 2012. *Qualitative research skills for social work: Theory and practice*.

Coffey, R.M., Buck, J.A., Kassed, C.A., Dilonardo, J., Forhan, C., Marder, W.D. and Vandivort-Warren, R., 2008. Transforming mental health and substance abuse data systems in the United States. *Psychiatric Services*, *59*(11), pp.1257-1263.

Cooper, M.L., Frone, M.R., Russell, M and Mudar, P,. 1995. 'Drinking to regulate positive and negative emotions: A motivational model of alcohol use', *Journal of personality and social psychology*, vol. 69, pp.990-990.

Corrigan, P.W., 2012. Research and the elimination of the stigma of mental illness. *The British Journal of Psychiatry*, *201*(1), pp.7-8.

Creswell, J.W., 2013. *Research Design: Qualitative, quantitative and mixed methods approaches,* 4th Edition, SAGE Publications, Los Angeles, London, New Delhi, Singapore , Washington DC.

Daniels, A.S., Bergeson, S., Fricks, L., Ashenden, P. and Powell, I., 2012. Pillars of peer support: advancing the role of peer support specialists in promoting recovery. *The Journal of mental health training, education and practice*.

Deady, M. B.-L. (2014). Deady, M., Barrett, E., Mills, K., Kay-Lambkin, F., Haber, P., Shand, F. Baker, Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check review. Sax Institute for the NSW Mental Health and Drug and Alcohol Office.

DeBeck, K., Wood, E., Montaner, J. and Kerr, T., 2009. Canada's new federal 'National Anti-Drug Strategy': An informal audit of reported funding allocation. *International Journal of Drug Policy*, *20*(2), pp.188-191.

Denzin, N. K. 1989. *The Research Act: A Theoretical Introduction to Sociological Methods*, SAGE Publications, United States.

Department of Health,. 2012. *Psychiatric Disability and Rehabilitation and Support Services Reform Framework Consultation Paper - Consultation Report*, Melbourne: State Government of Victoria.

Department of Human Services. 2007, *Dual diagnosis – Key directions and priorities for service development*, Melbourne: State Government of Victoria.

Des Jarlais, D.C., Friedman, S.R. and Ward, T.P., 1993. Harm reduction: a public health response to the AIDS epidemic among injecting drug users. *Annual Review of Public Health*, *14*(1), pp.413-450.

Drake, R.E., Cimpean, D. and Torrey, W.C., 2009. Shared decision making in mental health: prospects for personalized medicine. *Dialogues in clinical neuroscience*, *11*(4), p.455.

Drake, R.E. and Deegan, P.E., 2009. Shared decision making is an ethical imperative. *Psychiatric Services*, *60*(8), pp.1007-1007.

Drake, R.E., Mercer-McFadden, C, Mueser, K.T., McHugo, G.J., and Bond, G.R. 1998, 'Review of integrated mental health and substance treatment for patients with dual disorders', *Schizophrenia Bulletin*, vol. 24, no. 4, pp.589-608.

Dube, S.R., Cook, M.L. and Edwards, V.J., 2010. Peer reviewed: Health-related outcomes of adverse childhood experiences in Texas, 2002. *Preventing chronic disease*, *7*(3).

Duff, C., 2007. Towards a theory of drug use contexts: Space, embodiment and practice, *Addiction Research & Theory*, 15:5, 503-519, DOI: 10.1080/16066350601165448

Edenberg, H.J. and Foroud, T., 2006. The genetics of alcoholism: identifying specific genes through family studies. *Addiction biology*, *11*(3-4), pp.386-396.

Enoch, M.A. and Goldman, D., 2001. The genetics of alcoholism and alcohol abuse. *Current psychiatry reports*, *3*(2), pp.144-151.

Fisher, C.M., McCleary, J.S., Dimock, P. and Rohovit, J., 2014. Provider preparedness for treatment of co-occurring disorders: Comparison of social workers and alcohol and drug counselors. *Social Work Education*, *33*(5), pp.626-641.

Fisher, A., Mills, K., Teesson, M. and Marel, C., 2021. Shared decision-making among people with problematic alcohol/other drug use and co-occurring mental health conditions: A systematic review. *Drug and Alcohol Review*, *40*(2), pp.307-324.

Flynn, C., and McDermott, F,. 2016, *Doing Research in Social Work and Social Care: The journey from student to practitioner researcher*, SAGE Publications, London, UK.

Foster, M., Henman, P., Tilse, C., Fleming, J., Allen, S. and Harrington, R., 2016. 'Reasonable and necessary'care: The challenge of operationalising the NDIS policy principle in allocating disability care in Australia. *Australian Journal of Social Issues*, *51*(1), pp.27-46.

Frank, J. W., Moore, R. S., and Ames, G. M. (2000). Historical and cultural roots of drinking problems among American Indians. *American journal of public health*, *90*(3), 344–351. https://doi.org/10.2105/ajph.90.3.344

Gagne, C.A., Finch, W.L., Myrick, K.J. and Davis, L.M., 2018. Peer workers in the behavioral and integrated health workforce: opportunities and future directions. *American journal of preventive medicine*, *54*(6), pp.S258-S266.

George, T.P. and Krystal, J.H., 2000. Comorbidity of psychiatric and substance abuse disorders. *Current Opinion in Psychiatry*, *13*(3), pp.327-331.

Gringeri, C., Barusch, A. and Cambron, C., 2013. Examining foundations of qualitative research: A review of social work dissertations, 2008–2010. Journal of Social Work Education, 49(4), pp.760-773.

Groenkjaer, M, de Crespigny, C, Liu, D, Moss, J, Cairney, I, Lee, D, Procter, N and Galletly, C,. 2017, '"The Chicken or the Egg": Barriers and Facilitators to Collaborative Care for People With Comorbidity in a Metropolitan Region of South Australia, *Issues in Mental Health Nursing,* vol. 38, no. 1p, pp. 805-811.

Hamilton, M. and Rumbold, G., 2004. Addressing drug problems: The case for harm minimisation. *Drug use in Australia: preventing harm*, pp.129-143.

Hartz, S.M., Pato, C.N., Medeiros, H, Cavazos-Rehg, P, Sobell, J.L., Knowles, J.A., and Vivar, A., 2014, 'Comorbidity of Severe Psychotic Disorders With Measures of Substance Use', *JAMA Psychiatry*, vol. 71, no. 3, pp. 248–254.

Henderson, C., Evans-Lacko, S., and Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American journal of public health*, *103*(5), 777–780. https://doi.org/10.2105/AJPH.2012.301056

Horsfall, J., Cleary, M., Hunt, G.E. and Walter, G., 2009. Psychosocial treatments for people with co-occurring severe mental illnesses and substance use disorders (dual diagnosis): A review of empirical evidence. *Harvard review of psychiatry*, *17*(1), pp.24-34.

Humphreys, K., Blodgett, J.C. and Wagner, T.H., 2014. Estimating the efficacy of Alcoholics Anonymous without self-selection bias: An instrumental variables re-analysis of randomized clinical trials. *Alcoholism: Clinical and Experimental Research*, *38*(11), pp.2688-2694.

Intentional Peer Support (https://www.intentionalpeersupport.org/what-is-ips/?v=6cc98ba2045f, viewed 14th November 2018)

Kelly, T.M. and Daley, D.C., 2013. Integrated treatment of substance use and psychiatric disorders. *Social work in public health*, *28*(3-4), pp.388-406.

Kerstetter, K., 2012. Insider, outsider, or somewhere between: The impact of researchers' identities on the community-based research process. *Journal of rural social sciences*, *27*(2), p.7.

Kroes, S., Myers, K., Officer, S., O'Connor, S. and Petrakis, M., 2019. Dual diagnosis assessment: A case study implementing the reasons for use package to engage a marginalised service user. *Cogent Medicine*, 6(1), p.1630097.

Kulesza, M., Larimer, M.E. and Rao, D., 2013. Substance use related stigma: what we know and the way forward. *Journal of addictive behaviors, therapy & rehabilitation*, *2*(2).

Langton, M., 1992. Too much sorry business.-Summary of the full submission on substance abuse in Chapter Five, Appendix D of the Australia. Royal Commission into Aboriginal Deaths in Custody. National Report (1991)-. *Aboriginal and Islander Health Worker Journal*, *16*(2).

Leshner, A.I., 2001. Addiction is a brain disease. *Issues in Science and Technology*, *17*(3), pp.75-80.

Ling, D.J., 2019. *Investigating the relationship between the perception of common humanity and compassion in healthcare workers* (Doctoral dissertation, Monash University).

Livingston, J.D., Milne, T., Fang, M.L. and Amari, E., 2012. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*, *107*(1), pp.39-50.

Lowe, A.L. and Abou-Saleh, M.T., 2004. The British experience of dual diagnosis in the national health service. *Acta Neuropsychiatrica*, *16*(1), pp.41-46.

Lubman, D., Manning, V., Best, D., Berends, L., Mugavin, J., Lloyd, B., Lam, T., Garfield, J., Buykx, P., Matthews, S. and Larner, A., 2014. A study of patient pathways in alcohol and other drug treatment. *Fitzroy: Turning Point*.

Mackenzie, N., and Knipe, S., 2006, 'Research dilemmas: Paradigms, methods and methodology', *Issues in Educational Research,* vol. 16, no. 2, pp. 193-205.

Mac Suibhne, S. (2011). Erving Goffman's Asylums 50 years on. *British Journal of Psychiatry, 198*(1), 1-2. doi:10.1192/bjp.bp.109.077172

Mangrum, L.F., Spence, R.T. and Lopez, M., 2006. Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of substance abuse treatment*, *30*(1), pp.79-84.

Marlatt, G.A., 1996. Harm reduction: Come as you are. *Addictive behaviors*, *21*(6), pp.779-788

Marsh, T.N., Coholic, D., Cote-Meek, S. and Najavits, L.M., 2015. Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in Northeastern Ontario, Canada. *Harm reduction journal*, *12*(1), pp.1-12.

Martin, C.S., Chung, T. and Langenbucher, J.W., 2016. Historical and cultural perspectives on substance use and substance use disorders. *Oxford handbook of substance use and substance use disorders*, pp.29-49.

Martin, N. and Johnston, V., 2007. A time for action: Tackling stigma and discrimination. *Report to the Mental Health Commission of Canada*.

Maxcy, S., 2003. 'Pragmatic threads in mixed methods research in the social sciences: The search for multiple models of inquiry and the end of philosophy of formalism', in Tashakkori, A. and Teddlie, C. (eds), *Handbook of Mixed Methods*, SAGE Publications, Thousand Oaks, London, New Delhi.

McCabe, M., Staiger, P., Thomas, A., Cross, W. and Ricciardelli, L., 2011. 'Screening for comorbid substance use disorders among people with a mental health diagnosis who present to emergency departments', *Australasian Emergency Nursing Journal*, vol. 14, pp.163-171, doi: 0.1016/j.aenj.2011.06.001.

McDermott, F.M. and Pyett, P., 1993. *Not Welcome Anywhere: People who Have Both a Serious Psychiatric Disorder and Problematic Drug Or Alcohol Use: a Report*. Victorian Community Managed Mental Health Services.

Mental Health Australia., 2014. Getting the NDIS right for people with psychosocial disability https://mhaustralia.org/general/getting-ndis-right-people-psychosocial-disability. Viewed 23rd April2016

Mercer, J., 2013. Deliverance, demonic possession, and mental illness: Some considerations for mental health professionals. *Mental Health, Religion & Culture*, *16*(6), pp.595-611.

Miller, N.A. and Najavits, L.M., 2012. Creating trauma-informed correctional care: A balance of goals and environment. European journal of psychotraumatology, 3(1), p.17246.

Miller, W.R. and Rollnick, S., 2012. *Motivational interviewing: Helping people change*. Guilford press.

Mills, K., Marel, C., Madden, E. and Teeson, M., 2019. Lessening the burden of comorbid substance use and mental disorders through evidence-based care: The case for a national minimum qualifications strategy.

Minkoff, K. and Cline, C.A., 2004. Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics*, *27*(4), pp.727-743.

Morgan, D.L. 2014, *Pragmatism as a Paradigm for Social Research*. SAGE Publications, http://www.sagepublication.com. Viewed 23rd May 2016

Myers, K., Kroes, S., O'Connor, S. and Petrakis, M., 2017. The reasons for use package: Development research and implementation lessons for the field. In 26th Contemporary *TheMHS in Mental Health Services,'People: Authenticity starts in the heart': 2016 TheMHS Conference Proceedings*, Australia (pp. 1-10).

Myers, K., Kroes, S., O'Connor, S. and Petrakis, M., 2018. The reasons for use package: How mentoring aids implementation of dual diagnosis practice. *New Paradigm*, pp.25-29.

Myers, K., Kroes, S., O'Connor, S. and Petrakis, M., 2020. Reasons for use package: Outcomes from a case comparison evaluation. *Research on Social Work Practice*, *30*(7), pp.783-790.

Myers, K., Kroes, S. and Petrakis, M., 2018. A foundation for dual diagnosis practice: Wisdom, tools and resources. In *Social Work Practice In Health* (pp. 135-152). Allen and Unwin.

NDIS Eligibilty Criteria

NSW Health 2000, *The management of people with a co-existing mental health and substance use disorder - Service delivery guidelines*, Sydney: NSW Health Department.

https://www.ndis.gov.au/applying-access-ndis/am-i-eligible Viewed 21st August2017

Neami_National 2016. Reaching Out Moving Forward www.neaminational.org.au/about-us/ publications2015-16/annual report/ viewed 3rd November 2017

Newcombe, D.A., Humeniuk, R.E. and Ali, R., 2005. Validation of the world health organization alcohol, smoking and substance involvement screening test (ASSIST): report of results from the Australian site. *Drug and alcohol review*, *24*(3), pp.217-226.

Nicholas, D.B., Calhoun, A., McLaughlin, A.M., Shankar, J., Kreitzer, L. and Uzande, M., 2017. Care experiences of adults with a dual diagnosis and their family caregivers. *Global Qualitative nursing research*, *4*, p.2333393617721646.

Novella, E.J., 2010. Mental health care in the aftermath of deinstitutionalization: a retrospective and prospective view. *Health care analysis*, *18*(3), pp.222-238.

Nutt, D.J., King, L.A. and Phillips, L.D., 2010. Drug harms in the UK: a multicriteria decision analysis. *The Lancet*, *376*(9752), pp.1558-1565.

Oades, L.G., Crowe, T.P. and Deane, F.P., 2007. *The Collaborative Recovery Model: moving beyond 'us and them' in mental health*. Illawarra, NSW: University of Wollongong.

Olsen, W.K., Haralambos, M. and Holborn, M., 2004. Triangulation in Social Research:: Qualitative and Quantitative Methods Can Really Be Mixed. In *Developments in sociology*. Causeway Press Ltd.

Ouimette, P.E. and Brown, P.J., 2003. *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. American Psychological Association.

Ouzir, M. and Errami, M., 2016. Etiological theories of addiction: A comprehensive update on neurobiological, genetic and behavioural vulnerability. *Pharmacology Biochemistry and Behavior*, *148*, pp.59-68.

Padwa, H., Larkins, S., Crevecoeur-MacPhail, D. and Grella, C 2013. 'Dual Diagnosis Capability in Mental Health and Substance Use Disorder Treatment Programs', *Journal of Dual Diagnosis*, vol. 9, no. 2, pp.179-186, doi: 10.1080/15504263.2013.778441.

Pan, S.L. and Tan, B., 2011. Demystifying case research: A structured–pragmatic–situational (SPS) approach to conducting case studies. *Information and Organization*, *21*(3), pp.161-176.

Pennebaker, D., Robinson, S., Gomes, A., Quigley, A., Bennetts, A. and Browton, R., 2001. *Co-occurring mental illness and substance abuse services review*. West Perth, Western Australia: Centre for Mental Health Services Research.

Petrakis, M., Robinson, R., Myers, K., Kroes, S. and O'Connor, S., 2018. Dual diagnosis competencies: A systematic review of staff training literature. *Addictive Behaviors Reports*, *7*, pp.53-57.

Prochaska, J.O. and DiClemente, C.C., 1982. Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: theory, research & practice*, *19*(3), p.276.

Rapp, C.A. and Goscha, R.J., 2011. *The strengths model: A recovery-oriented approach to mental health services*. OUP USA.

Read, J.P., Brown, P.J. and Kahler, C.W., 2004. Substance use and posttraumatic stress disorders: Symptom interplay and effects on outcome. *Addictive behaviors*, *29*(8), pp.1665-1672.

Reason, P. and Bradbury, H., 2015. *Handbook of Action Research Participative Inquiry & Practice*, SAGE Publications, London.

Rees, A., Richards, A. and Shapiro, D.A., 2004. Utility of the HoNOS in measuring change in a community mental health care population. *Journal of Mental Health*, *13*(3), pp.295-304.

Reif, S., Braude, L., Lyman, D.R., Dougherty, R.H., Daniels, A.S., Ghose, S.S., Salim, O. and Delphin-Rittmon, M.E., 2014. Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, *65*(7), pp.853-861

Rhodes, T., 2009. Risk environments and drug harms: a social science for harm reduction approach. *International Journal of Drug Policy*, *20*(3), pp.193-201.

Rickards, L., 2003. Implementing Dual-Diagnosis. *Dual Diagnosis*, *2*, p.53.

Roberts, B. and Jones, R., 2012. 'Dual Diagnosis narratives and their implications for the alcohol and other drug sector in Australia', *Contemporary Drug Problems*, vol. 39, no. 4, pp.663-684, viewed on 3rd May 2015 <http://cdx.sagepub.com/content/39/4/663.short?patientinform-links=yes&legid=spcdx;39/4/663>.

Roberts, B., Maybery, D. and Jones, R., 2013. Reflections on capacity-building initiatives in an Australian state. *Advances in Dual Diagnosis*.

Roberts, B.M., 2015. *Dual diagnosis discourse and narratives in the State of Victoria, 1985-2012* (Doctoral dissertation, Monash University).

Ronnau, P., Papakotsias, A. and Tobias, G., 2008. " Not for" sector in community mental health care defines itself and strives for quality. *Australian Journal of Primary Health*, *14*(2), pp.68-72.

Room, R., 2005. Stigma, social inequality and alcohol and drug use. *Drug and alcohol review*, *24*(2), pp.143-155.

Rose, C., Myers, K., Kroes, S., Guglielmetti, M. and Hwang, I.D., 2018. *Reasons For Use Package Online*.

Royal Commission into Victoria's Mental Health System. 2019. *Royal Commission into Victoria's Mental Health System: Interim Report*, viewed 18 January 2021, <https://rcvmhs.vic.gov.au/>.

Royal Commission into Victoria's Mental Health System. 2021. *Royal Commission into Victoria's Mental Health System: Final Report*, viewed 25th June 2021, <https://rcvmhs.vic.gov.au/>.

Rubin, A., and Babbie, E. R. 2016. *Empowerment series: Research methods for social work*. Cengage Learning.

Sacks, S., Chaple, M., Sirkantraporn, J., Sacks, J., Knickman, J. and Martinez, J .2012. 'Improving the capability to provide integrated mental health and substance abuse services in a state system of

outpatient care', *Journal of Substance Abuse Treatment*, vol. 44, pp.488-493, doi: 10.1016/j.jsat.2012.11.001

Sacks, S. and Ries, R.K., 2005. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. *Substance Abuse and Mental Health Services Administration*.

Sagoe, D., 2012. Precincts and prospects in the use of focus groups in social and behavioral science research. *Qualitative Report*, *17*, p.29.

Salisbury Statement. 2009. The Salisbury Statement on practice research, http://www.socsci.soton.ac.uk/spring/salisbury/, University of Southampton. Viewed 18th September 2019

Satel, S. and Lilienfeld, S.O., 2014. Addiction and the brain-disease fallacy. *Frontiers in psychiatry*, *4*, p.141.

Schoenfeld, H., 2012. The war on drugs, the politics of crime, and mass incarceration in the United States. *Journal Gender Race and Justice*, *15*, p.315.

Sinha, P., Garg, A. and Prakash, O., 2018. Integrated Treatment For Dual Diagnosis: The Journey So Far. *Malaysian Journal of Psychiatry*, *26*(1), pp.47-51.

Skevington, S.M., Lotfy, M. and O'Connell, K.A., 2004. The World Health Organization's WHOQOL-BREF quality of life assessment: psychometric properties and results of the international field trial. A report from the WHOQOL group. *Quality of life Research*, *13*(2), pp.299-310.

Spencer, C., Castle, D., and Michie, P.T. 2002. 'Motivations that maintain substance use among individuals with psychotic disorders', *Schizophrenia bulletin*, vol. 28, no. 2, pp.233-247.

Staiger, P.K., Thomas, A.C., Ricciardelli, L.A., Mccabe, M.P., Cross, W. and Young, G., 2011. Improving services for individuals with a dual diagnosis: A qualitative study reporting on the views of service users. *Addiction research & theory*, *19*(1), pp.47-55.

Substance Abuse and Mental Health Services Administration [SAMHSA]. 2002. *Report to Congress on the prevention and treatment of co-occurring substance abuse and mental disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA) - US Department of Health and Human Services.

Sung, H.E., Mellow, J. and Mahoney, A.M., 2010. Jail inmates with co-occurring mental health and substance use problems: Correlates and service needs. *Journal of Offender Rehabilitation*, *49*(2), pp.126-145.

Talbott, J.A., 2004. Deinstitutionalization: Avoiding the disasters of the past. *Psychiatric services*, *55*(10), pp.1112-1115.

Teesson, M., and Burns, L. (Eds.). 2001. *National Drug Strategy and National Mental Health Strategy, National Comorbidity Project*. Canberra: Commonwealth Department of Health and Aged Care.

Teeson, M. and Proudfoot, H. 2003. *Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment*. National Drug and Alcohol Research Centre (NDARC), University of New South Wales, Australia.

Thornicroft, G., Mehta, N., Brohan, E. and Kassam, A., 2010. Stigma and discrimination. *Principles of Social Psychiatry*, pp.331-340.

Tsemberis, S., Gulcur, L. and Nakae, M., 2004. Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American journal of public health*, *94*(4), pp.651-656.

Vakharia, S.P. and Little, J., 2017. Starting where the client is: Harm reduction guidelines for clinical social work practice. *Clinical Social Work Journal*, *45*(1), pp.65-76.

Van Boekel, L.C., Brouwers, E.P., van Weeghel, J. and Garretsen, H.F., 2015. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Tijdschrift voor psychiatrie*, *57*(7), pp.489-497.

Verghese A. (2008). Spirituality and mental health. *Indian journal of psychiatry*, *50*(4), 233–237. https://doi.org/10.4103/0019-5545.44742

Volkow, N.D., 2001. Drug abuse and mental illness: progress in understanding comorbidity. *American Journal of Psychiatry*, *158*(8), pp.1181-1183.

Webb-Robins, L.M., 2004. Bringing integrated treatment for co-occurring disorders to life. *Behavioral Healthcare Tomorrow*, *13*(5), pp.19-24.

Weiss, R.D., Najavits, L.M. and Hennessy, G., 1998. Overview of treatment modalities for dual diagnosis patients. *Dual diagnosis and treatment: substance abuse and comorbid medical and psychiatric disorers, New York: Dekker*, pp.87-105.

Westermeyer, J., 2005. Historical and social context of psychoactive substance use disorders. *Clinical textbook of addictive disorders*, *3*, pp.16-34.

White, W.L. and Miller, W.R., 2007. The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, *8*(4), pp.12-30.

Wilkinson, S., 2015. Focus groups. *Qualitative psychology: a practical guide to research methods. 3rd ed. London: SAGE Publications Ltd*, pp.199-221.

Williams, T.M. and Smith, G.P., 2014. Can the National Disability Insurance Scheme work for mental health?. *Australian & New Zealand Journal of Psychiatry*, *48*(5), pp.391-394.

Wodak, A., 1995. Harm reduction: Australia as a case study. *Bulletin of the New York Academy of Medicine*, *72*(2), p.339.

Woody, G., 1996. The challenge of dual diagnosis. *Alcohol Health and Research World*, *20*(2), p.76

Worley J 2017, 'Recovery in Substance Use Disorders: What to Know to Inform Practice', *Issues in Mental Health Nursing*, vol. 38, no. 1

Ye, J., Chen, T.F., Paul, D., McCahon, R., Shankar, S., Rosen, A. and O'Reilly, C.L., 2016. Stigma and discrimination experienced by people living with severe and persistent mental illness in assertive community treatment settings. *International Journal of Social Psychiatry*, *62*(6), pp.532-541.

Young J, H. E. (2018). Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study. Lancet Public Health., e237-e248.

Zinberg, N., E. (1984) Drug, Set and Setting: The Basis for Controlled Intoxicant Use. *New Haven, CT*.

List of Appendices

Appendix 1

Reasons for Use Package Evaluation Neami National (RFUPE)

Staff Participant Information (Plain Language Statement)

Please read this Participant Information carefully and discuss any questions with the investigator.

Chief Investigators' names – Nexus Dual Diagnosis Service:
Simon Kroes Ph: 03 9231 3804
simon.kroes@svhm.org.au
Kevan Myers Ph: 03 9231 2375
kevan.myers@svhm.org.au

Associate Investigators' names – Neami National:
Adam Zimmermann, Kerry Stringer
Phone : 03 9481 3277
adam.zimmermann@neaminational.org.au

Purpose and Background

The aim of the study is to investigate staff participants' knowledge and confidence in dual diagnosis interventions.

Procedures

If you agree to take part in this project you will be asked to:

- Complete questionnaires at three times points which should take 30 minutes duration in total.
- You may be asked to participate in training and mentoring around dual diagnosis interventions.

Possible Benefits

It is likely that you will benefit from an opportunity to evaluate confidence and knowledge in dual diagnosis work and to reflect on improvement and challenges in a supportive manner.

Possible Risks

There is no foreseen inconvenience and/or discomfort to the participant.
This is a low risk research activity; inclusive of an opt-out clause should participants choose at any time to discontinue involvement.

Privacy, Confidentiality and Disclosure of Information

If you agree to participate in the project (by signing the Staff Participant Consent Form) any information you provide will remain confidential. In all reports or publications, responses by individuals will be de-identified. During the project, and for seven years after, all related information will be kept in a secure office at Nexus Dual Diagnosis Service.

Participation is Voluntary

Participation in this research project is voluntary. If you decide to take part and later change your mind, you are free to withdraw at any stage. Your decision will not affect participant relationship with Neami National nor with Nexus Dual Diagnosis Service.

Further Information or Any Problems

If you require further information, or if you have any problems concerning this project, please contact the Nexus Dual Diagnosis Service Manager, Chris Hynan, on (03) 9288 2353.

Appendix 2

Reasons for Use Package Evaluation Neami National (RFUPE)
STAFF PARTICIPANT CONSENT FORM

Name of participant: _____

1. I consent to participate in this evaluation project. I have read the Plain Language Statement and the details have been explained to me

2. I understand that after I sign and return this consent form it will be securely stored by the evaluation team

3. I understand that my participation will involve me completing three questionnaires**.** I agree that the evaluation team may use the results as described in the plain language statement.

4. I acknowledge that:

   (a) The possible effects of participating in the research have been explained to my satisfaction;

   (b) I have been informed that I am free to withdraw from the project at any time. I do not have to give an explanation and it will not affect ongoing care in any way. I can also withdraw any unprocessed data that I have provided;

   (c) The project is for the purpose of service improvement;

   (d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;

   (e) I have been informed that all the information I have provided will be stored confidentially at Nexus Dual Diagnosis Service and will be destroyed after seven years;

   (f) In any publications arising from the quality assurance project the data will be de-identified.

I consent to provide data through completion of three questionnaires □ **yes** □ **no**
(Please tick)

Participant signature: Date: / /2014

Appendix 3

Staff Participant
Reasons for Use Package Evaluation Neami National Questionnaire

1. Please tick to indicate which state you're based in:
Victoria [ ] NSW [ ]

2. Please tick to indicate at which time point this form is being completed.

[ ] Baseline [ ] 3 Months [ ] 6 months

3. I am <u>confident</u> about dual diagnosis strategies for coping with positive symptoms e.g. delusions, hallucinations

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

4. I am <u>knowledgeable</u> about dual diagnosis strategies for coping with positive symptoms e.g. delusions, hallucinations

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

5. I am <u>confident</u> about dual diagnosis strategies for how to manage medication side effects

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

6. I am knowledgeable about dual diagnosis strategies for how to manage medication side effects

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

7. I am confident about dual diagnosis strategies for managing drug use related to social situations

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

8. I am knowledgeable about dual diagnosis strategies for managing drug use related to social situations

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

9. I am confident about dual diagnosis strategies for managing drug use related to peer pressure

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

10. I am knowledgeable about dual diagnosis strategies for managing drug use related to peer pressure

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

11. I am confident about dual diagnosis strategies for coping with unpleasant affect i.e. low mood, distress, anxiety

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

12. I am knowledgeable about dual diagnosis strategies for coping with unpleasant affect i.e. low mood, distress, anxiety

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

13. I am confident about dual diagnosis strategies for managing drug use when it is perceived as a positive activity, e.g. enhancement

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

14. I am knowledgeable about dual diagnosis strategies for managing drug use when it is perceived as a positive activity, e.g. enhancement

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly Disagree

Appendix 4

Reasons for Use Package Evaluation Neami National (RFUPE)

Consumer Participant Information (Plain Language Statement)

Please read this Participant Information carefully and discuss any questions with the investigator.

Chief Investigators' names – Nexus Dual Diagnosis Service:
Simon Kroes Ph: 03 9231 3804
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Kevan Myers Ph: 03 9231 2375
kevan.myers@svhm.org.au

Associate Investigators' names – Neami National:
Adam Zimmermann, Kerry Stringer
Phone : 03 9481 3277
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adam.zimmermann@neaminational.org.au

Purpose and Background

The aim of the study is to investigate staff participants' knowledge and confidence in dual diagnosis interventions after training and mentoring in the Reasons for Use Package. As part of the evaluation of the package, consumers who have been involved are given the opportunity to give feedback following their experience of the Reasons for Use Package.

Procedures

If you agree to take part in this project you will be asked to:

- Complete a questionnaire which should take 10 minutes duration.

Possible Benefits

It is likely that you will benefit from an opportunity to discuss dual diagnosis issues with your worker in a supportive manner which may lead to improved treatment planning.

Possible Risks

There is no foreseen inconvenience and/or discomfort to the participant.
This is a low risk research activity; inclusive of an opt-out clause should participants choose at any time to discontinue involvement.

Privacy, Confidentiality and Disclosure of Information

If you agree to participate in the project (by signing the Consumer Participant Consent Form) any information you provide will remain confidential. In all reports or publications, responses by individuals will be de-identified. During the project, and for seven years after, all related information will be kept in a secure office at Nexus Dual Diagnosis Service.

Participation is Voluntary

Participation in this research project is voluntary. If you decide to take part and later change your mind, you are free to withdraw at any stage. Your decision will not affect participant relationship with Neami National nor with Nexus Dual Diagnosis Service.

Further Information or Any Problems

If you require further information, or if you have any problems concerning this project, please contact the Nexus Dual Diagnosis Service Manager, Chris Hynan, on (03) 9288 2353.

Appendix 5

Reasons for Use Package Evaluation Neami National (RFUPE)
PARTICIPANT CONSUMER CONSENT FORM

Name of participant: _____

5. I consent to participate in this evaluation project. I have read the Consumer Participant Plain Language Statement and the details have been explained to me

6. I understand that after I sign and return this consent form it will be securely stored by the evaluation team

7. I understand that my participation will involve me completing a questionnaire**.** I agree that the evaluation team may use the results as described in the plain language statement.

8. I acknowledge that:

   (a) The possible effects of participating in the research have been explained to my satisfaction;

   (b) I have been informed that I am free to withdraw from the project at any time. I do not have to give an explanation and it will not affect ongoing care in any way. I can also withdraw any unprocessed data that I have provided;

   (c) The project is for the purpose of service improvement;

   (d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;

   (e) I have been informed that all the information I have provided will be stored confidentially at Nexus Dual Diagnosis Service and will be destroyed after seven years;

   (f) In any publications arising from the quality assurance project the data will be de-identified.

I consent to provide data through completion of a questionnaire □ **yes** □ **no**
(Please tick)

Participant signature: Date: / /2014

Appendix 6

Consumer Participant Reasons for Use Package Evaluation Questionnaire

You have recently been participated in using the Reasons for Use Package with your Neami National Worker. We would like to hear your views and experiences as part of the evaluation of this package. Your answers will be de-identified and will not impact on your current relationship with Neami National.

Please read the following statements in relation to your experience of using the Reasons for Use Package (RFUP) with your worker. Please circle one response per question on the right,	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The process of completing the RFU scale questionnaire was straightforward and didn't take too long.	①	②	③	④	⑤
The process of feeding back the RFU scale results to me was clear.	①	②	③	④	⑤
The RFUP helped me to explore my use of substances.	①	②	③	④	⑤
The RFUP helped me to explore areas of my life in relation to substance use.	①	②	③	④	⑤
	①	②	③	④	⑤

The RFUP helped me and my worker develop goals to work on.					
The RFUP process as a whole felt collaborative.	①	②	③	④	⑤
The RFUP assisted in building rapport between myself and my Neami National worker.	①	②	③	④	⑤
Any additional Comments….					

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE ☺

Appendix 7

neami national
Improving Mental Health and Wellbeing

8 January 2014

Kevan Myers
Senior Clinician Nexus Dual Diagnosis Service
St Vincent's Hospital Melbourne
41 Victoria Parade
Fitzroy 3065

To whom it may concern,

Commencing March 2015 Neami National will undertake an evaluation in conjunction with Nexus, St Vincent's Hospital and Monash University of the Reason for Use Package. As part of this process Neami will share de-identified with Nexus as appropriate.

Yours sincerely,

Merrilee Cox
Manager Service Development

Appendix 8

ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Hospital
(Melbourne) Limited
ABN 22 052 110 756

41 Victoria Parade Fitzroy VIC 3065
PO Box 2900 Fitzroy VIC 3065

Telephone 03 9288 2211
Facsimile 03 9288 3399
www.svhm.org.au

16 March 2015

Kevan Myers
Nexus Dual Diagnosis Service
St Vincent's Hospital (Melbourne)

Dear Kevan Myers,

QA 013/15 - Reasons For Use Package Neami National Evaluation

Thank you for submitting your application for approval of Quality Assurance activity. The Quality Assurance Sub-committee of Human Research Ethics Committee (HREC)-A has approved the above mentioned project as a Quality Assurance activity at the following sites:

1. St Vincent's Hospital (Melbourne)

This approval will be ratified by St Vincent's Hospital (Melbourne) HREC-A at the next meeting.

The project complies with the principles of the *National Statement on the Ethical Conduct of Human Research* (NHMRC; 2007).

Approved documents
The following documents have been reviewed and approved:

Document	Version	Date
Quality Assurance Activity Application	1	23 Feb 2015
Neami National Letter	1	23 Feb 2015

Terms of approval

1. It is the responsibility of the Principal Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as specified in the application.
2. You should notify the Research Governance Unit immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
3. **Amendments to the approved project:** Changes to any aspect of the project require the submission of a Request for Amendment to the Quality Assurance Sub-committee and must not begin without written approval. Substantial variations may require a new application.

4. **Future correspondence:** Please quote the reference number and project title above in any further correspondence.
5. **Final report:** A Final Report must be provided at the conclusion of the project.
6. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by the Research Governance Unit at any time.

We wish you well with your project.

Yours sincerely,

Brenda Ly
Research Directorate Intern
Research Governance Unit
St Vincent's Hospital (Melbourne)

Appendix 9

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Chair of the Monash University Human Research Ethics Committee. The Chair was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number:	**CF15/2948 - 2015001213**
Project Title:	**Reasons for Use Evaluation**
Chief Investigator:	**Dr Melissa Petrakis**
Approved:	**From: 17 August 2015 To: 17 August 2020**

Terms of approval - ***Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.***

1. Approval is only valid whilst you hold a position at Monash University and approval at the primary HREC is current.
2. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
3. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
4. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Professor Nip Thomson
Chair, MUHREC

cc: Ms Rebecca Robinson; Mr Kevan Myers

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Appendix 10

Abstract

The objective of this research was to describe the use and utility of a dual diagnosis assessment scale and intervention strategies package for clinical and community mental health staff to better engage service users and explore reasons for use regarding dual diagnosis issues. A case study was developed, with the service user's consent, to be used to train others in use of the Reasons for Use Package (RFUP). Findings were that the RFUP can enable staff to better tune in to service users in terms of how they are managing symptoms, side effects, social situations, peer pressure, affect and ambivalence. The RFUP helped enable the service user to feel a sense of being listened to and respected with regard to their dual diagnosis experiences. Conclusions drawn were that service users can engage with dual diagnosis assessment more readily when workers use dual diagnosis tools and mentoring purpose-designed to enhance an understanding of motivations and reasons for use of substances.

Keywords: mental health, dual diagnosis, substance use, case study, reasons for use scale, nicotine

https://www.tandfonline.com/doi/full/10.1080/2331205X.2019.1630097

Appendix 11

Rose, C., Myers, K., Kroes, S., Guglielmetti, M. and Hwang, I.D., 2018. *Reasons For Use Package Online https://reasonsforusepackage.com*